

E-Book of Articles



***Music Therapy: A Global Mosaic - Many
Voices, One Song***

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Table of Contents

TABLE OF CONTENTS 2

THE ROLE OF MUSIC THERAPY IN ESTABLISHING CULTURAL IDENTITY IN A MULTI-CULTURAL STATE, NAMELY ISRAEL 6

DORIT AMIR..... 6

ANALOGY AND METAPHOR IN MUSIC THERAPY THEORY- AND THE METAPHORIC NATURE OF GIM..... 25

LARS OLE BONDE 25

THE EDUCATIONAL FORMATION OF THE MUSIC THERAPIST ACCORDING TO BENENZON’S THEORY 57

D’ULISSE M. E..... 57

FOR THE TRAINING OF MUSIC THERAPISTS ACCORDING TO THE METHOD OF PROF. BENENZON 60

D’ULISSE..... 60

MUSIC THERAPY CONDUCTED ON A CHILD WITH INTELLECTUAL DISORDERS AND PSYCHOSIS, WITH SIMULTANEOUS PSYCHOTHERAPY CONDUCTED ON THE PARENTS..... 63

D’ULISSE M.E., GRAZIANI P., POLCARO F. 63

A MUSIC THERAPY PROJECT INVOLVING AN AUTISTIC CHILD AND HIS PARENTS IN AN ATTEMPT TO FIND NEW WAYS OF COMMUNICATING..... 71

M.E.D’ULISSE, FERRARA CARMEN, ARBORIO FULVIO, MONTORI ADRIANA, PICCONI CRISTIANA 71

APPLICATION OF THE BENENZON MUSIC THERAPY TO PATIENTS AFFECTED WITH ESSENTIAL HYPERTENSION..... 76

D’ULISSE, M.E.; FERRARA, C. 76

THE MUSICAL TIME-SPACE, CANNABIS AND THE BRAIN IN AN EEG-MAPPING INVESTIGATION 84

JÖRG FACHNER 84

FORMS OF EXPRESSION IN COMMON TO MOVEMENT AND TO THE PRODUCTION OF SOUND AND MUSIC 103

DR.SSA MARÍA ELENA GARCÍA..... 103

COMING TOGETHER: THE HEALING PROCESS OF MUSIC THERAPY GROUPS 114

TABLE OF CONTENTS

GARY HARA.....	114
THE INFLUENCE OF SOFT MUSIC ON NEWBORNS IN INDONESIA.....	124
JOHANNA NATALIA.....	124
MUSIC THERAPY IN BRAIN INJURY REHABILITATION: A PILOT STUDY:.....	134
SANGEETHA NAYAK.....	134
EFFECTS OF HEALING MUSIC ON ENDOCRINOLOGICAL CHANGES.....	141
MICHIKO NUKI, KAZUHIRO YOSHIUCHI , SHINOBU NOMURA	141
QUALITATIVE RESEARCH.....	154
ALFREDO RAGLIO	154
THE PROCESS OF EVALUATION IN MUSIC THERAPY CLINICAL PRACTICE	176
PATRICIA L. SABBATELLA.....	176
WHEN AGGRESSIVENESS IS DISTURBED.....	194
LONY SCHILTZ-LUDWIG.....	194
MANY VOICES IN ONE: HEALING THE EFFECTS OF COLLECTIVE TRANSGENERATIONAL TRAUMA THROUGH THE BONNY METHOD OF GUIDED IMAGERY AND MUSIC, A GIM CASE STUDY	210
CECILIA H. SCHULBERG	210
BEYOND THE ORDINARY.....	222
JULIE SUTTON	222
PERFORMANCE AND PRODUCT: CLINICAL IMPLICATIONS FOR THE MUSIC THERAPIST.....	246
ALAN TURRY	246
<u>PROCEEDINGS OF THE WMFT COMISSION ON EDUCATION , TRAINNG AND ACCREDITATION</u>.....	264
BARBARA L. WHEELER	264
INTRODUCTORY COMMENTS – SETTING THE SCENE.....	264
ERDONMEZ GROCKE, DENISE.....	264
ENTRY LEVEL STANDARDS FOR MUSIC THERAPY EDUCATION AND CLINICAL TRAINING OF THEAMERICAN MUSIC THERAPY ASSOCIATION (USA).....	267
MARILYN SANDNESS	267

TABLE OF CONTENTS

AMERICAN MUSIC THERAPY ASSOCIATION: STANDARDS FOR EDUCATION AND CLINICAL TRAINING	269
MARILYN SANDNESS	269
NEW DEVELOPMENTS IN MUSIC THERAPY	281
BARBARA HESSER	281
NORDOFF-ROBBINS TRAINING WORLD-WIDE.....	287
HELEN TYLER	287
GERMAN MODELS OF TRAINING	293
MECHTILD JAHN-LANGENBERG	293
SOUTH AMERICAN MODELS OF TRAINING.....	298
MAYRA HUGO.....	298
MUSIC THERAPY TRAINING IN CANADA.....	305
CONNIE ISENBERG-GRZEDA	305
MUSIC THERAPY TRAINING IN THE UNITED KINGDOM.....	311
HELEN ODELL-MILLER.....	311
SCANDINAVIAN MUSIC THERAPY EDUCATION.....	318
TONY WIGRAM	318
MODELS OF MUSIC THERAPY COURSES IN AUSTRALIA AND NEW ZEALAND	324
DENISE ERDONMEZ GROCKE.....	324
MUSIC THERAPY TRAINING PROGRAMS – EUROPE.....	328
CHAVA SEKELES	328
SELF EXPERIENCE FOR MUSIC THERAPY STUDENTS – EXPERIENTIAL TRAINING IN MUSIC THERAPY AS A METHODOLOGY – A COMPULSORY PART OF THE MUSIC THERAPY PROGRAMME AT AALBORG UNIVERSITY	331
INGE NYGAARD PEDERSEN.....	331
TEACHING RESEARCH AT THREE LEVELS OF EDUCATION	342
KENNETH E. BRUSCIA	342
STUDENTS WHO BECOME UNSUITED TO MUSIC THERAPY TRAINING	345
DENISE ERDONMEZ GROCKE.....	345
QUALIFICATIONS OF MUSIC THERAPY EDUCATORS	348
TONY WIGRAM.....	348

TABLE OF CONTENTS

QUALIFICATIONS OF MUSIC THERAPY EDUCATORS OF THE AMERICAN MUSIC THERAPY ASSOCIATION..... 349

 MARILYN SANDNESS 349

QUALIFICATIONS OF MUSIC THERAPY EDUCATORS OF THE CANADIAN ASSOCIATION FOR MUSIC THERAPY 351

 CONNIE ISENBERG-GRZEDA 351

QUALIFICATIONS OF CLINICAL TRAINING SUPERVISORS FOR ENTRY-LEVEL STUDENTS..... 352

WFMT GUIDELINES FOR MUSIC THERAPY EDUCATION AND TRAINING 355

The Role Of Music Therapy In Establishing Cultural Identity In A Multi-Cultural State, Namely Israel

Dorit Amir

In this presentation I will:

1. Describe the issues that are involved in "establishing a cultural identity" in a
2. Multi-cultural state
3. Examine Israel's cultural identity and show its connection to Israeli folksong repertoire
4. Examine the role of music therapy in representing, bringing out and dealing with such issues
5. Discuss my own dilemmas as a clinician and as a head of a music therapy program in regard to these issues

In order to illustrate these points, I will bring examples from my clinical work and my music therapy-training program. I will conclude with my own feelings about establishing a cultural identity in Israel.

1. What are the issues involved in "establishing a cultural identity" in a multi cultural state?

Cultural identity and mental health are closely related. Needless to say, I am going to examine the issues involved in establishing a cultural identity as they are related to issues of health and quality of life, since improving health and quality of life are my main concern as a music therapist. By multi-cultural I mean various ethnic, religious, political, social and special sub-cultures that exist in the same place.

Ruth Bright, in her book: Grief and Powerlessness, helping people regain control of their lives talks about grief over cultural losses themselves and change of old living styles. She asks the following questions:

“How far can old traditions be maintained in the face of increasing urbanization and the opening up of travel networks so that remote areas are remote no longer and modern technology changes patterns of living?”

Should migrants and refugees be encouraged to keep their old traditions and language or be encouraged to assimilate?

Does the idea of separate cultural identity contribute to conflict with the population of the host country?

How much do we lose of cultural diversity in world terms if we insist upon assimilation and the adoption of the culture of the new homeland? And, anyway, can we insist on assimilation? Will it happen?

How will people ever adapt to their new way of life if they strictly maintain their original tongue, their old customs, old ways of thinking? Does it matter if they do not adapt at all?

If the parents and grandparents maintain the old ways, will this cause conflict with their children whom, because of school life and contacts with their local peers, adapt to the new language, the new customs?

These are, indeed, crucial issues. I would like to sum it up and form in into one question: in order to have a cultural identity, does a culture or an individual need to "forget" his/her/its roots and completely adopt the new identity? Another words, does past tradition have to be preserved or rejected?

I also want to add another question that has to be taken into consideration while discussing cultural identity: What is the right balance between "personal identity" and "cultural identity"?

2. Examining Israel's cultural identity as mirrored by Israeli folksong repertoire

For Israel, being a predominantly immigrant state, the concept of cultural identity has been a complex one. 50 years ago, when the state of Israel was born, the "Israeli identity" was very clear: it was "Hebrew culture", Zionist in spirit. After the holocaust, Jews from all over the world came to Palestine. The main goal was to build this country and to make it the home of the exiles. The kibbutzim that were built were unique to Israel and

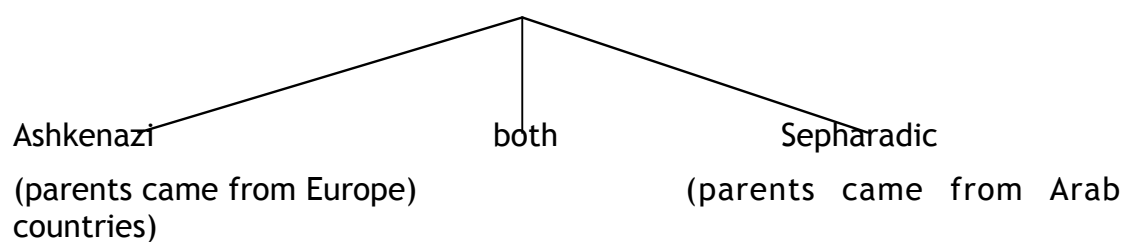
mirrored this idealistic and Zionist trend. There are songs that belong to this period in the nation's history; songs that talk about these themes. Many of the melodies, as we can hear, are march like, giving musical encouragement to the hard work of building the country.

When the goal of building the country was accomplished and it, indeed, became the home of the exiles, the Israeli identity, that has always consisted of many cultures, started to change. In the last 20 years, it became a multi-cultural identity that has been effected by the political, geographical, immigration and religious aspects. Various ethnic groups that were united around these ideals and tasks, started to pay more attention to life itself and deal with other issues. Even though these ideals haven't lost their influence, these cultures were no longer living together in harmony, and the contemporary Israeli society is in the process of becoming a very torn and split society:

Table I : The population of Israel a wide array of ethnic groups, religions and cultures

In my music therapy training program I have:

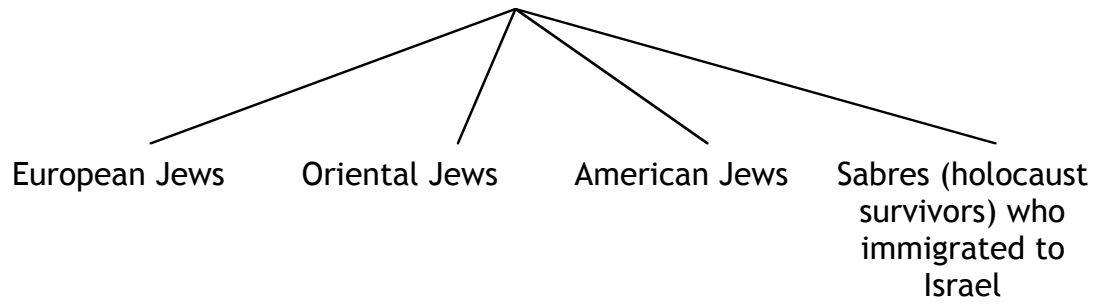
native born Israelis (Sabres)



new immigrants
from the former Soviet Union and America.

In my practice I work with:

Jews with different cultural backgrounds:



As a supervisor, I supervise:

An Arab music therapist

Jewish music therapists who work with:
Arabs, Ethiopians, very religious Jews,
Russians

There are Jews and Arabs, who have been in conflict ever since the country was born. The Jews come from different cultural backgrounds: European Jews (some of them are holocaust survivors), Oriental-Sepharadic Jews, who till this day feel somewhat rejected in the Israeli society, American Jews who immigrated to Israel and Sabres - native born Israelis, some of them are Ashkenazi (meaning their parents came from Europe), some are Sepharadic (meaning their parents came from Arab countries), and some are both.

In the last 30 years new immigrants from the former Soviet Union and Ethiopia came to the country and have had adjustment problems in all aspects of living. There are additional problems and conflicts between generations. In a predominantly immigrant state, there is conflict not only among the various ethnic groups but also between generations when parents and grandparents want to keep the old ways and their children and grandchildren want the greater freedom generally open to their school friends and contemporaries who were born in the new country. As Bright points out, conflict arise even for those children of migrants who were born in the new country while their parents "adhere closely to the ways of the past" (p. 87). More than that, the children learn quickly Hebrew, and then, the weigh of responsibility moves to their back. They don't want to cause pain to their parents. They listen to what people are saying about the new immigrants, they see what is written in the municipality's letters to their parents, and they decide what to tell their parents and what not to tell. They take upon themselves the functions of adults, and it goes to their heart and stops there". (Igaal Sarena, Yediot Achronot, Friday, July 9th, 1999). "'To be immigrant is a weak place', said the father of a Russian soldier in the Israeli army who committed suicide, in an interview with an Israeli journalist. He confirmed what the journalist knew already: that the removal and the replanting are breaking points. Some pass the crisis and get stronger, others crush and get lost.

There are various religious groups, who are conflicted within themselves and also do not live in harmony with each other: The group of extremely Orthodox Jews that has its own inner conflicts, the gush emunim group - religious Jews who are politically located in the extreme right wing and

occupy the settlements in the west bank (Jews who will not give up the land that they think belong to the Jews), Jews who keep their tradition but who are not considering themselves religious and go against the religious groups, etc. In addition, due to Israel's constant struggle to survive and constant being in a war state, there are sub-cultures that are unique to the state of Israel, and go across all ethnic groups mentioned above. I am talking about war widows, families who are bereaved of offspring and families who lost their loved ones in wars and in terrorist attacks, each of them present a personal, yet a national tragedy

Carlo Strenger, a philosopher and psychotherapist, who was born in Switzerland and immigrated to Israel, who came from a religious family and later on rejected this tradition, describes the Israeli society as being "in a critical point: the main stream is towards openness and pluralism, but the forces that need historical certainties are still strong, and there are many reasons for that. Israel, during its most years, has lived under threat, and as such it needs high unity around mutual ideals. A second reason is that the struggle on the representation of the Israeli society is in its midst. Most of the population don't trust that various life styles, belief and value systems can exist side by side without pushing one of the groups to the edge of society or completely deny its right to exist. This social tendency is reflected in the individual experience of many Israelis. Every time, says Strenger, I am newly impressed how much the fear of being abnormal haunts people, until they can't even ask the question of who are they and what is their real will. Instead, they try to imitate collective successful models instead of searching for authentic individuality" (Strenger, 1999, p. 9).

Israeli folksongs (SLI - Songs of the Land of Israel) play a special role in contemporary Israeli culture and serve many functions in Modern Hebrew culture. The functions are context-related. When sung at "*Shira Betzibur*" gatherings (communal singing), SLI function as entertainment, creating a sense of "togetherness" and a special joyous atmosphere. On Independence Day, SLI represent feelings of victory, heroism, national pride, military strength and camaraderie. When heard on the radio in the context of regular programs,

these songs often arouse feelings of nostalgia and provide a sense of belonging and connection to the land of Israel. Singing Israeli folksongs also serves as a substitute for prayer and keeps the spirit of the nation alive.

I would like to give several examples of the role of Israeli folksongs in the Israeli culture:

Prior to and during the Gulf War crisis in Israel, Israeli radio broadcasted folksongs. The songs served to instill feelings of emotional strength and national unity and to assist the entire population in developing more adaptive methods to cope with the stress of living in sealed rooms (Brotsky 1991:110).

Radio stations play a special song repertoire on two dates on the Israeli calendar: *Yom Hazikaron Lashoa Velagvura* (Remembrance Day, which commemorates the genocide of six million Jews in the Holocaust) and *Yom Hazikaron Lechalalei Zahal* (Memorial Day for all Israeli soldiers killed during the Israeli-Arab wars). All songs played on these days are sung in Hebrew. These songs are part of SLI, and we will call them *shirei zikaron* (memorial songs). Both their verbal and nonverbal contents describe national unity, important events in Jewish and Israeli history, places and landscapes in Israel, heroic people, loss and longing, nature and love. These songs are very emotional and sad; they are associated with these specific dates and touch the pain of losing loved ones (Eliram, 1995:103). When heard on these dates, *shirei zikaron* create a special atmosphere and give a feeling of belonging and togetherness.

Shirei zikaron are also broadcasted whenever a nationwide tragedy occurs. For example, in the immediate aftermath of the 1994 terrorist bombing of Bus Number 5 in Tel-Aviv and of the 1995 bomb attack at the Beit-Lid intersection, radio stations changed their regular programming and broadcasted *Shirei zikaron* in between news reports. In fact, whenever Israelis hear these songs on the radio, they intuitively know that a tragedy has occurred.

In our days, there are songs that represent the tear in our society. Shir Lashalom is such a song for me. It was sung on November 4th, 1995, the day when Prime Minister Itzhak Rabin was murdered. Towards the close of the peace rally held on the night of Rabin's murder (a peace rally that was organized by the Labor party during which thousands participated in saying "yes to peace"), the Israeli singer Miri Aloni sang "Song for Peace." Prime

Minister Rabin, Minister of Foreign Affairs Shimon Peres and thousands of others joined her in singing. It was a moment of unity, hope and awe. A few minutes after singing the song, Rabin was murdered, and in his pocket was the text for "Song for Peace," stained with his blood. Since then, this song has been sung endless times and has now emerged as a symbol of this tragedy. It symbolizes mourning for the man who led the country towards peace, and at the same time represents the mission that must be continued: keeping up the peace process in order to ensure a better future. The song has become both the symbol of the tear in our society and the symbol for hope.

3. What is the role of music therapy in representing, bringing out and dealing with such issues?

The Diaspora, the holocaust, the immigration to Israel in all of its meanings, the pain of belonging to the North Africa ethnic group in the modern Israeli society, being a war widow and losing a family member in wars and terrorist attacks - all of these have been central elements in my clients' and students' life stories and in the structure of their psyche.

There are students and clients who tend to preserve their tradition. Their parents' traditions become a source of comfort, pride and confidence. For example, in times of discomfort, pressure or personal crisis, the natural thing for my students or clients who are new immigrants from the former Soviet Union is to go back to their native language - Russian, and to sing Russian songs from their childhood.

There are others, who have rejected their tradition, and will not speak Russian or sing Russian songs because they don't want to emphasize a feeling of being strange, foreigner and even ashamed. They want to erase any sign of their past in order to become "assimilated" into being an Israeli. Examples of that are students who present themselves musically only with music that they identify with an Israeli identity, or songs in English that can be identified with liberation and being a cosmopolitan, a worldly citizen.

Here is an example. Ana is a 22-year-old MT student who immigrated to Israel from Russia 5 years before enrolling in the program. Her Hebrew is quite good, and she has almost no foreign accent at all. She is a very talented classical

pianist and quite a good improviser. She also has a very lovely voice, and loves to sing. Her musical presentation at the beginning of the program consisted of classical music and no songs at all. When the students questioned her about that, she said that she does not want to sing Russian songs because she feels embarrassed, and she can't sing any songs in Hebrew because she is not familiar with those yet. The group decided to sing for Ana a Russian song in Hebrew, and Ana smiled, because she knew the song. The group then encouraged her to sing this song in Russian. She sang the song while the whole group was humming the melody. It was a very beautiful experience of welcoming her. Later on, while doing her internship, she had to learn many Israeli songs that her clients wanted her to sing and play with them. For her, being a part of the music therapy program and having to learn a big repertoire of Israeli songs speeded up her process of being an integral part of the Israeli culture.

Singing Israeli folksongs in my music therapy groups have become many times a mirror to the tension connected to complicated issues of the Israeli society. Specific Israeli folksongs have become political symbols. Such songs are being identified with left or right wing and elicit strong positive or negative feelings and emotions to these songs, depending upon my clients' political opinions. Specific folksongs that are closely identified with religion and nationalism bring up powerful, sometimes negative associations by certain clients. Singing these songs sometimes causes arguments among members that bring up the tension between religious and non-religious people in Israel. The tension and strong feelings and emotions around the songs are being expressed in very heated discussions among clients in these groups after the singing ritual. Political discussions that we experience so often in our lives enter the therapy room and can become very intense. The songs open the door and bring issues we all have in common from the very fact that we all live in a small country that struggles for peace, identity, meaning and life quality.

Here is an example. Bar Ilan University is the only religious university in the country, and therefore, many of the students are religious, though not all of them. In my program it is app. 50%. Among the religious ones, some are more

religious than others, and among the non religious there are students who are traditional (keep Kosher homes, go to the synagogue on the high holidays, etc.), and there are students who don't have anything to do with religion.

Rosi is a religious student who lives in a Jewish settlement in Judea and Samaria (the West Bank), and culturally - in her principles, ideas, behavior and belief system she belongs to the right wing organization - "Gush Emunim", the people of "the complete, whole Eretz Israel". Their belief system is that the West Bank is an integral piece of the land of Israel, belongs to the Jews who have lived there since the time of the Bible; It was released in the six days war and it is the Jews' right to live there.

Rosi's presentation consisted mostly of Israeli songs, some of them religious songs that are identified with the settlers in the occupied territories. I found myself having a very strong reaction to this presentation. Some of the hasidic* songs gave me a very spiritual feeling and yet, the more the presentation continued, the more I found myself feeling angry and upset. I felt that I don't like this person because of her total immersion and identification with the right wing religious culture, the culture that I totally disagree with its ideas and its deeds evoke strong angry feelings within me. I felt that I could not find Rosi, as an individual, unique human being through the presentation. Group members had mixed feelings about Rosi's presentation. Several group members said that they couldn't relate at all to this presentation due to its heavy religious and right wing song repertoire, some shared that even though they have a similar belief system, they could not identify with Rosi. They felt as if she lost and even erased her individual identity for the cultural identity, and that started a very heated discussion. The group then became microcosms of the torn and split Israeli society. I focused the discussion on questions like: what is the "right" balance between "personal identity" and "cultural identity"? what happens if the two are extremely unbalanced? Maybe the work with Rosi will be around this theme. Maybe, as the group continues its path, Rosi will be able to open herself up to other types of songs, develop a more personal taste by listening to other presentations, learning new songs and remembering songs from her childhood.

Rosi needed to find her own authentic voice before she could become a music therapist who can work with various ethnic groups. She had to learn to be open and tolerant to other individuals. And me too. I had to work very hard on my inner staff and my countertransference issues with Rosi. It was very difficult yet challenging, for both of us. Unfortunately, at the end of the program she still couldn't find herself in this group and felt rejected by me and by the group.

In this example we could see how Israeli folksongs could become the symbol of extremism and fanaticism and enlarge the gap among sub-cultures of religious and non-religious Jews, between right wing and left wing Israelis. Some of my students or clients consciously or unconsciously choose not to sing Israeli folksongs. They prefer to sing other musical styles that appeal to them and they can identify with. Refusing to sing Israeli folksongs can be understood as a rebellion against nationalism, protest against what is going on in the country in terms of political and cultural tension, and as an act of anti patriotism, a declaration of being a citizen of the world.

Many times, the individual identity mixes with the cultural identity and they become inseparable. In various treatments singing Israeli folksongs reveals hidden feelings that relate to the history of the country and its constant struggle for survival. Touching the pain and processing it through singing give room for inner freedom, followed by a new awareness and understanding that strengthen the clients and allow them to make meaningful changes in their life.

Here is an example from my clinical work. The women's music therapy group comprises eight women, all of whom have lost a husband or a child. Five women lost their husbands in wars or terrorist attacks. The other three lost children; one child was killed in a car accident and two died from cancer. Five of the women were born in Europe (Germany, Russia and Poland) and three in Israel. Their ages range from 35 to 55 years of age. For two years, the group met once a week for two hours.

In this music therapy group, we established an opening ritual: at every session, one participant would bring a song that was significant to her, and the whole group sang the song together. This ritual served two purposes: firstly,

the creation of an atmosphere of togetherness and intimacy within the group; secondly, the establishment of the emotional tone of the group's here and now. Group singing created a framework within which clients felt protected and secure in working through important personal issues. It also served as an overture for group discussion and verbal processing of emerging issues and as preparation for further musical processing of the group member who brought the song. This ritual often became the most powerful experience in the group, either for the member who brought the song or for other members.

The women generally selected Israeli folksongs. The repertoire consisted of Russian songs, Yiddish songs, songs from the Bible and Hasidic songs, all sung in Hebrew. In this group, songs became symbols of different periods in life, through which clients remembered and re-experienced specific events and significant people. The selected songs often helped clients express feelings that they could not say in words or otherwise repressed. From this group I chose to focus on Sonia.

A 45-year-old native Israeli, Sonia is a child of Holocaust survivors. She grew up in a kibbutz, met her husband in high school, married when she was 20 and raised two children. Sonia's husband was killed in battle on the second day of the 1973 Yom Kippur War. At the time of her husband's death, Sonia was 28 years old, left with a five-year-old daughter and a three-year-old son. Sonia raised the children by herself and never remarried. In the initial interview, she told me that she has been quite depressed over the years and could not make any meaningful changes in her life. Now that the children have grown up, she feels even more lonely and isolated. She wants to meet new people, but lacks the energy to socialize.

In the group, Sonia usually remained quiet. She sang some of the songs in a very quiet voice and only occasionally participated in group discussions. When her turn came to sing her song, she told the group she couldn't decide between two songs. The first song was "*Shuva Elai*" (Return to Me), written by A. Etinger and J. Hadar.

The melody is written in A minor and has a ballad-like style. The text includes the words: "The lights went out again and the voice of my horse lost in the sand is still ringing. Return to me from the desert and together we shall gallop

away.” The second song was entitled “*Halicha Le’caesaria*” (Going to Caesaria), written by C. Senesh and D. Zehavi, and is also written in A minor. A prayer to God, the song expresses the wish that the sand, the sea, the rush of the waters, the crash of the heavens, and the prayers of man will endure for eternity. Chana Senesh, who wrote the words, was a Jewish parachutist who was killed by the Nazis in World War II. The group felt sadness and longing while singing these songs. In the discussion, some members felt that Sonia still lives in the past. She is still waiting for her husband to come back and refuses to go on with her life. The group felt that both songs convey a powerful message concerning Sonia’s attitude: “I want things to be the way they used to be, to stay as they were, never to end, never to change.” The two songs and the connection between them made Sonia realize that she had been refusing to acknowledge reality or change. Sonia told the group that even though more than 20 years have passed since her husband’s death, she still keeps his clothes and other personal things the way had he left them. Sonia realized that by keeping him so “alive” in her life, she could not end the grieving. She therefore was unable to go on with her life and meet other men. At the end of the discussion, I asked Sonia to sing “*Halicha Le’caesaria*” again. This time she sang in a loud voice and with the intent of using the song as a prayer—a prayer for the courage to change the things she can in her life. Sonia transformed the song into a song of hope, singing it with new energy and strength. This was a very different experience for all those who participated.

In the women’s group, singing folksongs in music therapy can be seen as a bridge between the individual identity and the cultural identity. Singing Israeli folksongs can be seen as a bridge that connect all women and go across among all the sub cultures. Sonia’s first song (“return to me”) became the symbol for Sonia’s stuckness in the past, yet singing it together with the whole group gave room for emotional expression of the pain of grief, thus increasing a sense of inner freedom. Sonia’s second song (“going to Caesaria”) brought her memories and pictures back from her family of origin. This song helped Sonia and other members in the group share and deal with issues concerning the holocaust, a most traumatic event that influenced so many Israelis. Here, again, we can see how the individual

history is so connected to the history of the Jewish people. The holocaust affected almost everybody in one way or another, but mainly remains repressed. People usually go on with their lives and do not talk about it. The song opened the subject and allowed the participants to share their experiences concerning the holocaust.

The second time Sonia sang the song "going to Caesaria" she transformed it into a song of hope. She sang the song with new energy and strength, and this time it became the symbol of the future, of courage, of change, of peace and joy. Not only for her, but for the whole group, and maybe for the whole nation. This memory, that could now be stored as a picture in Sonia's and all the other women's imagery album might be able to help in dealing with difficult times in the future.

Some of my students and clients are caught between the past and the present tradition, and thus feel lost, as they do not know how to behave or express their feelings in an appropriate manner (Palgi 1974). I can see it especially with students and clients who come from homes where there is no direct expression of emotions and feelings and no dealing with conflicts, yet, in therapy they are being asked to show their feelings and emotions and deal with intra and inter-personal conflicts.

Dina, another client of mine, whom I see individually, is a 45-year-old woman, is married and has two children, a 10-year-old girl and 6-year-old boy. Dina lives in a nice apartment in the large city where she works as an architect for a construction company. She works diligently and is considered to be one of the best architects in her company. People respect her and she is highly appreciated among her colleagues. Dina's husband is also an architect.

In her initial interview, Dina told me that for the past two years she had not been well. She had been suffering from constant headaches and fatigue, and after returning from work each day, she could no longer move. She went to bed early but awakened tired. Dina took all the necessary physiological tests; the results indicated no pathological conditions. She told me that she felt tense and unable to control her temper toward her children and colleagues.

When I asked her in one of our music therapy sessions. "How do you feel today?" she replied, "I don't know. There is an inner chaos, as usual." I asked her to close her eyes, to breathe, and to inhale each breath deeper than the previous one. After a few minutes, I asked her to listen to what was happening inside her. "I feel many streams storming inside me and I hear a cacophony of sounds: loud and soft, long and short, high and low, coming and blending with one another...." I asked if she could try to recreate the cacophony of sounds that she heard in her inner world using musical instruments. Dina chose a variety of instruments: bongos, two maracas, wind chimes, two drums, Tibetan bells, a kazoo and whistles. She placed the instruments near her on the carpet and tried to play several instruments simultaneously. With the kazoo in her mouth, she made shrieking sounds like sirens. In one hand she held two maracas, shook them strongly and occasionally hit them on the bongos. In her other hand, she shook the Tibetan bells and created fast and loud sounds. After a few minutes she put the maracas and the bells on the carpet and created metal chaotic sounds with the wind chimes. The improvisation lasted ten minutes. As I listened to the music, I felt myself shrinking inside, as though my ears asked me to protect them. Suddenly I felt fear and imagined I was on a battlefield with wounded and dead soldiers, sirens shrieking, bullets flying, and bombs exploding around me. I started to hum to myself an Israeli song that came to my mind. The song was: hyacinth song. I started to hum it very quietly and then, while Dina's improvisation quieted down and ended, she joined me and we sang the song together.

Dina started to cry. "It is scary, but this is exactly what is going on inside me," she said, and thanked me for soothing her with a song she loves. She wondered how did I know to choose this particular song. I said that this song calms me down and I sing it whenever I need to be soothed. The session ended.

Later on I wondered what happened to me in this particular session. It brought me back to two personal experiences I had: one had to do with the six days war in 1967, when I was in junior high school. It brought me back to the sudden moment we heard that the war started. I felt very scared and confused, and I started whistling the hyacinth song. The other one was the

memory of a feeling I had during the 1973 Yom Kippur War. I was then 22 years old, a student in the university, who 2 years ago finished my service in the army, sitting in the shelter and listening to the radio reports from the battlefields. The feeling was a horrible one. It seemed that even though no one said it out loud, the rumors were that we were losing the war and that many of our soldiers got killed. I knew that many of my friends are in combat and I was extremely worried, sitting there with high anxiety and a feeling of total helplessness. There, in the shelter, I sang this song in order to calm myself down. This is a song that my father used to sing to me when I was a little girl. My father died when I was 14 years old. To this day, one of the most vivid memories I have from my childhood is having my father singing to me Yiddish and Russian songs. He had a beautiful voice and loved to sing. Two of the songs he sang to me, and this is one of them, have been very meaningful in dealing with the loss of my father and other losses in my life. It soothes me and symbolizes for me a parental caring, a love and warmth between a father and his little daughter, a feeling that I cherish and miss till this day.

In the following session I asked Dina to talk about her experience in the last session. Dina said that she felt that she let herself express in an authentic and powerful manner her difficult feelings concerning her marital crisis. She told me that her husband has slowly started to withdraw from her. She felt that he has lost interest in her both physically and as a friend and partner. Even though they were living under the same roof, they were living apart from each other. She felt as though he did not love her anymore and had no idea why not. "We don't talk about these things." I had a suspicion that the music she made presented more than her present situation with her husband. I asked her if she has some other things that she does not talk about, and she could not say. I, then, shared with Dina my sensations and the image I had while listening to her music. I asked her where she was during the two wars, and it turned out that during the six days war she lost her fiancé, who was killed in the Sinai. We were both stunned by that. I never heard about it before and she told me that she completely blocked this experience out of her memory.

4. What are my own dilemmas and thoughts as a clinician and as a head of a music therapy program in regard to these issues?

In my music therapy clinical work and training program, singing serves as a main contributing force to the creation of the "Israeli identity" that, for a moment, overshadows all ethnic variations and cultural conflicts. We saw that with Ana, the Russian student, when the group sang for her the song. Yet, Ana chose to reject her past in order to feel a sense of belonging. She thought that in order to feel part of the Israeli society, she needs to forget her roots and completely adopt the new identity. Will Ana give up aspects of her authentic self that have to do with her national and individual history, in order to adjust to the new country, to the more suitable, accepted and successful models in order to become Israeli? Will she go all the way in assimilation in the Israeli society until she won't even ask the question of who she is and what is her real will? And what is my role as the teacher/therapist here? On one hand, I loved the warm welcome of the group and the way they accepted her. On the other hand, I want her to keep her own individuality, not to give up important and integral aspects of her identity. If I encourage her to sing in Russian, I force her to show parts of her that are different from the rest of the group and she does not want to expose them at this time. If I accept the fact that she does not want to sing, maybe I participate in the conspiracy to deny her true voice and therefore not to have the possibility of adjusting in a more balanced way into the Israeli society. The question if past tradition has to be preserved or rejected is a very personal one. There is not a simple answer.

Rosi, the religious student, brought other challenges and conflicts: can a student who is so extremely attached to one style of music and cannot identify herself with other styles, work with people who have different taste and have other political opinions? Or maybe she can only work with a very limited population and not with others? What do I do with the fact that I find her personally very extreme and fanatic and I don't like her? Will I be able to cope with my feelings and not let them in the way, and treat her like I treat other students?

In the case of both Sonia and Dina, the immediacy of hearing certain songs and singing them, and the immediacy of making and hearing certain improvisations can bring back personal memories that belong to the history of the country and its struggles for survival. In the example of Dina, my countertransference reactions to Dina's improvisation forced me to pay attention to and explore my inner experience in order to understand what happened to me. I had to process my own feelings in regard to the wars and to realize their existence within me. This is an example of having both the personal and the cultural identity so intimately connected that there is almost no separation between the two, and therefore I could take it back to Dina's process and explore this direction with her, a direction that was completely ignored up to this point in therapy.

Conclusion

"An important aspect of the everyday therapy work is trying to help the clients to find their authentic voice....The more a society includes in her more life models and more kinds of cultural experiences, the better chances the individual has to find his natural place within the society" (Strenger, 1999, p. 8).

Discussion seems endless without any clear answers to the questions asked at the beginning of this presentation. Either extreme has its own risks to human happiness.

Maybe the role of music therapy is to create a balance between the individual and the cultural identity, between past and present, to act as a bridge among clients and students from diverse cultural backgrounds, to act as a main contributing force in the creation of moments of unity that overshadows conflict and hatred yet gives room and respects all ethnic, religious, social and political variations. Maybe the role of music therapy in establishing cultural identity is about listening and being open to all these cultures. Maybe it means to be more flexible and creative in seeing how to enhance communication and interaction among these cultures, to honor their existence one next to the other and to be able to nurture each other and learn from each other. For me, personally, living in a different culture and getting all my music therapy training outside of my country (in the USA)

allowed me to be with people from all over the world, to hear their music, and to get to know their culture. These experiences made me richer and widen my personal identity. I am an Israeli, but I prefer to look at myself as a world citizen.

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Analogy And Metaphor In Music Therapy Theory- And The Metaphoric Nature Of GIM

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Introduction

One of my favorite games is a question game that goes like this: If your marriage was a car - what kind of car would it be? In a new Danish film (*The only one*, Susanne Bier 1999) the question is asked this by a councillor/ psychologist, and the answer of the male client makes his wife very upset. He says: "I think it is a van, a solid van".

You can ask yourself similar questions: If my ambitions were an animal, what animal would it be? Or: If my childhood was a dish, what dish would it be?

The Italian film *The Postman (Il postino)*, M. Troisi 1994) is a wonderful story about love and how to express: the protagonist learns from the great poet Pablo Neruda how language is not only a lexical system, but also a living source of emotional self expression: the postman learns about metaphors. This makes him able to win the woman he loves and fills the rest of his (short) life with a new dimension: poetry.

Metaphor is a way of thinking and expressing ideas and emotions about the world (Lakoff & Johnson 1980). Metaphor and related speech figures like analogy and symbol (see Table 1) - is not a special gift of poets or artists; it is a unique human ability, and it is - or can be - a crucial element in psychotherapy.

Metaphor is best understood within the framework of the narrative. This has been demonstrated in many books on narrative psychology and verbal psychotherapy (Polkinghorne 1988, Siegelman 1990, Combs and Freedman 1990, Kopp 1995), and the idea of the symbolic function and its importance in psychotherapy goes back to Freud and especially to C.G. Jung (1990). This has been elaborated in modern analytical theory and practice under the headline "Active imagination" (Kast 1990, Johnson 1986).

But how is the status of the concepts analogy - metaphor - symbol in current music therapy practice and theory? In the ongoing discussion about how to generate a 'general theory' of music therapy, initiated by Henk Smeijsters (1998) and Carolyn Kenny (1998, 1999) (and the topic of a round table discussion at the 4th European MT Conference in Belgium 1998, documented on CD-Rom, ed. David Aldridge (1998)), they play a very important role. The title of Smeijsters' paper was *Developing concepts for a general theory of music therapy. Music as representation, replica, semi-representation, symbol, metaphor, semi-symbol, iso-morphé, and analogy*, and Kenny in a new article (1999) mentions the following elements as suitable for a general theory: representation, analogy, metaphor, symbol, empathy, intersubjectivity, uniqueness and aesthetics.

The whole idea of the psychotherapeutic process is metaphorical in itself. As Siegelman points out we can just look at the large scale metaphors used by Freud ('psychotherapy as archeology'), Jung ('psychotherapy as alchemy' or integration as the 'Temenos'), Langs (psychotherapeutic 'framing' as indicating an area of safe control), Milner (psychotherapeutic 'framing' as indicating an area of symbolism) or Winnicott ("Transitional space", "Holding" and "Mothering") - From Music therapy theory we can add the idea of "Music as a bridge" in Analytical Music Therapy, and Kenny's concept of "The field of play" - all illustrations of how the unique in-between-area of the therapeutic encounter ("the area between inner and outer world", Kast 1990) has been understood and labelled metaphorically. While discussing this question, we are walking on a bridge, connecting the banks of cognitive understanding with the island of fantasy and imagination.

I will come back to the discussion of metaphor and general theory in the last part of this paper (including my doubts whether quantitative, positivist theories of MT can be included). In this first part I will discuss how a specific MT model can be understood as a metaphoric process: The Bonny Method of Guided Imagery and Music.

Table 1: Figures of speech

FIGURES OF SPEECH. In written and spoken language there are certain effective ways of saying things without saying them directly. Called figures of speech, they

are used to emphasize, clarify, and embellish what is being said. Most figures of speech simply take what is well-known and use it to depict what is less familiar.

Metaphor is a figure of speech that is used to indicate resemblance. A Shakespeare example (from 'As You Like It'):

All the world's a stage, / And all the men and women merely players: / They have their exits and their entrances; / And one man in his time plays many parts, The author uses the theatre as a metaphor to construct a word picture about the meaning of life

Simile resembles the metaphor. Whereas a metaphor is an implied resemblance, a simile is a stated resemblance in other words, a similarity. And it uses the words "like" or "as" in showing how one thing is similar to another. A frequently quoted simile from the Scottish poet Robert Burns is: *My love is like a red, red rose.*

Personification. While the metaphor and simile have fixed and slightly differing grammatical structures, other figures of speech are generally much freer in their construction. Personification is the application of human qualities to something that is not human, ex. "The walls have ears," "Money talks," and "Fear stalked the land". Another term is anthropomorphism, from the Greek meaning "to have the form of man." The device is often applied to animals, like Mickey Mouse, Donald Duck.

Metonymy and Synecdoche. Metonymy means using the name of one thing for another closely related term. In the question "What would the Pentagon think of the president's new military proposals?" the Pentagon is used instead of Department of Defense, although it is only the building in which the department is housed. Synecdoche means using a part to imply the whole, as in saying "There are a lot of hard hats working on this new building." The term "hard hats" refers, of course, to a construction crew.

Hyperbole and Understatement Hyperbole is a form of exaggeration, and understatement is a negative exaggeration. To say, for instance (using a metaphor), "I have a mountain of work to do" is obviously an exaggeration unless one is a mountain climber "Adolf Hitler was not the most beloved person of the 20th century" is a remarkable piece of understatement

Alliteration and Onomatopoeia are used generally in poetry and fiction to create sound effects in words. Alliteration is the use of the same sound, usually a consonant, at the beginning of neighboring words in a sentence or phrase such as "the dear, dead days beyond recall" or Shakespeare's "Full fathom five thy father lies" from 'The Tempest'. Onomatopoeia uses words to imitate natural sounds such

as the ringing of bells, the singing of birds, or the voices of animals. In a broader sense it refers to any combination of imitative sounds and rhythms that are used to reinforce the sense or moods of a passage of poetry or prose.

Idiom and Slang An idiomatic expression is a phrase that has become an accepted part of a language but that makes little sense if taken literally. Most idioms are difficult, therefore, to translate from one language to another. Common English idioms include "Hold the door," "Catch a cold," "Run up a bill," "Beat a retreat," and "Strike a bargain." - Slang consists of words and phrases that came into use in one of the many subgroups that make up society. Eventually this vocabulary comes to be known and used by the general population. Slang is, therefore, a middle ground of words and expressions between standard and informal speech on the one hand and jargon, dialect, and vulgar speech on the other.

Symbol In one sense, every word is a symbol. "Tree" is four letters and a certain sound, but it is also a thing with bark and leaves. Put into a context which includes the word Calvary it becomes a metaphor for the cross on which Christ was nailed. That kind of extension of meaning, which is called symbolism, is actually one of the most suggestive and economical ways of communicating the aesthetic experience. Prof. Harry Levin of Harvard University distinguishes between the conventional and the explicit levels of symbolism. Much poetic symbolism is conventional. A journey often symbolizes human life; a season often suggests the age of a man. An example of explicit symbolism is this line by Henry Wadsworth Longfellow: "Thou, too, sail on, O Ship of State!" A third sort described by Levin is the implicit, which takes the reader into more ambiguous country. In Herman Melville's 'Moby-Dick', Moby Dick is more than whale, but what precisely is it? God? The spirit of evil? A manifestation of pure mindless force? No single explanation will fully satisfy. It is in this area of unexplained, private, or ambiguous meaning that much contemporary writing exists.

GIM as a metaphoric process

The standard format of a GIM session is well known (e.g. Short 1991, p. 67). I will express my point by adding the following identification of metaphorical tasks in the discrete phases:

Prelude: Identification of a (potential) core metaphor in the client's here-and-now language

Induction: Transforming the metaphor into an embodied induction image

Music travel: Exploration and elaboration of the metaphor through music-assisted imagery

Postlude: Using integrative imagery as a metaphoric bridge to cognitive operations.

In this way the whole GIM session can be understood as a movement into the world of images, metaphors and symbols (through the induction of ASC), a thorough exploration in the musical-metaphoric mode of consciousness (in ASC), and a return to normal cognitive mode (NSC) using the imagery as a bridge - potentially synthesizing the wellknown and the unknown into insights of the client (and the therapist) through metaphoric and cognitive dialogue.

But what is the relationship between image(ry) and metaphor? The question will be discussed more extensively later in the paper. My first, simple answer is that a metaphor is a lexical/verbal transformation of an embodied image. The image is the client's experience in a specific representational mode (Horowitz 1983); the metaphor is a specific way of communicating it. Or speaking with Paul Ricoeur: The language of metaphor is a language of images (Kemp p. 18)

Siegelman (1990, p. ix) writes that metaphors have three characteristics:

- “1. They often represent “the outcropping of an unconscious fantasy”.
2. They combine the abstract and the concrete in a special way, enabling us to go from the known and the sensed to the unknown and the symbolic.
3. They achieve this combination in a way that typically arises from and produces strong feeling that leads to integrating (i.e. affectively grounded) insight.”

Any GIM facilitator will recognize these points from successful sessions and therapies. It is also my point that the use of carefully selected music - meeting the needs of the client (and using the ISO-principle) and her level of metaphoric thinking - 1. makes the “outcropping” easier, 2. prolongs and deepens the experience of meeting the unknown, 3. secures a deep

affective grounding of the whole process, often more intense in character than in a verbal psychotherapy model.

In this paper I cannot go into a deeper discussion of the role of the music (in GIM), or of the metaphoric qualities of music, in spite of its crucial importance. Important papers on these topics are Bruscia (1994), Summer (1995), Skaggs (1992), Goldberg (1995).{1}

Image, Language, and Metaphor

Imagery based psychotherapy is often presented as an 'alternative' to verbal psychotherapy, the last type addressing secondary processes of insight and understanding. However, the therapeutic dialogue is still based on language and verbal communication - and we need to clarify the nature and function of the 'special language' required, both during imagery work (verbal report from the client and interventions from the therapist) and in processing. With the exception of Ansdell's important paper (Ansdell 1997) I have not found any discussion of this aspect of 'the language problem' in the literature, probably because it addresses the question of imagery and language as representational systems. My understanding of this is inspired by Horowitz (1983), who has developed a model of three modes of representation: enactive, image and lexical. I suggest the following working definition: The metaphoric language - the special language used in verbal communication of imagery in all modalities - connects the lexical and the image modes, as well as the enactive and the lexical modes. It is a special discourse within verbal communication, enabling verbal representation of imaginal and enactive experiences.

The so-called "Oneirotherapists" (Sheikh & Jordan 1983, Högberg 1991, - the term covers 'daydream therapies' like Desoille's "Directed daydream" and Leuner's "Guided affective Imagery") use "extended visual fantasies in narrative form to obtain information about the motivational system of the individual, including elements of conflict, perceptual distortion, self-perception, and early memories." (Sheikh & Jordan, p. 401). I think the metaphoric language is what makes the narrative possible. It is

the quality mentioned by Ricoeur in a very interesting section in *The Rule of Metaphor* (p. 247). The headline is "Towards the concept of 'metaphorical truth', and the assumption is: "In service to the poetic function, metaphor is that strategy of discourse by which language divests itself of its function of direct description in order to reach the mythic level where its function of discovery is set free....We can presume to speak of metaphorical truth in order to designate the 'realistic' intention that belongs to the redescriptive power of poetic language."

Levels of metaphoric thinking in GIM

I will go on by presenting three levels of metaphoric thinking and exemplify how they appear in GIM therapy. The clinical material is mainly from my own practice, with clients using GIM for self development purposes. I include references to the GIM literature. The theoretical inspiration comes from the French philosopher Paul Ricoeur and his theory of metaphor and narrative (Ricoeur 1977, 1984; Kemp 1995). A brief introduction to this theory will follow.

Level one:

The Key Image as a discrete metaphor of an important problem area. A *narrative episode*.

Example: "The Leg" (Client: Harriet) - (Example: Session excerpt and transcript)

Level one: GIM Session transcript (excerpt)

(Music: Sibelius: The Swan of Tuonela, final section)

It is awkward to hop on one leg. And it is easier just to sit down, doing nothing.

It is easier to do nothing?

Yes, when you have only one leg it is much easier just to sit or lie down.....

Then nothing will happen... eh....when you just sit there.

Mm. How does it feel to sit there?

It feels 'half'.

Aha....

Eeh... It feels almost wrong, because.... I ought to go out and do something.

You ought to do something?

(Pause in the music)

Yes, it is wrong just to sit there, watching and not doing what I want.

(Music: Villa-Lobos: Bachianas Brasileiras #5, arr. guitar+voice)

Do you feel, what is holding you back?

Eeh... what is holding me back is that I miss a leg. That I have cut it off, somehow.

Mmh?

So it is not a part of me.

Mmm.

It would look funny to fool around

Mmmh (smiles)

....he - he - he --- (laughs)

What are you experiencing?

(Laughs) I see myself jumping round on one leg! (Laughs again)

And how does that look?

It looks totally ridiculous!

Mmh.

On the other hand it is also funny. It is possible to do it, and if I don't care, how it looks, then it is just pure fun.....

References to examples in the GIM literature: Goldberg (1995: Clinical vignette #2), Rinker (1991), Bush (1995), Bruscia (1991), Pickett (1996).

Level two:

The Key Image as a metaphor of the Self (in therapy) - *A narrative position of the Self*

Example: The Storehouse (Client: Billie)

The Storehouse (a GIM poem written by a client, Billie)

I am an old storehouse
Virginia creeper climbing my walls
and many lopsided windows
During my restoration
I enjoy the toplighting
from new atelier windows

The foundation and the walls are solid
almost beautiful
there is a fine atmosphere
even when insides are empty
Craftsmen are working
on every floor

Soon I will be
an old well-restored storehouse

References to examples in the GIM literature: "The Wall" (Case from Bruscia 1991), "Judge, Nasty, Tender, Child, and Shame" (Personality parts of a client, in Pickett 1991), "Anita, Faiblesse, Carmen, Higher Self, August" (Sub-personalities in Erdonmez 1993), "Al Cohol" (Summer 1988), "The Vista" (from Clark 1999), Goldberg (1995): Clinical vignette #1.

The Vista is a fine example of positioning the Self: Clark (1999) quotes from examples of encounters with vistas from imagers' experiences:

"A man who starts his experience on a path walks up first a slight incline and then a steeper one. He finds that he is able to see things in the distance, including mountainsides and a valley. He feels good, looking out and enjoying the view. With a hill at his back, he can see a panorama and finds the experience very soothing. He is beginning to see new possibilities in his life."

Level two metaphors are often opening metaphors. When set in (e)motion - by the music and the interaction - they may develop into a 'Level three' narrative.

Level three:

The Narrative - Metaphors of the Self in motion and transformation.
Spontaneous emplotment: configuration of episodes.

Example: "The Castle" (Client: Mary, Program: Imagery, tape version + Rhosymedre)

(Background information: Demo-session with woman round 40, who has separated from her former partner because of his infidelity, and she is now struggling to find her own way. She has no contact with or support from her parents: her father is an alcoholic, her mother dependent. - M. wants to use GIM to explore her own present situation.

INDUCTION: Autogenic relaxation with a color - Induction image: a meadow.

PROGRAM: Imagery + Rhosymedre

IMAGES (Transcript re-written in first person):

(Ravel) It is a sunny and warm day in the meadow; I walk along in green grass, with butterflies following me. - A black raven tries to catch the butterflies, but a strong wind (music: big accelerando & crescendo) wipes them away. I realize that they have done their job with me. I feel stuck, and look down to my feet. My shoes hold me back in mud. I slip out of my shoes and continue my walk barefoot, feeling soft grass under my feet.

(Copland) I climb a small hill, look down at a valley - it is breathtakingly beautiful. The valley is covered by a soft mist, but I see a white castle in the distance. It is quite far away, and I am not sure I want to visit it. Well, my feet wants to go there; a part of me wants to visit the castle. I sense it is the part of me that wants to dance... But I have no dancing shoes. (A sudden change in the music). Suddenly I am dressed up in dancing shoes and a white silk dress. The silk shoes are light, and feel almost like skin. (The shoes I left in the mud were brown and worn out). I feel light, almost like a fairy - I move with the wind towards the castle. It is close now, and I enter a garden; I have not been invited, so I have to sneak in. It feels OK; I want to see what is in there.

(Tjajkovskij) A door to the hall is open: I enter through the heavy door. There is noone around, but I am not afraid. The atmosphere is friendly, and I know the castle is not abandoned, somebody should live there.... I

suddenly realize, that it should be me! Someone has stolen the castle from me. But it is my castle, and I have a right to take it back!

(Respighi) I have to go inside, to the area between the wall and the castle. There is a garden there, and the atmosphere is quiet and still. I know why: Time has stopped here! There is something very sad about it: Time stopped, when the castle was stolen. The fruit trees need to be cut, a gardener should take care of it. But time stopped, when I left... But I am back now, and it feels like coming home (tears).

(Turina) The castle is in good shape, it is clean and shines white... I feel body tension all over: the tension goes with coming back: I feel cold, there is a coldness inside me [a carpet is provided], even if my body wants to produce warmth. [Tp: ?Does the feeling have a shape?] It is a bright blue, square box, wrapped in blue paper with strings around it. I want to throw it away, but don't know where and how. I throw it into the fire, it burns! I feel warmer, but it doesn't go away easily.

(Vaughan Williams: Rhosymedre) I enter the castle again, there is a warm living room with a fireplace and a bathtub. There is a majestic, good atmosphere in the room. I want to take in the warmth from the fireplace, and I can do that.

(POSTLUDE : M. realizes that the castle is a self image and interprets it: she has let her boyfriend invade and 'steal' it, and thus she has turned cold and stuck. The butterflies are metaphors of her delusions and her naive dreams about the relationship. She feels a deep satisfaction getting "her castle" back, and finding it in good shape. Anger/coldness doesn't go away that easily, she knows it will take time. - Draws MANDALA: Finding love (#9))

References to examples in the GIM literature: Bush (1996), Short (1997), Smith (1997, case study #1), Hanks (1992), Wesley (1998).

A special type of level three metaphor is the "therapeutic narrative": When therapy is terminated (or for the last session), the therapist may write a narrative using core metaphors from (some of) the sessions, thus giving back to the client the therapist's own experience of the process. Or the client

may sum up his/her impression of the whole therapy or a phase in the therapy in the same way. - These narratives very often resemble fairy tales.

Discussion

The examples illustrate that the theory of metaphors unfolding at specific levels in GIM is a narrative theory. A session can be seen as a part of a short story - or a chapter of a novel. A complete therapy is - metaphorically spoken - like a complete short story, or even a novel. A human being is a narrator and a narrative at the same time - we tell our life story and it is told by others into a complex texture of facts, interpretations (based on narrative causality) and metaphors. In psychotherapy the narratives can be deconstructed and reconstructed, following the principles of the narrative and involving some or all of the levels of metaphors.

From GIM theory we know how Leuner (1972) interpreted the "Standard imagery scenes" (the Meadow, the House, climbing the Mountain etc.) within a rather narrow psychoanalytic framework. This attitude of interpretation is not appropriate - I find it reductionistic, knowing that metaphors in therapy are primarily personal, individual, and dynamic (not denying that clients may 'tap into' greater - cultural or archetypal - narratives){2}. A much more open, yet systematic guide to symbols and their interpretations is offered by Stevens (1999).

As Ricoeur says: The language of symbols and metaphors, in which mental life expresses itself, is not just an expression of drive conflicts, but also attempts to release or solve the conflicts by indicating possibilities for a better life (which is the goal of any therapy). Understanding a person is not limited to explaining its behavior from its conflicts; we also understand through our wish to come to terms with the conflicts (Kemp,1995, p.17). "The Living Metaphor" (Ricoeur 1977) is not just a metaphoric re-writing (or 'second draft'), explaining a phenomenon with other words. It is a new way of understanding the 'real' world and ourselves. Not just a (boring or funny) repetition or variation, but a genuine indication of new ways. (Kemp 1995, p. 19)

Levels of understanding. Psychotherapeutic levels of metaphors

The three narrative levels of the metaphor can be related to other hierarchic models in psychotherapy. Perilli (1999, in press) discusses GIM as a “metaphorical and transformative therapy”. She compares four levels of imagery (Summer 1988) with the four wellknown levels of psychotherapy: Summer distinguishes between these four levels of imagery (experiences):

1. *Abstract/aesthetic*- with visual and kinaesthetic imagery
2. *Psychodynamic*- with memories and imagery on literal relationships
3. *Perinatal* - with somatic and/or existential experiences
4. *Transpersonal* - often peak experiences and universal symbolic imagery

Perilli associates these levels with the four wellknown levels of psychotherapy :

1. *Supportive*
2. *Insight/Re-educative*
3. *Reconstructive*
4. *Transpersonal*.

Perilli adds: “An intervention at supportive level may present metaphors with transpersonal content; psychodynamic experience of repressed material etc. may happen at supportive, re-educative or reconstructive level. To work more or less deeply, using elicited metaphors, will depend from the purpose of the therapeutic intervention.”

We have tried to identify “levels of experience” in the music travel of GIM (Bonde & Pedersen 1996), relating the developmental flow and dynamics of the music to the imagery potential. This might be empirically related to Klein et al.’s “experiencing scale” (1970, 1986, here from Hougaard 1996 p. 237f). Level 3-7 of Klein’s 7 levels seem relevant for GIM. -

The identification of *the experiential quality and potential of the image/metaphor in GIM* is complex. A symbolic image may be condensed in a time perspective, but still have deep transpersonal perspectives for the

client. And the client's imagery may seem transpersonal (cf. Lewis 1998) yet still be stream-of-consciousness. Metaphors of defense and resistance are as important to consider as metaphors of transformation. The quality and potential of images and metaphors can only be determined in the narrative context and configuration of the therapeutic process.

Theoretically I think the identification of the *level of imagery* - especially the identification of the psychotherapeutic level of the imagery - can be furthered considering the theory of metaphor by Paul Ricoeur.

Ricoeur's theory of metaphors and narratives

"When changing its fantasy a human being changes its existence".

Ricoeur's theory of narrative starts with a critique of Aristotle. In the classical lexical theory metaphor is merely ornamentation in language. In contrast, Ricoeur understands metaphor as "a semantic event made possible by three kinds (levels or elements) of tension....Metaphor announces an explosion of meaning (the text is broken open to the life-world [Husserl's "Lebenswelt", comment LOB]) for the first time) to more."(McGaughey 1992) He agrees with Ernst Cassirer in his view of the role of the metaphor, when he asks: "Can one not say that the strategy of language at work in metaphor consists in obliterating the logical and establishing frontiers of language, in order to bring to light new resemblances the previous classification kept us from seeing? In other words, the power of metaphor would be to break an old categorization, in order to establish new logical frontiers on the ruins of their forerunners?" (Ricoeur 1977, p. 197) Now, how does the metaphor 'break old categorizations'? It does it through semantic tension.

The three levels of tension are:

"(a) tension within the statement: between tenor and vehicle, between focus and frame, between principle subject and secondary subject;

(b) *tension between two interpretations*: between a literal interpretation that perishes at the hands of semantic impertinence and a metaphorical interpretation whose sense emerges through non-sense;

(c) *tension in the relational function of the copula*; between identity and difference in the interplay of resemblance. " (Ricoeur 1977, p. 247){3}

Ricoeur's understanding of the difference between symbol and metaphor leads him to the following statement, which has profound meaning in a psychotherapeutic context:

"It appears as though certain fundamental experiences make up an immediate symbolism that presides over the most primitive metaphorical order...symbolic experience calls for a work of meaning from metaphor, a work which it partially provides through its organizational network and its hierarchical levels. Everything indicates that symbol systems constitute a reservoir of meaning whose metaphoric potential is yet to be spoken. And, in fact, the history of words and culture would seem to indicate that... this deep layer only becomes accessible to us to the extent that it is formed and articulated at a linguistic and literary level since the most insistent metaphors hold fast to the intertwining of the symbolic infrastructure and metaphoric superstructure." (Ricoeur: Interpretation Theory..., quoted from McGaughey 1992, p. 425).

McGaughey suggests in his attempt to distinguish metaphor and symbol, that one must speak about 'the narrative symbol' as of 'the semantic metaphor' (p.427). This leads us to Ricoeur's understanding of *Mimesis*, the key concept of the narrative - be it of a novel, a life story - or a therapeutic journey. His concept of mimesis is threefold:

Mimesis1 is the originary pre-understanding of action/praxis (prefigured temporal aspects)

Mimesis2 is a midpoint of mimetic action or 'structuration': the narrative (mediator: the time of emplotment; configuration of temporal aspects)

Mimesis3 is a subsequent action/praxis of application in understanding [by the reader] (refiguration of temporal experience)

The three levels are connected through a (poetic) 're-configuration', making us (the reader) able to 'see' the world in new ways. This is also the 'subversive' quality of the narrative. Or in Ricoeur's own words: "We are following therefore the destiny of a prefigured time that becomes a refigured time through the mediation of a configured time." (Ricoeur: Time and Narrative, quoted after McGaughey, p.429)

The literary framework of Ricoeur's theory consists of epics, dramas, and novels, but it does not take much imagination (!) to see the fictional narrative replaced with a client's own narrative: his/her life story, as configured in the therapy. In metaphoric psychotherapy - like GIM - the client is engaged in a confrontation between the world of images & metaphors and his/her troubled life/ semantic world: Using Ricoeur's concepts the client's life world is Mimesis1, the metaphoric therapeutic narrative (in which the three levels of metaphoric imagery are identified) is Mimesis2, and the (positive) outcome may be Mimesis3. -

Metaphor works at the level of the sentence, and symbols at the level of the narrative, is McGaughey's suggestion. I will now briefly illustrate, how this makes sense in the context of GIM - how the three levels of tensions and of mimesis may be experienced by a GIM client:

Vignette: A male client (50 years old) gave, as a reason for continuing his GIM work, when challenged by his wife, who wanted couple counseling: GIM "gives me images of myself as a functioning person in my own right. I don't just want to adjust my behavior". - He had experienced how metaphoric imagery evoked by the music in GIM would allow him to experience what in this discourse is called the tension inherent in metaphors at the levels of the sentence and the episode (example: finding his way to a large, beautiful mansion with many empty rooms and no proper road leading to it; or experiencing himself as a dancer, allowing himself to dance as a soloist and enjoying it fully). Like many clients he was encouraged by the narrative

configurations at the level of Mimesis² to go back to his everyday life story, facing the challenges of refiguration at the level of Mimesis³.

Even Ruud (1997, p. 198, my translation) paraphrases Ricoeur: "Life becomes human through narrative articulation. In creating plot and coherence in our unclear understanding of everyday life we change/transform it in a more comprehensible literary configuration. The narratives we create about our lives will change it and give it a specific form - just like in a hermeneutic circle."

Metaphor and symbol in general music therapy theory. A discussion

A bibliographic search (EndNote "MusicDatall" library, Aldridge 1996) on the keywords analogy or metaphor and psychotherapy reveals very few titles (15 references; adding symbol gives 30 extras). PsycInfo or RILM searches give almost the same result. The concepts do not seem to be very prominent in the literature. On the other hand they play an important part in some of the most important contributions to Music Therapy Theory: Ken Bruscia's "Improvisational models..." (Including IAP) and his contributions to the theory of transference dynamics (Bruscia 1987, 1995, 1998); and Henk Smeijster's theory of analogy in MT (Smeijsters 1993, 1998). Also David Aldridge (1996, especially in Chapter 5 on "Aesthetics and the Individual in the Practice of Research) makes extensive use of metaphorical thinking, and he includes symbolic thinking in the (necessary, complementary) individual perspective on health (p. 33), and Even Ruud (1997, 1998) has integrated metaphorical meaning in his theory of music and identity.

In related fields, such as Musicology, Aesthetics and Art Theory, Psychology, Psychotherapy, Philosophy and of course Semiotics (of Music) the concepts have played an important role in the development of theory and practice (Combs & Freedman 1990, Pochat 1983, Ricoeur 1986, Black 1962, Nattiez 1990, Hougaard 1996).

Definitions may differ surprisingly, and raise several important (meta)theoretical questions. According to Hougaard (1996, p. 344ff) the use

of metaphors plays an increasingly important role in clinical psychotherapy, because they seem to contribute to the (re)connection of emotional and cognitive or lexical representational modes. However, very little empirical research has been carried out within this area of psychotherapy.

Advantages and disadvantages connected to the idea of generating a 'General Music Therapy Theory' has been debated in the 90ies (Smeijsters 1997 and 1998, Kenny 1998, Bruscia 1998, Aigen 1990 and 1998). - Does it make sense to develop 'grand' or 'general' theory in a postmodern era, where 'multiple perspectives' and 'local narratives' and 'regional constructs' seem to dominate the theoretical discourse? The discussion has centered round questions and dichotomies like:

Developing an indigenous theory vs. shared terminology/import from other discourses

Music in therapy/analytic type - music as therapy/synthetic type

Verbal/cognitive understanding vs. non-verbal transformation in music

The (intra)personal vs. the interpersonal perspective

.....etc.

In my opinion it is important to discuss the possibility of a meta-theoretical discourse, including not only local/regional narratives and constructs, but also:

- Active as well as Receptive Music Therapy
- Quantitative as well as Qualitative Research within Music Therapy
- Biologically as well as Culturally founded theories
- Positivist/Behavioral as well as Humanistic/Existentialistic 'Paradigms'.

This integrative ambition may be criticized as epistemologically naive; and ontologically impossible or absurd; clinically eclectic - and not very realistic! On the other hand: It may be possible - and certainly useful for the

dialogue between the clinical and the theoretical perspective - to identify some core concepts, and some consensus of levels of understanding.

One of my reasons for bringing Ricoeur into this discussion is his theoretical ambition of dissolving the conflict between what C.P. Snow in the Fifties called "The Two Cultures": humanities and natural science. The conflict is interpreted as a conflict between two time perspectives: analogue, existential time (kairos; as experienced from within) vs. digital, measurable time (chronos; as observed and measured from without).

Ricoeur's concept of "historical time" dissolves the conflict: Historical time must be experienced by human beings in order to give meaning to external events, in which they have participated (Kemp, 1995). Ricoeur's theory of Time and Narrative is a large scale attempt to find a unitive perspective in meta-theory.

In the context of music therapy theory I think, that concepts like representation, analogy, metaphor, symbol and empathy may be the right point of departure (as suggested by Smeijsters, Kenny, Ruud & Mahns). I also think it would be a good idea to concentrate on our music concepts: music unfolding in time and space; the identification of dimensions (parameters) of music and their metaphoric, symbolic and existential qualities and potentials. This may lead to useful constructs and frameworks for theoretical understanding as well as clinical description (knowing that 'The map is not the territory; the field is not the play'). It may even facilitate communication between music therapists and psychodynamically oriented psychotherapists, who are opposed to the increasing use of medical metaphors (*reference missing*)

I suggest that 'The symbolic attitude' (Siegelman 1990, p. 159) may be a possible theoretical core concept - embracing metaphor and symbol as well as empathy. However, I am not sure that these constructs will also cover behavioral music therapy, some of the cognitive models and theories founded on positivist notions in therapy. The ambiguity of metaphors and

symbols does not seem to fit with the scientific axioms of these models. But this discussion remains open.

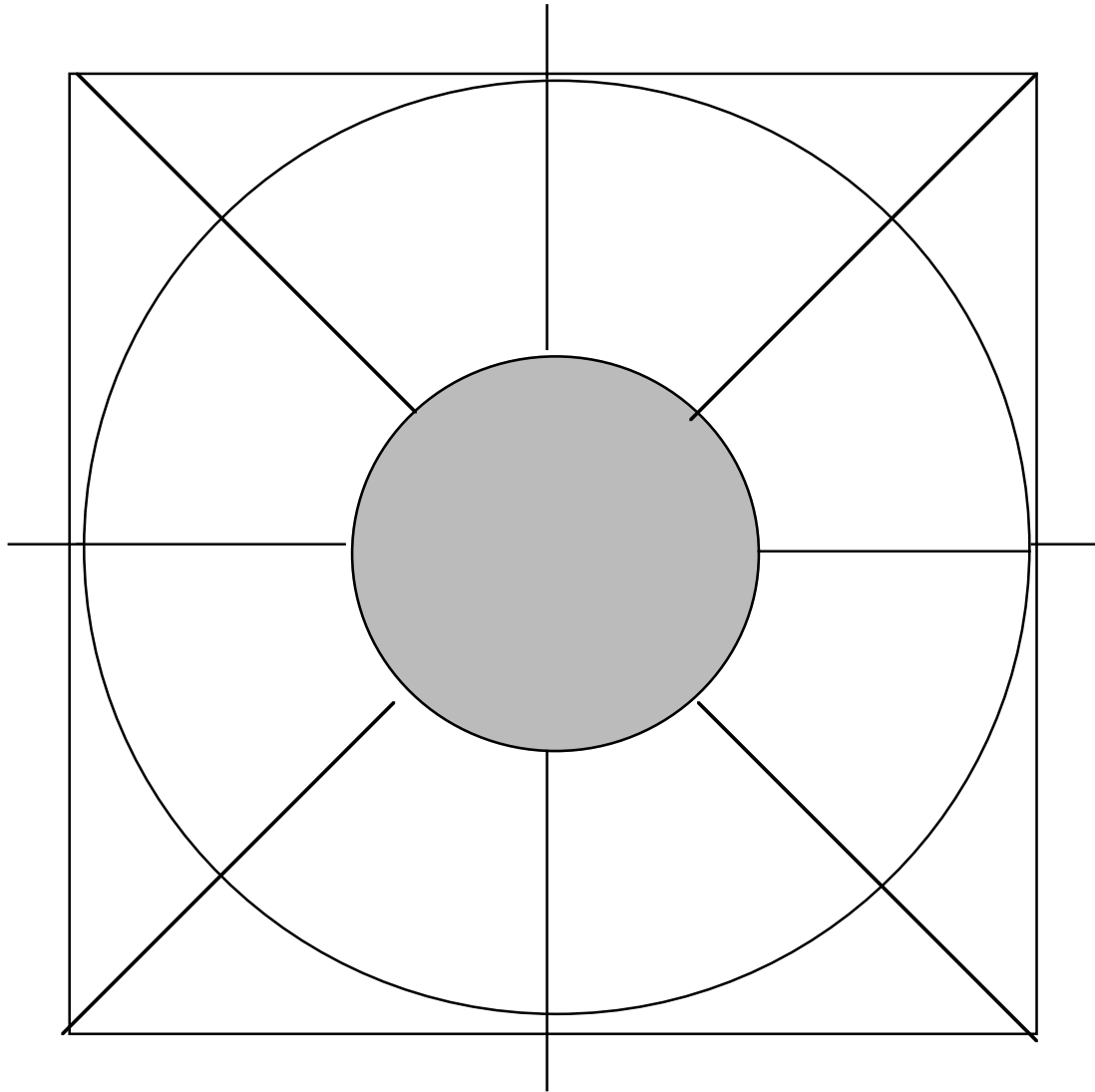
In the following tables I have included Kenny's "Eight Cultures of Inquiry" (1998) and Junge's "9 Cultures" (1998).

The music of the encounter

In Siegelman's final chapter she introduces "Resonance" and "Attunement" as key metaphors of the therapeutic encounter. The chapter is based on a case example, in which music and affect is linked in a way, most music therapist will recognize immediately.

The consequences of this are best illustrated by using field theory and the related 'mapping' technique, used by scholars as diverse as Kelly in his Personal Construct Grid technique (see Aldridge 1996), and Jung in his use of the "quaterneon" (a graphic symbolization of the self) in his late theoretical understanding of transference in psychotherapy (Agnel 1999).

Table 2: Quaterneo 1



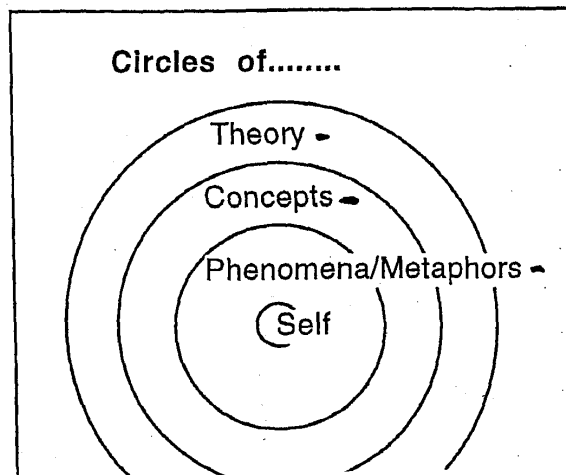
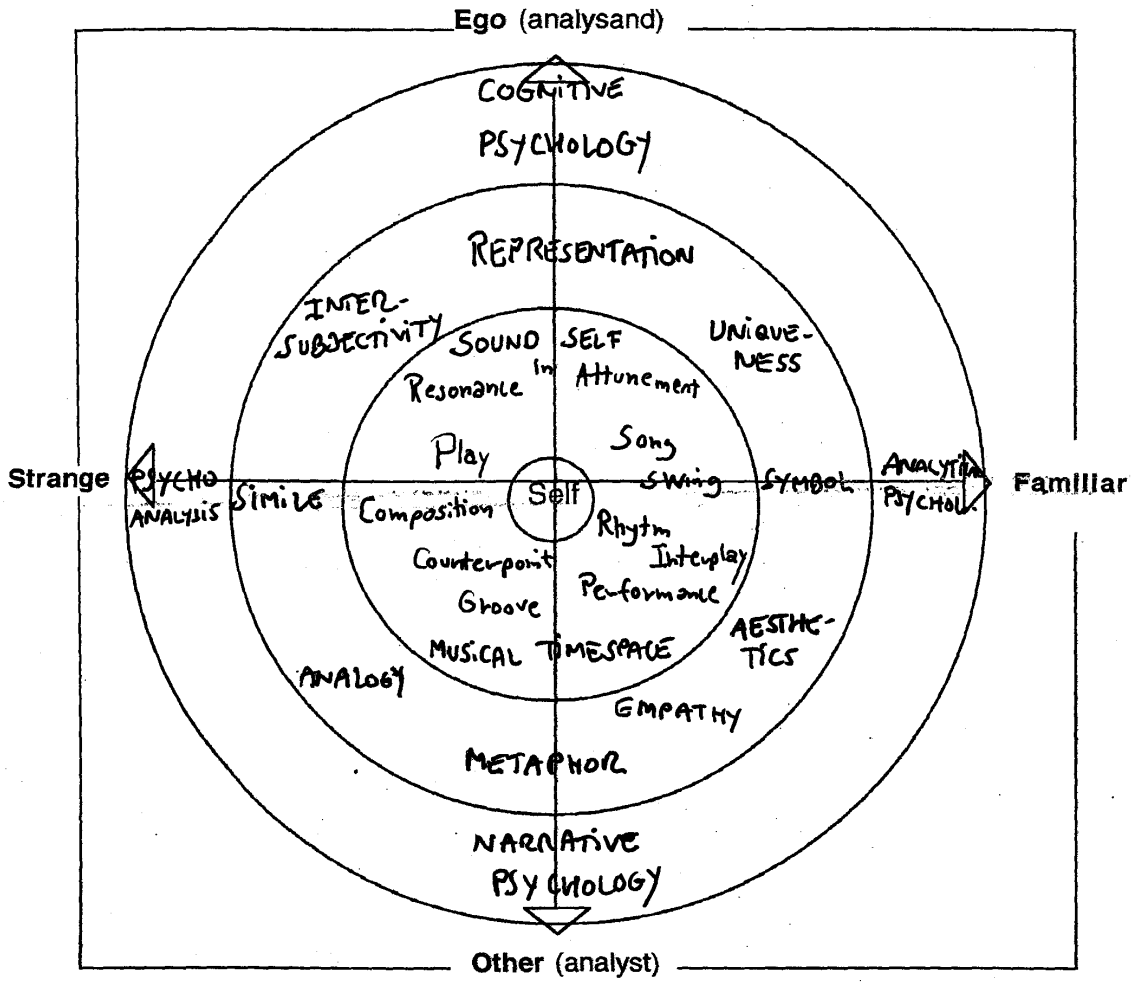
This schematization of the archetypal fields of self and transference relationships can be used as 'ground' for meta-theoretical figures, representing the field of 'Self in a dynamic musical time-space'. This is meant as a first draft, and an invitation to dialogue.

My idea right now is, that core concepts in general music therapy theory should be metaphors themselves, containing the tension inherent in metaphors according to Ricoeur, with the potential of bridging the gap between the clear, unambiguous world of technical/theoretical concepts and the unclear, ambiguous world of imagery and embodied experience.

The (living) metaphors should be not only suggestive and useful, but also dynamic and interactive. (Siegelman, p. 178) I prefer and suggest "Resonance", "Attunement", "(Dis)Harmony" (Dis-/Concord), "Rhyth",

“Sound”, “Song”, “Swing”, “Field”, “Orchestration”, “Performance” (and similar) as core concepts.

Table 3/Model: The metaphoric field in music therapy theory



You will find these metaphors in the Music Therapy literature (on both theory and practice) as well as in the Infant Psychologies of Stern and Trevarthen, probably because they have both a specific and a metaphoric meaning, an interactive and an active quality.- Like music itself has - as a concept and as a sound phenomenon. Ruud (1997) offers this formulation on playing with metaphors of identity: "We can tune an instrument, change the strings, play with a variety of techniques. We can perform the music of other people our our own melodies, play solo or together - and in the same way identity is composed and performed an numerous ways."

"Metaphor" belongs together with concepts like analogy and representation etc. to the next level - what I call the circle of theoretical concepts. - Ruud (1997) writes in a chapter with the headline "Music - a Metaphor of Identity" about the way our narratives of our life - and its music - may influence or change it and give it a specific form. (p.198). In the words of David Aldridge (1996): "Our lives are best described in the dynamic expressions of a lived language. The essence of language is that of musical form, which is the vehicle for the content of ideas." Stories - or narratives, broadly understood as artistic expression in either medium, "lend an understanding of pattern to our lives. They are a way of perceiving, feeling, relating and existing." (p. 101)

Music may have a 'mirror function' in this narrative, if and when you enter the metaphoric discourse. A man suffering from schizophrenia addressed this function, when he wrote the following: "Classical music is a mirror, in which mankind can watch and recognize itself." (Jensen 1983, Appendix 1).

Siegelman writes (p.183) that what we do as therapists "is to help patients recover their own inner music....and learn to sing the songs that are uniquely theirs". This is a beautiful and precise metaphor on the essence of (music) psychotherapy and how we may understand it theoretically, and I will close with that.

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Appendix 1: A Man suffering from Schizophrenia ON CLASSICAL MUSIC AND ITS MEANING:

- (1) Sublime music tells in its own way about unknown regions of the human mind, about lost horizons, about sorrows and joys, shortly: about all the innumerable nuances of the human mind.
- (2) What the natural sciences and the fine arts cannot tell about man, classical music can.
- (3) Classical music is a mirror, in which mankind can look and recognize itself.
- (4) Classical music draws an eternal portrait of the human mind.
- (5) Sublime music tells man about eternal, unreachable ideals and about the vanity of all matters.
- (6) Ideal music tells man, that his life on earth is only an fragile dream filled with passions and illusions, and that it will break sooner or later, to man's great sorrow and pain.
- (7) God, Nature, Nirvana illuminates aspects of its consciousness through music.
- (8) Therefore music is an exact image of eternity.
- (9) Through classical music God tells man an ever new story.
- (10) Music is a precise appearance of unity in nature

Reference:

Robert Henningsen Jensen (1983) Små strøtanker. Eget forlag. Horsens (p. 14-15)

Through many years my parents had contact with RHJ, a former butcher (born 1944) who was diagnosed as schizophrenic when he was in his early twenties. He was hospitalized 3 times during the period 1969-1973. After that time he used writing as a form of 'self therapy', describing his experiences and formulating his credo's and life philosophy. LOB

Appendix 2: THEORETICAL CONCEPTS developed in Henk Smeijsters (1998): *Developing concepts for a general theory of music therapy. Music as representation, replica, semi-representation, symbol, metaphor, semi-symbol, iso-morphé, and analogy.*

Concepts:

REPRESENTATION: aesthetic, resembling reference to object
(in music: Tone paintings, (iconic representations, LOB), sound imitations).

REPLICA: representation with physical and relationship (copy)

ANALOGUE/ANALOGY. Representation with only formal relationship (no physical copy, but resemblance with object) No dualism, no need for interpretation, 'same and different' (Ansdell). - "An expression in music and music interaction which in essence shares the same characteristics as the (manifest) processes of the psyche" (ex. playing soft in background//being shy; playing slow//endogenic depressive behaviour; playing fixed patterns of rhythm//compulsive behaviour). Leads to: "In MT the music dimension (c: vitality affects) of a client's Self is augmented." (Smeijsters 1995) "The aesthetic expression means what is manifest"- thus making interpretation superfluous, but still a "trans-formational language" is necessary

SEMI-REPRESENTATION: partly realistic representation with extra meaning (ex. Freudian dream symbols.) (The realism is there, but as a metaphor)

SYMBOL: Dualism between object and symbol: no direct correspondence. - A third cognitive aspect is needed to understand the link. (Need for interpretation).

(*Comment, LOB: This is in my opinion a definition of metaphor)

DIRECT EXPRESSION (Aigen) - purely musical dialogue. ('Intrinsic interpretations')

(*Comment, LOB: the question is, whether music (in MT) ALWAYS has a psychological meaning. I don't see, why this should be the case. But I think, that when we meet Direct Expression it is when MT is more like music teaching or aesthetic communication pure.)

METAPHOR: Almost like symbol: A third aspect opens interpretation. "During improvisation it is the imagination of the metaphor which guides the client, not the musical proces" (*comment, LOB see below)

*According to Pochat (1983) Smeijsters' understanding of symbol/metaphor places him on the Aristotelean/rationalistic line (in psychology represented by the Freud-line), while I am on the neo-Platonean/idelistic line (in psychology represented by the Jung-line). It may be necessary to go through some of the most important symbol theories in art history and aesthetic theory to make the lines clear.

NOTES

{1} My main assumption is that music is an unfolding of a non-verbal narrative in an auditive timespace, and that this unfolding at a deep - emotional and bodily - level - stimulates the "outcropping" of images and metaphors via the permanent experience of tension and release in the musical dynamics.

{2} The GIM literature presents many examples of 'Heroes/Heroines' Journeys' and archetypal narrative structures - even across cultural borders. See Clark (1991), Hanks (1992), Wesley (1998), McIvor (1998)

{3} It is not possible to give a just account of Ricoeur's theory in this context. I recommend McGaughey's article as a concentrated introduction of the theory and a discussion of the relation between metaphor and symbol. - However, I must explain some of the concepts used by Ricoeur here. The *tenor* is the starting point or described concept (also called the *target* domain) and the *vehicle* is the comparison concept or the analogy (also called the *source* domain). The *copula* is the referential function ('is/is not') announced in the metaphor. The tension is raised because the lexical reference is not 'proper' but a disturbance of the proper meaning: *Life is a cabaret.... or... Life is a tale told by an idiot.....* (Shakespeare: *Macbeth*)

The Educational Formation Of The Music Therapist According To Benenzon's Theory

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In Italy , as opposed in other countries, the figure of the music therapist does not yet have a specificity of its own, as far as its legal and professional recognition is concerned.

Given the current proliferation of courses and seminars of music therapy, it therefore becomes necessary to address the question of the educational and personal formation of the music therapist in a systematic and serious way.

The schools that follow the BMT (Benenzon Music Therapy) identify a number of different fields of study of which the music therapist should have a basic theoretical knowledge: these fields range from anatomo-physiology and body expression, to pedagogy, and include studies of ethno-musicology and evolution psychology.

This evidently entails an interdisciplinary education which should precede, if only partially, the actual beginning of the course of study in any school of Music Therapy.

The heterogeneity of the cultural and academic backgrounds of future music therapists must thus lead to a broadening of perspectives as regards their educational formation, as well as to a more focused approach to the problems that are inherent to this discipline.

Beyond this 'informative' aspect, which deals with the methodologies of learning as applied to different subjects, we should not forget however, that in each music therapy meeting, there develops an actual relationship between the music therapist and his/her patients, which in turn brings to the surface problems of interaction, notably those of elaboration of transferal and counter-transferal processes. It therefore becomes necessary, for the future music therapist, to follow a path of constant personal analysis in order to be able to know and face his/her own internal conflicts and regressive tendencies, comprehend the various modes of

interaction which may apply to such a relationship and acquire a direct experience with the communication and interpersonal processes which are developed within that given setting.

The music therapist should moreover get used to the dynamics that regulate the non-verbal context, within which he/she should experiment and refine his/her observation skills. In order to support the music therapist along his/her educational and learning path, Benenzon's theory envisages three levels of "didactic music therapy" along with a fourth level which corresponds to a phase of supervision.

This type of experience enables the student to progressively and independently deepen the universal and relational phenomena that are developed within the setting: each student will thus have the possibility to work with his class-mates, both as part of a therapeutic couple and as a patient, within a group which is coordinated by a professional music therapist and an observer. At the same time, the student will learn about the various protocol writing techniques and about how to use indications.

As part of this kind of formation it is therefore essential that each student be supported in the exploration and elaboration of the unconscious regressive nuclei that manifest themselves in the non-verbal context and which he/she shall in turn recognize in his/her patients. At the same time a personal tutor shall be chosen among all faculty members to act as a point of reference for the student throughout the entire course of his studies.

Another central aspect of the formation process, concerns the need to deepen the knowledge and use of one's own body language and expressions. The laboratories of dance-therapy and vocal technique allow the student to acquire the awareness that is essential to the utilization of space within the setting, and to the creative use of his/her own expressions within a therapeutic context as well as to his/her ability to listen to the inner dynamics which determine a patient's behavior. A music therapist, for instance, learns how to prevent conflicts and frustrations that are engendered from the patient's immobility or hyper-kinetic tendencies from overtaking him/her: in order to be present to oneself while in therapy, one necessarily has to first become familiar with one's own body language, and

learn how to recognize one's own sound identities (ISOs) and the intermediary personal and integrative objects which enter into the relationship.

To this aim, throughout the formation process, the technical knowledge of each GOS (instrumental operative group) instrument, their division into different categories and their historical evolution is also deepened, and so is the knowledge about the use of different materials. Within each level of didactic music therapy, the student will construct instruments of his/her own creation so as to explore his/her own creative and experimental resources.

The last phase of the academic course will be accompanied by a period of in-service internship within public or private structures, which will allow the student to closely observe different pathologies.

Among the requirements for becoming a music therapist, are, according to Benenzon, the vocation for service, the ability to maintain the professional secret and the knowledge of the moral and ethical problems related to the application of Music Therapy. It is thus important to start, with due caution, from the desire of the patient to establish a link, while respecting all expressions of rejection and keeping in mind that Music Therapy relies on some acoustic phenomena whose effects upon the human being are not directly known to us.

The orientation of those schools which apply Benenzon's theory leads the student to have a rather strong methodological imprinting, especially as far as concerns the clinical application of its two basic principles, the sound identity and the intermediary object.

Both the theoretical study and the stage/internship experience provide the future music therapist with a clear reference through which he/she will then independently find his/her own mode of therapeutic intervention.

FOR THE TRAINING OF MUSIC THERAPISTS ACCORDING TO THE METHOD OF PROF. BENENZON

Title: Theoretic and Didactic Models

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We believe it is important to read two works written with the intention of responding to this argument: the first produced by the coordinator of the school and the second by a 1st-year student. It is important to note the congruity of the two papers.

The school's objective is to train its students not in the music therapy discipline in a broad sense but to continually furnish the information and training along with clinical practice. In any environment in which one works: preventive, rehabilitative or therapeutic in the strict sense, the music therapist acts directly with the patient or group of patients. Since this interaction can be productive, we maintain that the music therapist must possess specific skills which, according to the model proposed by Prof. Benenzon, are:

- know and recognize his own sound identity and his own sound patrimony
- know and recognize the sound identity of the group into which he has been inserted and in which he works in a continual manner
- learn the use of the non-verbal code and the analogic type of communication
- learn to use a complex type of communication composed of verbal, non-verbal and corporal phenomena, always within the non-verbal channel
- the capacity to enter into communication with his own regressive levels
- awareness of the conflicts that are produced in the use of non-verbal channels
- a knowledge of transfer and counter-transfer processes.

In conclusion, the music therapist is a person able to perceive and manage the non-verbal context, through the use of the corporal-sound-musical instrument, with the aim of establishing a stable relationship with the patient who, within this context, can find the possibility of recuperating his healthy parts and changing his perception of himself.

Dr. Benenzon's theory maintains that the patient will acquire several theoretical concepts such as those of ISO, of setting, of GOS (Instrumental Operational Group), of classification of the instruments according to their use (intermediary, integral, incisive, etc.) and analysis of several models of corporal-sound-musical communication (imitation, question-and-answer, complex associations).

The training provides that after three years, every student, through the use of simulations, can experiment with the work with a therapist pair in conducting variable groups, in conducting a fixed group (the development over time of a therapeutic process) and individual type work in which the accent is on the relationship between the music therapist and the patient, always within a rather large range of sessions and aimed at learning the therapeutic process in its entirety.

The theoretical reference model is proposed in an experimental manner to all teachers of the course.

Other references of a theoretical and epistemological nature can be traced to various fundamental elements of Freudian psychoanalytic theory (Freud's first doubt) and to several elements of systematic-relational thought (Bateson, Theory of Systems and Watzlawick, Pragmatics of Human Communication).

For the entire duration of the training period, each student is assigned a teacher from the school in the role of tutor, to accompany and assist the student during the natural evolution of the personal experiences that will emerge during the training.

During the third year of the course, the students, also on the basis of the apprenticeship undergone, come under the indirect supervision of accredited teachers as supervisors and learn little by little the most fitting

modalities for presenting their work and the terms for gaining the most benefit possible from the work instrument.

The supervision model leads to the technical and lecture elements of psycho-dynamic events according to the BMT (Benenzon Music Therapy).

MUSIC THERAPY CONDUCTED ON A CHILD WITH INTELLECTUAL DISORDERS AND PSYCHOSIS, WITH SIMULTANEOUS PSYCHOTHERAPY CONDUCTED ON THE PARENTS

D'ULISSE M.E., GRAZIANI P., POLCARO F.

This case concerns R, a ten-year-old boy, the only child of parents who originally came from southern Italy, living in subsidized public housing provided by the Rome City Council since the family's economic conditions are precarious. In fact, neither of the parents has a steady job and they are unable to find employment because of their son's illness and the continual treatment he requires.

The first interview with the neuro-psychiatrist and the psychologist, both from the public health service, who have been following R's case, provided the following clinical information: R had suffered prenatal problems leading to delay in learning to walk and speak, though not particularly serious. Up to the age of eight, the child developed without showing any particular symptoms of disorder. From that age on, the situation changed and R began to show disorder symptoms, often falling down and apparently becoming unconscious.

After a series of clinical tests (including several CAT scans), the following two-part diagnosis was made:

- 1) congenital dilatation of the cerebral ventricle due to probable hyper-oxygenation at birth;
- 2) basic neurological problem combined with a subsequent psychotic disorder. His tendency to fall down was diagnosed as being due to functional hysteria.

Since October 1997, he has attended a special school for handicapped children but has had difficulty in settling down. At school, as at home, he displays randomly aggressive behavior, he frequently falls down, and often suffers from periods of hallucination.

He has made a number of day-visits to the "Bambin Gesù" pediatric hospital where he has been given anti-psychotic and anti-epileptic treatment.

At the time when we began music therapy, R showed the following symptoms: incontinence, randomly aggressive behavior, and frequent falling down. In addition, he wore a rigid corrective brace to help control the movements of his body and lower limbs, due to a serious form of scoliosis.

The therapy sessions were organized as follows:

- five or six weekly observation sessions in a music therapy setting, to evaluate the case and decide whether music therapy was a suitable form of treatment;
- five or six interviews with the parents (at the same time as R's music therapy sessions).

The music therapy sessions were conducted by two therapists (male and female), and the interviews with the parents were carried out by the female psychologist in charge of music therapy, who is also specialized in systemic psychotherapy.

The setting for the music therapy sessions was a room which had insulated walls, four windows along three sides, and a wooden platform at one end. The instrumental group we used was made up of thirteen instruments: a large sounding box, seven metal sounding plates, a pair of maracas, a bongo drum, a suspended plate and a xylophone.

The sessions had no fixed time limits since R used to leave well before the end which was originally planned for 35 minutes.

A total of thirteen sessions were held over a period of time running from April to October 1998.

After the first sessions, we realized that we were going to have to restrict R in some way by changing the layout and contents of the setting. In fact, one of the main problems was that we had great difficulty in dealing with R who would frequently leave the room, much to our anxiety.

Another problem which became evident was that the instruments we had chosen were not really suitable, in the light of R's randomly aggressive behavior. During one of the early sessions, he broke some of the instruments as well as a window in the room, causing slight injury to himself and one of the therapists.

After the evaluation period, having decided to continue the music therapy treatment, we made some changes to the setting from the sixth session onwards so as to establish clear rules of behavior:

- 1) every time R rushed out of the room, one of the therapists would stay in the room while the other would follow him without interacting with him;
- 2) the instruments could not be taken outside the setting;
- 3) some instruments were changed for others which would enable R to act out his aggression without any danger.

These new rules immediately gave shape to the sessions and caused a change in R's behavior - at first he was surprised, but this was followed by partial acceptance. Another aim of the changes was to differentiate normal sessions from those with the parents. From the outset, they had shown themselves to be incapable of consistent behavior towards their son, always saying yes to him and giving in to his every wish.

From the seventh session onwards, R began to accept the fact that he would have to take off his shoes and the heavy corrective brace before starting the session. Apart from making him feel more at ease, this enabled the two therapists to relax a little more since these items had been used by R to show his aggression (throwing the brace around and kicking us with his heavy shoes).

Generally speaking, during early observation-evaluation sessions with children, the normal practice in "Anni Verdi" centers is to interview the parents (or at least one of them) in order to gather all pertinent information about the child's background and audio experience, and to set up an atmosphere of collaboration and comprehension with the family so as to facilitate the working of the music therapy sessions. In the case of this family, these interviews proved to be extremely difficult right from the outset because both parents, especially the father, talked without stopping not so much about their son's therapy but more about their situation - their desire to be recognized as victims of their son's illness and their desperate need for every sort of help, in search of someone or something to whom they could delegate all decisions regarding themselves and their son. The father's manner of speaking was excited, overwhelming and often

accompanied by tears, tremors and fainting fits alternating with sudden outbursts of anger. The mother took little part, trying to control her husband more for the manner of his speaking than the content of what he was saying, and generally appeared to be in a submissive position. The father can only be defined as a borderline case (later we heard from the public health service neuro-psychiatrist that the father had been diagnosed as a potential manic psychotic and that attempts had been made to entrust R to the social services, thus removing him from his parents' care).

After the first three interviews, and when the parents had been told about R's tendency to leave the room, they expressed their fear that the therapists were unable to "control" their son and that he might end up hurting himself. They suggested that they should keep an eye on their son so as to be able to intervene at any time. At this point, the team of therapists took a stand and asked the parents to continue their interviews with the psychologist saying that these encounters would take place at the same time as R's music therapy sessions. The therapists explained to the parents that this decision was motivated by the need to work together in order to find an explanation for their son's behavior.

After eight sessions, the case was brought to the attention of Prof. Rolando Benenson because there were still serious problems with controlling R's behavior during the sessions.

Following this, further changes were made in the arrangement of the setting:

- 1) the door to the room was locked during sessions;
- 2) potentially "dangerous" musical instruments were exchanged for lighter, more maneuverable ones (newspapers, water clock, sponge balloon, rattles, etc);
- 3) the therapists kept their distance from R so as to preserve his territory and not invade his private space.

The sequence of events in the next session was as follows:

- a) the locked door provoked an aggressive demand from R that it should be opened - this was not done;

b) the two therapists created a sequence of movements accompanied by singing; in fact, the whole session was made up of rapidly changing movements accompanied by singing and often by musical instruments;

c) they kept their distance from R so as not to invade his space; this however made him try to approach the male therapist ever more closely, leading to prolonged bouts of wrestling and body contact.

In spite of this, some important changes in the therapeutic relationship began to appear for the first time. After having tried, and failed, to open the door several times, R seemed to accept the fact and began to take an interest in some of the musical instruments. First he explored them, then he turned to the therapists with the clear intention of wanting to communicate. In these brief moments of attention, R managed to abandon his aggressive manner and allowed the therapists to approach him, almost as if he wanted to be coddled (he allowed the therapists to put on his shoes, his brace, his glasses and all the other clothes which he would usually throw off during the sessions).

After this session, in the three subsequent sessions before the summer break, two main aspects of the relationship emerged:

- 1) his aggressive behavior was aimed almost exclusively at the female therapist with whom he had the same prolonged bouts of wrestling and body contact as he had done previously with the male therapist;
- 2) we noted an increase in R's acceptance of the therapeutic situation in which he found himself, as shown by less tendency to run away and the emergence of questions such as "How long before I can go away?" "Where are my parents?" etc.

At the same time, the interviews with the parents continued always with the aim of trying to make sense of R's behavior. They were both asked to observe carefully at home, and to report back in their own words, on whatever took place immediately before their son's aggressive crises. This information was produced at subsequent interviews in spoken but very disjointed comments. And yet there appeared to be a logical thread in R's behavior who became more aggressive whenever he was ignored or overlooked (talking about his illness in front of him as though he didn't

exist; giving him orders as though he were incapable of any rational decision, etc.).

An attempt was made to help the parents understand their son's situation and an appropriate course of action was adopted on the rare occasions whenever the two therapy groups - the parents and the son - came into contact at the center. In fact, every time R left the setting ahead of time or at the end of the session, to go to the room where the parents were being interviewed by the psychologist, she welcomed him, explaining what was going on and getting him to take part; she would ask him, for example, why he thought they were so worried about his behavior and would then bring the interview to an end with a suitably phrased word of thanks. On these occasions, R never showed any type of aggressive behavior and managed to handle the situation and his interaction with the group in a reasonable manner; he was able to express himself in a way that was understood by everyone, and sometimes even managed to communicate with metaphoric language.

Then and there, the parents seemed to accept this approach and even seemed to begin to take more interest in their son's problems. What was not immediately obvious (even to those who should have expected it) was the gradual distancing of R from the sessions.

For bureaucratic reasons relating to national health system regulations, when the sessions began again after the summer pause, we were forced to change the music therapy setting.

We had to move to a smaller room in another "Anni Verdi" Center which did not have the wooden platform we had been using with R up until then.

In spite of this, the main features of the new treatment sessions were as follows:

- 1) During the first five or six minutes of each session, R would vent his aggression on the surroundings (breaking musical instruments, hitting the walls, doors and windows), all of which could be called a cathartic reaction. Although this linked back to a constant feature in his behavior, it was a different type of aggression in that it was not directed at the therapists.

2) During the sessions of 35 minutes each (the longest since the beginning of the treatment), R never asked to leave the room and never threw himself against the door trying to open it, as he had done previously.

3) Moments of interaction with both therapists increased (during games) and he showed more interest in the musical instruments and other objects present in the setting.

4) R began to use suitable and comprehensible verbal language to which both therapists replied verbally.

5) He began to show compulsive/sexual behavior patterns and continually tried to make physical contact exclusively with the female therapist. His mother, in her talks with the psychologist, said that at home he often tried to make "unacceptable" physical contact with her.

6) R's display of negative behavior no longer took place during the sessions but only when we told him that it was time to say goodbye.

The parents were very anxious about him. The tone of the interviews had been that R was not "raving mad" but was trying to show his insecurity, and that his aggressive behavior was an attempt to attract attention. Moreover, if R is not mad and begins to interact with his surroundings in a more manageable way, then the parents will have to deal with their problem as a couple (for years, they have had no time for themselves, they are no longer intimate and spend all their time looking after R) and as individuals (inability of both of them to hold down any sort of work; any work they do manage to find is immediately interrupted by one of R's crises when both have to run to his side).

In the later therapy sessions, R used to arrive at the center with both his parents, but every time he created a scene so as not to come in (crisis on the bus, symptoms that required an ambulance, physical block outside the door to the center). For this reason, since it was impossible and unadvisable to hold the sessions somewhere else other than the established setting, the two therapists were forced to stop the music therapy treatment.

In fact, we saw R for the last time in October 1998 and since then we have only had occasional news of him from colleagues in the national health service; they say that his condition has worsened, that he is frequently in

and out of hospital, and that, at home, he often has to be tied to a bed with sides (like a hospital bed) to stop him falling out.

The members of the music therapy team have discussed this case amongst themselves; each person was deeply affected by it and, at a distance of a year, its emotional impact is still felt by all concerned. The treatment undertaken was of a complex nature and the good level of communication and interaction achieved by one of the groups (two music therapists with R), which gave some indication of possible improvement in R's main symptoms, conflicted with the rigidity of the other group (psychologist with parents) who were unable to see their way towards adopting a different mental attitude when faced with a changing situation.

It is important to bear in mind that the parents did not have any other support, apart from the interviews with the psychologist, in their attempt to change their approach because everybody else who came into contact with the family confirmed the original diagnosis - that the parents attitude was dictated exclusively by their son's illness.

Even the psychologist was aware that such radical changes do not come about without a massive effort by everyone concerned - first and foremost, society as a whole and the community in which the family lived. However, R needed our attention (just as any other child or adult patient would) and we are grateful to him for what the experience taught us, both professionally and at a human level.

A MUSIC THERAPY PROJECT INVOLVING AN AUTISTIC CHILD AND HIS PARENTS IN AN ATTEMPT TO FIND NEW WAYS OF COMMUNICATING

M.E.D'Ulisse, Ferrara Carmen, Arborio Fulvio, Montori Adriana, Picconi
Cristiana

This experimental music therapy project, promoted and financed by the "AnniVerdi" Association, involves children with autistic traits, and is aimed at improving the communicative ability of such children within the family circle.

For this project, we based our research on the work of Prof. Benazon in whose opinion autistic children (irrespective of the causes of the illness) continue to show behaviour patterns typical of the intra-uterine phase, during their extra-uterine life, after birth. These behaviour patterns include: isolation, a marked tendency to return to the foetal position, pleasure in contact with water, and a perception of time based on their own psycho-biological rhythms.

Prof. Benazon's observations also cover the communication patterns within the subject's family unit. He has noted the recurring feature of stereotype messages that force the child to close up in a pseudo-protective shell. He defines these rigid and repetitive systems with the term "communicative cysts".

Against this background, it was decided to carry out active music therapy treatment, seen as dynamic interaction between the therapist and the patient who uses non-verbal messages as a means of communication, by means of a combination of body-sound-music techniques. This non-verbal approach is a fundamental characteristic of music therapy since the "communicative cysts" are generally made up of verbal messages.

Organisation of the project

The sessions were held in two separate premises of the "Anni Verdi" Association; they were recorded on video cassettes and were as far as possible in a uniform setting especially with regard to the Instrumental Group (GOS) made up of percussion and melodic instruments, conventional and otherwise.

The project involved 24 individual sessions on a weekly basis, lasting about 40 minutes each, and was arranged in the following stages:

1. a phase of observation and evaluation;
2. a phase during which the therapeutic process took place;
3. inclusion of recorded audio material relating to the family background;
4. several sessions with the child's parents;
5. a final phase involving gathering data and saying goodbye to the patient.

Communicative process

The children came from outside the field of the Association's activities and were chosen by random selection. The team psychologist explained to the parents the aims and procedures of the project, the time involved and the methodology of the research project.

During these interviews with the psychologist, several questions emerged regarding the fact that participation was free of charge, the possibility of continuing the music therapy sessions afterwards, and the reason for the active presence of the parents during the sessions.

Further clarification took place in interviews with the therapeutic team, enabling a rapport of trust and collaboration to be set up. In fact, the families were kept informed (after every four or five sessions) by written reports and further interviews, on the progress that had been made.

For their part, the families provided recorded audio material on the background of each member, and filled out a music therapy questionnaire.

The following summarises briefly the case of F., as an example of the work carried out:

F. is nine years old and has been diagnosed as being slightly retarded in a cognitive sense, with autistic traits and having difficulty in socialising. His family is made up of two parents and a younger brother aged six.

The mother is extremely forceful and, in her rapport with her elder son, has transferred into the family setting some of the attitudes and methods of her work as a teacher. She seems unable to encourage any spontaneous behaviour on the part of her son. She has a predominant role in the family even though she often retreats behind her husband in order to gain time before taking decisions. The father resents the mother's predominant role and seems not to have any say in matters relating to F's activities.

He is a person of few words and tends to have a passive attitude to life (he doesn't express his ideas openly), but at the same time he has a strong influence on the child. Initially, the boy was indifferent towards the setting and the music therapists; he would only use the piano which belonged to the family and which the father played.

During the second session, the two music therapists brought in several other instruments hoping to draw F. away from his isolation with the piano. Amongst the instruments, the water clocks caught the boy's attention and extended his interest to the rest of the setting which he still hadn't explored. But mainly they served as a stimulus for the first contacts with the music therapists. This was the beginning of a process in which the boy changed his way of behaving, coming closer and joining in more often with the music therapists, sometimes interacting with them but more often with the water clocks used as intermediary objects. He imitated and sometimes responded to the sounds both vocally and with movement. Furthermore, his body movements became less rigid, his use of space less selective, and more eye contact was established.

His strumming on the piano began to take on a more structured form and eventually he began to play a simple tune which was reinforced vocally by the music therapists using words evoking water in movement ("It goes...glug, glug"). This became the guiding theme for subsequent sessions.

In the later sessions, F. still kept up his tendency towards isolation but at the same time he responded well to tasks involving water and enjoyed listening to the recorded material provided by the family. In this way, communication within the sessions increased and also within the family, according to the parents. The introduction of the parents into the sessions

in a non-verbal setting highlighted the communication difficulties within the family. But at the same time, this enabled the music therapists to analyse the "communicative cysts" which had emerged during the initial interviews. These are the cause of the difficult relationship between the members of the family.

Analysing the sessions with the parents in detail, it was noted that the boy came into the room, reacted slightly to the music therapists' welcome by going over to the piano, but then didn't play. It seems that the presence of the parents, especially the father, inhibited F's behaviour.

Subsequently F increased his moments of interaction with his mother and the music therapists by playing with water. By contrast, the father started playing the piano inviting his son to join him. Both parents, in particular the mother, used verbal communication in spite of the fact that it had previously been agreed that this was a non-verbal setting. The child continued to wander around with the water clocks for the whole session, using them in a defensive manner as he had done with the piano during the first session. Towards the end, one of the music therapists sang the child's tune involving the parents as well. It was noticed that stereotype messages emerged within the setting whenever the parents did not follow the expressive techniques used by the music therapists. In attempting communication with his parents, F tried several times to use the modes of expression used in the sessions by the music therapists since by now they were his point of reference.

Summarising the information gained in the project, it can be said that the use of non-verbal techniques encouraged in part changes in the way the patients communicated, increasing the rapport with the music therapists, and with the family according to the parents.

The use of non-verbal communication enables patients to increase their interaction with the surroundings and with the musical instruments, also modifying their body movements. The development of the rapport enables patients to accept the close presence of the music therapists and to initiate and maintain eye contact, thereby setting up a body-sound-music relationship. In conclusion, we can say that the use of non-verbal techniques

and of alternative communication channels, as well as experimenting with the child's own expressive modes leads to increased communication and exchange of information within the family unit.

APPLICATION OF THE BENENZON MUSIC THERAPY TO PATIENTS AFFECTED WITH ESSENTIAL HYPERTENSION

D'ulisse, M.E.; Ferrara, C.

Premise

This work refers to an experimental application of the BMT in psychosomatic medicine whose aim is to test the potential of this therapy in regard to essential hypertension. We are speaking of an experience that lasted about six months, conducted by the Music Therapy Service of the "Anni Verdi" Association in collaboration with the Università Cattolica del S. Cuore (Psychiatric Institute, Medical Pathology Institute), which was presented and discussed at conventions (Louvain, 1998; Rome, October 1998), while amplifying the conceptual and procedural references, especially regarding organization and quantification of the data. Then the complete treatment and conclusive exposition of the aspects that have emerged up to now in the described pilot program, with reference to possible later developments, will be given.

The basis of the work consists of several psychological conceptions of psychosomatic illness to which we will make a preliminary reference, limiting our observations solely to those cultural aspects that can best be articulated with the BMT.

Theoretical considerations

In general two fundamental aspects can be discerned in psychosomatic medicine: one is a basic attitude that considers man in his entirety and aims at considering psychological and organic phenomena as a whole. The second aspect, less ambitious but better grounded empirically, seeks to trace the psychological determinants of disturbances, whether anatomical or functional.

Literature on the subject is vast and it is therefore difficult to limit this introductory note to those fields of research that can be most easily articulated with the BMT. We will only mention several authors who have written about the emotional expression of the psychosomatically ill person,

while adding several more specific concepts regarding the organization of the personality of the hypertensive individual.

To begin with, we can cite Alexander (1950), whose hypothesis we indicate below: "Whenever, in voluntary behavior, there is inhibition of the expression of the competitive, aggressive or hostile attitude, it is the adrenal-sympathetic system that sustains the excitement. The vegetative symptoms are the result of a sympathetic excitement, sustained and persistent, due to the fact that in the field of voluntary coordinated behavior there is no outlet for the struggle and flight reactions; this is demonstrated by the example of the patient suffering from essential hypertension whose behavior appears inhibited and excessively controlled". In agreement, Weiss (1950) affirms that "Regarding the impossibility for the subject to express the tension adequately with words or actions, an outlet is created in the circulatory system. The hypertension arises from vasospasm of the arteries which, throughout the years, will lead to a hyperplastic sclerosis and insufficient activity of important organs such as the heart, brain and kidneys. It can be considered that, despite the organic nature of essential hypertension, the psychic factor becomes important due to its etiology". Finally, Alexander and Soul (1950) noted in their hypertensive patients attitudes of cordiality and self-control that defended them from strong aggressive impulses accompanied by anxiety.

In 1970, Némiah and Sifnéos studied word-for-word transcriptions of the psychiatric interviews of 20 patients who showed classic psychosomatic illnesses. In 16 of these patients, they noted a great affinity in the mode of expression and they introduced the term, "alexitimia" (a=without, lexis=word, thymia=emotion) to describe the notable difficulty in verbally expressing their sentiments, emotions and affections, and also the poverty of their phantasmal and oneiric lives and a type of thought that was essentially pragmatic (Pedinelli 1985). Therefore, alexitimia is a particular mode of functioning of the psyche both at the cognitive level and at the affective level and is defined also by its difference from the neurotic picture, to which it presents characteristics that are diametrically opposed. The alexitimic (alexik) subject, in fact, expresses boredom, frustration,

emptiness, describing events in detail but not finding the words to express the sentiments and resorting to uncoordinated nervous activity to resolve conflicts and his relational life is generally poor. According to several writers, the alexitimic (alexia) disposition contributes to the appearance of certain somatic disturbances through the rupture of the psychosomatic homeostasis, described as "separation of the subject from his unconscious" or as a loss of all "phantasmal liberty" and the capacity to represent affections (Marty 1963).

Keeping in mind what has been stated so far, music therapy can be considered on various levels. First of all we will consider the ISO (from the Greek: equal) as a sound and internal movement phenomena that affects our sound archetypes; we will then consider the gestalt ISO as a dynamic mosaic that characterizes the individual and is made up of the intrauterine sound experience, that of birth and infancy, up to the present age; and finally we will consider the complementary ISO which is the sum of the small changes that occur each day, or in every music therapy session, under the environmental effects and dynamic circumstances. According to Benenzon (1997), in the therapeutic process, "The energies deriving from the gestalt ISO are mixed in the unconscious with those of the complementary ISO of the preconscious, thus becoming conscious and opening up towards the outside". In addition, "In the therapeutic situation, the energies of the patient are liberated and when he or she undergoes music therapy, the energies touch their complementary and gestalt ISO. There is an emission from the energetic response that, on reaching the conscious, re-elaborates the message as part of the discrimination between the person's recognized ISO and that of the patient. The direct objective of the response, re-elaborated by music therapy, is to touch the complementary and gestalt ISO of the patient, from which will clearly emerge a reconstructive dialog of the internal dynamics."

From the dynamic described, we note the mobilization of a flux of energy that begins within the personality without the mediation of language or thought, making the patient able to avoid the difficulties caused by an

passive disposition or by the operative structure of the thought we described above.

Description of the experience

The Medical Pathology Institute includes a department for the study and treatment of patients affected by essential hypertension. The medical team carries out a preliminary screening of the patients to be sent to music therapy according to specific indications. Among these are age, sex, and the absence of drug-taking.

During preliminary talks with the individual patients, information is furnished regarding the work methods: the non-verbal context of the therapy and the active use of musical instruments, both conventional and non-conventional; contextually, a Sound History File is compiled for each patient, in order to inform the music therapists of the musical characteristics present in the family and in the personal history of each patient.

In all, 15 sessions were held, from November 1997 to March 1998, which took place weekly at the Policlinico "Agostino Gemelli" in Rome - the Institute of Psychiatry and Psychology.

The methodological approach of the BMT provides for the constitution of a therapeutic conductor pair of the experience and the establishing of "before and after" protocols for the phenomenological surveying of the individual sessions held. In addition, in reference to this specific field of application, consideration was also given to outside observers who would point out, during each session, certain specific parameters concerning the sound production during the sessions, such as: intensity, rhythm, melody and movement.

Following this, the video recordings were studied while noting, for each individual patient, the quantifying elements regarding the two variables, that is the relationship with the instruments and the relationship with the therapists (Raglio 1996). Elaboration of the data at first followed the statistics laws described by the calculation of the average (\bar{x}) and the standard deviation (S). The elements observed and written down were collected to investigate the course of the phenomena for each session under

examination and to ascertain a correlation between the data obtained by the observers, in order to establish the reliability of the judges.

The Medical Measurements

At the end of the cycle of music therapy sessions, the patients were subjected to a careful examination of their pressure condition and in all cases under examination there was found to be an appreciable improvement of between 15 and 18%.

The Observations of the Music Therapist

We will comment on the work done so far by giving the description relative to patient "A" regarding the music therapy process and the clinical data achieved.

"A" states during the interview that he is annoyed by loud, repetitive sounds.

To our amazement, during the session he expresses himself exclusively with obstinate rhythms and with a high intensity of sound production.

The use of instruments is mainly defensive and there are no dialog elements present. When asked to bring instruments constructed from everyday objects, "A" does not come to the session and at the next session he does not mention his previous absence. There is a gradual gratification in the music therapy work from the moment it is verbally and non-verbally confirmed that there will be no judging of his production, which is often accompanied by discharge of catarrh. During the 5th session, where he was alone due to the absence of the other participants, a particular relationship was set up which we considered a counter-transference of the parent-son relationship. The addition of the water element to the therapy allowed "A" to adopt sounds that were less loud, producing silence and an opening for dialog. In the concluding feed-back, "A" pronounced judgments regarding his friends and acquaintances that put him in a better humor.

In reference to the group life in its entirety, it can be affirmed that there were three work phases: experimental, defensive and communicative. The last was the prelude to the acquisition of new modes of interaction with

the space and stimulation, necessary for the modification in the vital elements of the individual.

Regarding the first point, the approach of a “free” *setting*, but with the presence of semi-rules, prepared the patient for *experimentation* with new modes of communication aimed at entering the environment of the non-verbal and seek out expressive capacities different from the conventional ones. This was verified by means of:

- eye contact with the music therapist and the surrounding environment.
- the search for a prevalently corporal approach to the free space of the environment.
- seeking and understanding the “functioning” of an instrument.
- the building of a *communicative code* different from the verbal one.

Later, regarding the second point, it emerged that the approach to new expressive modalities created difficulties in their acceptance and in maintaining prolonged contact with them; there then occurred a phase, called “defensive”, in the music-therapy environment that expressed itself in the continual use of instruments and the fabricating of structures that were rhythmic, incessant and repetitive. This is a necessary phase until the patient can trust his unconscious energies to the establishment of a “here and now” therapeutic.

In the advanced phase of the work, the last point, the acquired use of the space, the transformation of the instruments from defensive to intermediary allowed the actuation of the energetic discharge necessary for communication between the ISO of the patient and that of the music therapist, a principle of the Benenzonian theory.

Borrowing a view from the experience of the subject in Existential Analysis (Dasein), the patient can be considered to be affected by essential hypertension as a form of existence that, living in restricted time and space, expresses it analogically through the mechanisms of vasoconstriction, as a restriction of the experience of the patient.

Conclusions

We can summarize the change in behavior and nervous movements of the three patients by the end of the music therapy treatment in two observations: musical and sound production and relationship with the space.

In addition, beyond the obvious individual differences, we will indicate what characterized the change in sound production by the three patients, which was accomplished through:

- increased rhythmic articulation. There was a gradual passage from an obstinate binary production to more complex rhythmic cells (triplets, binary rhythms);
- connections between rhythm and movement. The appearance of dance rhythms and the functional use of music (they beat time as they danced or played to induce dancing);
- increased aleatory in the rhythmic/melodic production;
- the appearance of moments of silence, pauses, at first declared intolerable;
- the unconventional use of instruments, as integrated objects (thrown, exchanged, strummed together).

This last point is closely linked with the actions of the group in the freer space in the management of the defense of the personal/individual kinesphere; the appearance of dance movements, the exchange of instruments, the experimentation with the sounds of the room (beating on the furniture and walls).

In our opinion, all these observations agree with the general consideration of the benefit the patient affected by essential hypertension can derive from the use of a structured setting as "permissive", facilitating free expression and a therapeutic relationship that is gratifying and not dominating.

This work was characterized by "systematic observation", in the sense that all the empirical operations were essentially repeatable and it represents a premise for successive experiment. By this we mean that music therapy treatment, when determined environmental conditions are

repeated, can be correctly applied even in institutional contexts that do not provide music therapy. Secondly, the therapeutic process was organized in a manner to be observed from various points of view: this is the reason for the use of the video-cassette grill, of the presence of non-participating observers. The material collected can be subjected to later analysis. In particular, the simple procedures of statistics calculation described offer a panoramic view of the course of those phenomena that have an intrinsically quantitative structure (intensity of sound production, movement in the space) and the successive correlation procedures, indicate significant links (direct and inverse) between the variables.

The final conclusion to be drawn from the organization of this observational evidence is that music therapy treatment is capable of great variability (regarding subject, instances of experience and observers) and this variability, far from representing an inconvenience, is a great source of scientific knowledge, as long as it can be gathered and treated conveniently. For this reason, a future experimental operation on this theme should include the enlistment of at least two samples (experimental and control) subjected to two treatments (e.g. BMT and vocal production) scrutinized with two models of variance analysis.

The musical Time-Space, Cannabis and the Brain in an EEG-Mapping Investigation

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Abstract:

The use of psychedelics in psychotherapy setting with music, as well as comparative research on drug-induced altered forms of perception have been roots of music therapy, (e.g. GIM). Changed perception filter functions have been used for psychotherapeutic issues but the uncontrolled use of psychoactive substances in popcultural environments increased social and personal problems. Valid estimations of drug-induced music perception are of certain interest for music therapists working with addicts. The question arises, "Is there a lasting imprint of state-dependent music experience and habituation on the use of music?"

Since the beginnings of jazz the connection between cannabis consumption, music production and creativity has been controversially discussed; but research on this topic has been very rare. The recently discovered endogenous cannabis receptor sheds a new light on memory, movement, space and time perception processes and imagery and association patterns.

Presented here is an explorative study on Cannabis and Music Perception, conducted in a qualitative and quantitative way in a habituated setting. EEG-Brainmapping Data (rest; pre/post listening; 28 EEG traces; smoked Cannabis, containing 20 mg Δ^9 THC) were averaged and treated with a T-test and a visual topographic schedule.

Compared to pre-THC-rest and pre-THC-Music in the post-THC-Music-EEG a rise of Alpha percentage and power was observed in the parietal cortex on four subjects, while other frequencies decreased in power. Decreased amplitudes could represent a decreased cell-firing mode caused by cannabinoidreceptor mechanism. Comparing pre/post music EEGs, differences ($p < 0.025$) were found in the right frontotemporal cortex on Theta and on Alpha in the left occipital cortex.

Changes in temporal and occipital areas and increasing α -signal strength in parietal association cortex seem to represent a neural correlate of altered music perception and hyperfocusing on the musical time-space. Alpha amplitude changes remind on 'reverse Alpha' findings in studies with gifted individuals.

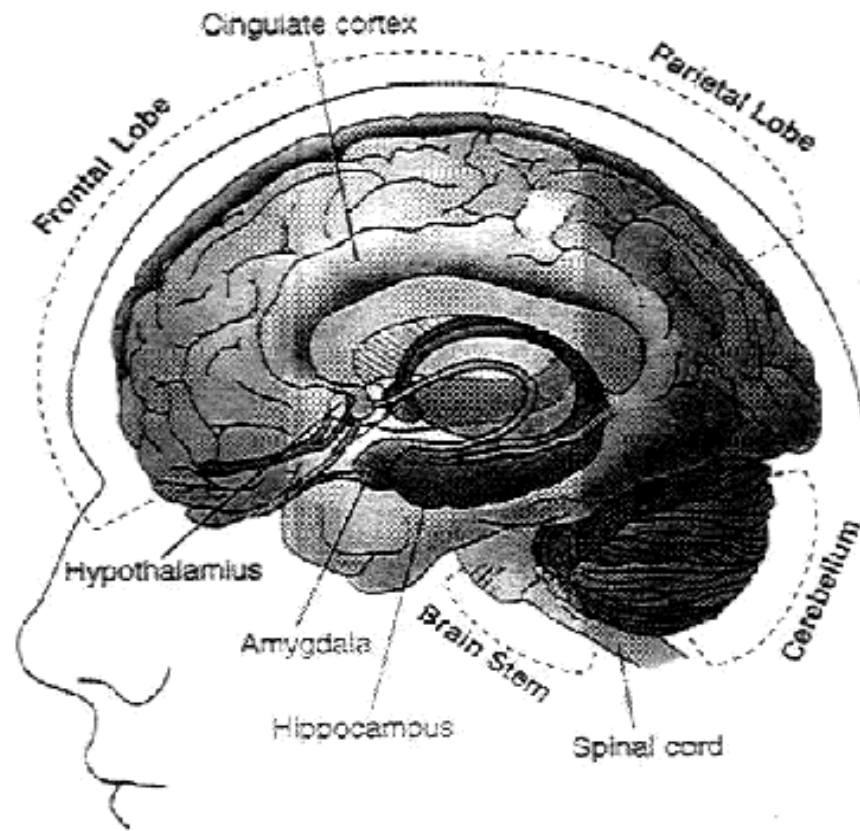
Cannabis-induced changes

- Seashore-Rhythm-Scale Aldrich 1944, Reed 1974)
- Time and space estimation tasks (Jones Melges 1970/1, Tart 1971, Casswell 1973, Mathew 1998)
- Auditory intensity perception (Caldwell 1969, Tart Globus 1978)
- Preferences for higher frequencies deSouza 1974)
- Synesthesia (Baudelaire 1845, Tart 1971, Marks
- Visual depth perception (Emrich 1989)
- Imagery (Tart 1971, Koukkou 1976/8)
- Cognitive style (Dinnerstein 1968, Curry 1968)

Cannabis induced perceptual changes and a possible link to musician's creativity has been discussed since the early days of Jazz. Research on this topic has been very little.

In the 40th Aldrich observed a little change on the Seashore-Rhythm-Scale (Aldrich, 1944), a result, which was replicated with higher changes by Reed in the 70th (Reed, 1974). Melges explained Cannabis-induced effects on time perception as speeding up of the internal clock (Melges, Tinklenberg, Hollister & Gillespie, 1970; Melges, Tinklenberg, Hollister & Gillespie, 1971), which is experienced as time expansion (Tart, 1971). Changed time estimation may temporarily enable an increased insight into the space between the notes (Whiteley, 1997). In audiological tests cannabis changed metric units of auditory (intensity) perception (Globus & al, 1978) and induced preferences for higher frequencies (de Souza, Karniol & Ventura, 1974). Descriptions of synaesthetic effects (Baudelaire, 1988), weakened censorship of perceptual filter functions (Emrich et al., 1991) and a transition to a divergent style of thinking, suggest an intensification of individual cerebral hearing strategy, resulting -like Curry proposed (Curry, 1968)- in a hyperfocusing on sound, on acoustic space and musical time-structure.

Cannabinoid Receptors in



Even that it is possible now to link cannabis action mechanism to the density spread of recently discovered cannabinoid receptor system in brain and immune system, topographic pre/post EEG studies are not available. Most receptors have been found in frontal and parietal lobe, gyrus cinguli, hippocampus and cerebellum (Joy, Watson & Benson, 1999).

CAN EEG

- Aims: Brain Damage?
- Methods:
 - laboratory pre/post rest EEG
 - visual analysis
 - QEEGs
 - mostly 1-2 Electrodes (Cz, O2, P3) attached to rear right Hemisphere (Rodin 1970, Hollister 1970, Volavka 1971/3/7, Roth 1973)
 - Hanley 1976 (QEEG F3+4; C3+4, P3+4, O1+2)
 - Koukkou 1976/8 (QEEG T6-, P4, + O2)
 - Lukas 1995 (QEEG C3+4, P3+4)
- Results (visual and QEEG)
 - transient EEG changes spread over the timecourse of drug action
 - in- or decrease of α - % and power
 - slowing of main α - frequency and transition to θ
 - decrease of θ - % and power
 - decrease of β - % and power
 - slower or faster β - frequency
 - task , dose and setting related results
 - sensitivity lack to drug action and timecourse

Transient cannabis induced EEG changes are known from laboratory tests. Most EEG studies were centred on a proof of brain damage with casual or long-term use. Quantitative EEG measuring of the 70th commonly used 1 or 2 Electrodes for analysis, mainly attached to the right occipital, or parietal areas (Hollister, Sherwood & Cavasino, 1970; Rodin, Domino & Porzak, 1970; Roth, Galanter, Weingartner, Vaughan & Wyatt, 1973; Volavka, Crown, Dornbush, Feldstein & Fink, 1973; Volavka et al., 1971; Volavka, Fink & C.P., 1977). Results are somewhat contradictive. Hanley's quantitative EEG-Study, done with 8 electrodes from frontal to occipital areas, concluded only decreased amplitudes and percentage over the whole spectrum (Hanley, Tyrrell & Hahn, 1976). Others reported an increase in relative α -percentages and power, a decrease in main or centroid frequency and a transition to θ during contemplation, as well a decrease of relative θ - or β -percentage and power (Struve & Straumanis, 1990). Only in Hess and Koukkous work music has been part of the experimental setting (Hess, 1973; Koukkou & Lehmann, 1976; Koukkou & Lehmann, 1978). Both reported the above mentioned results, but results spread over the timecourse of drug action. Lukas correlated euphoria and higher α -Index during the first 20 minutes (Lukas, Mendelson & Benedikt, 1995).

Aims Section

It seemed to me as if most of the laboratory studies lacked of sensitivity in experimental setting. Cannabis induces a field-related perceptual style as Dinnerstein concluded (Dinnerstein, 1968). To reduce the laboratory bias in EEG results, the field-dependence of drug action in personal set and experimental setting has to be kept in mind by conducting a research paradigm (Weil, 1998) on the topographic changes induced by Cannabis in rest and during listening to music.

Method Section

Experimental Schedule

Pre-THC-EEG (music and rest - eyes closed)

Listening to 3 Rock music pieces (defined order)

1 minute silence/rest between the songs

30 minutes intermission

Smoking 0.3 gr. Cannabis (20-25mg THC) in tobacco joint

After 10 Minutes EEG start

Post-THC-EEG (music and rest with THC)

**Listening to the same music / same measuring situation
and setting**

4 Subjects (3male/1 female)

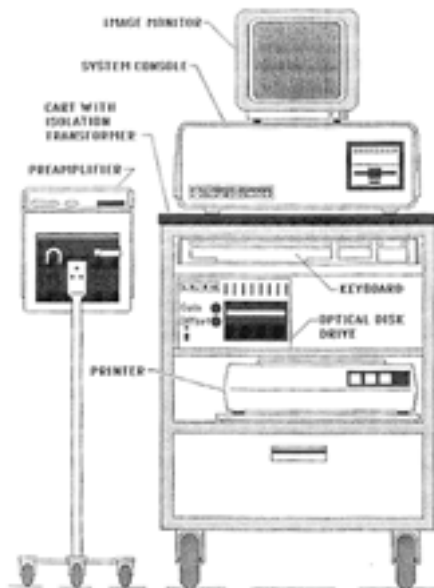
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To explore, how laboratory bias can be reduced, a non-blind pilot study was conducted with a mobile bedside EEG-Brainmapping system in the consumers habituated setting of a living room. Four subjects (3 male/1 female) smoked a tobacco joint mixed with Nepalese hash, containing the psychoactive ingredient Delta-9-Tetra-Hydro-Cannabinol - in the following

THC - listened with closed eyes to three pieces of rock music in a comfortable armchair. EEG was recorded through rest and music listening

NeuroScience BrainImager (1988)

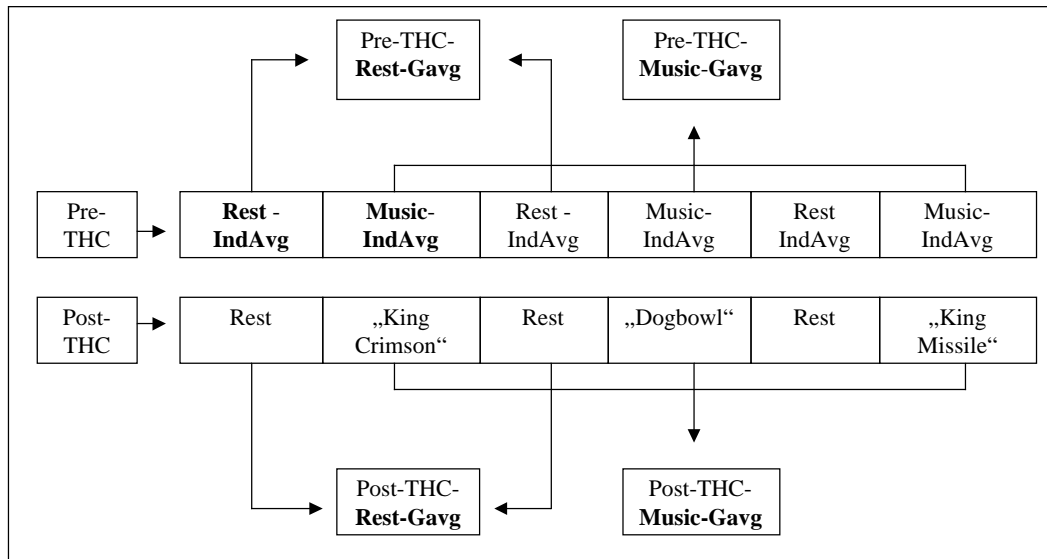


- 28 Electrodes; 12 Bit A/D (4096 d/s @ 256 μ V DR); Notch Filter; Cut-off: 0.3+40Hz (used)
- Average Maps over 2.5 seconds
 - Delta (0.39 -3.9 Hz);
 - Theta (4.3-7.8 Hz);
 - Alpha (8.2-11.7 Hz);
 - Beta I (12.1-16.0 Hz);
 - Beta II (16.4-30.0 Hz);
 - Spectral Map;
 - Roll-off (3 dB in 0.25 HZ)
- Individual and Group Averages Sub-Avg; Standard Deviation Mapping;

The NeuroScience BrainImager, manufactured 1988, samples 28 EEG traces with a 12 Bit analogue/digital converter. This offers 4096 dots per second within a dynamic range of 256 μ V. It provides a sample accuracy of 1/16th μ V. Average maps are processed every 2.5 seconds. Using it for example in an intensive care unit, the Imager is equipped with an isolation transformer and shielded pre-amplification, as well as a notch filter on 60 Hz to reduce electromagnetic fields influences in hostile environments.

Impedance levels have been kept under 11 k Ω . Cut-off filters were set to 40 and 0.3 Hz. EOG, ECG or EMG traces for artefact control have not been administered to avoid laboratory bias. Artefact control was done visually by a time coded video protocol. After removing potential artefact maps individual and group averages have been processed using the statistic software package of the NeuroScience Brainimager.

Individual and Group Averages



1 single case with follow up → 4 cases → total group averages

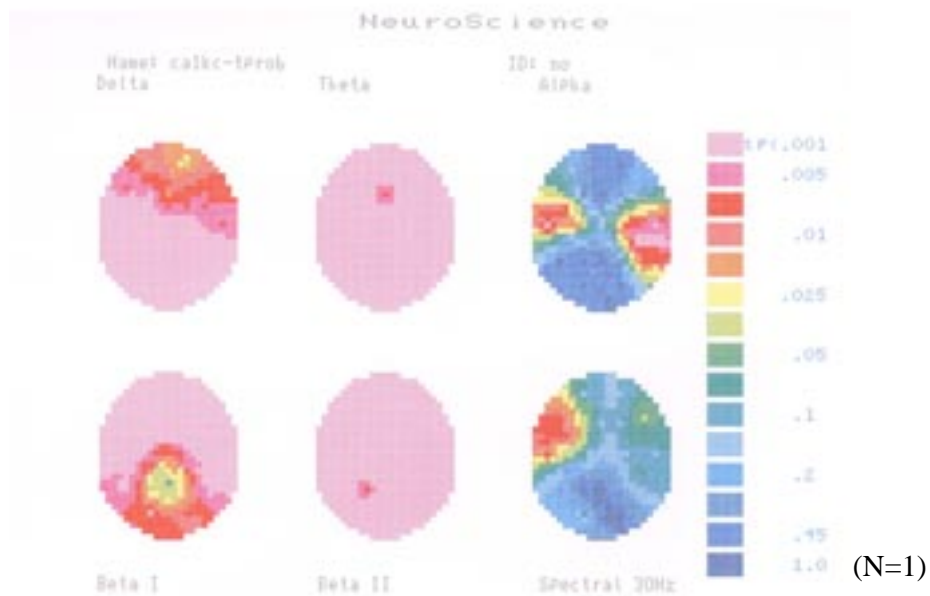
Pre/post rest and pre/post music listening was averaged and treated with a T-Test.

The investigation included one extended single case study with a follow-up; research focus for each person was on individual drug and music reactions and the total group average of the pre/post rest and music sessions over the sample.

Result Section

The first picture shows the T-Probability mapping of the EEG Changes from pre- to post music listening for the first piece of music on subject "ca1". Reference file was pre-THC listening and it was compared to post-THC Music listening. From the upper left to the right we see δ -, θ -, and α -probabilities, below Beta I+II and the spectral mapping. The view is from above as a dual Mapping. Significance decreased with the second and third piece of music.

T-probabilities EEG-Changes Music
Reference: pre-THC-Music-IndAvg (King Crimson)
Comparison: post-THC-Music-IndAvg (King Crimson)

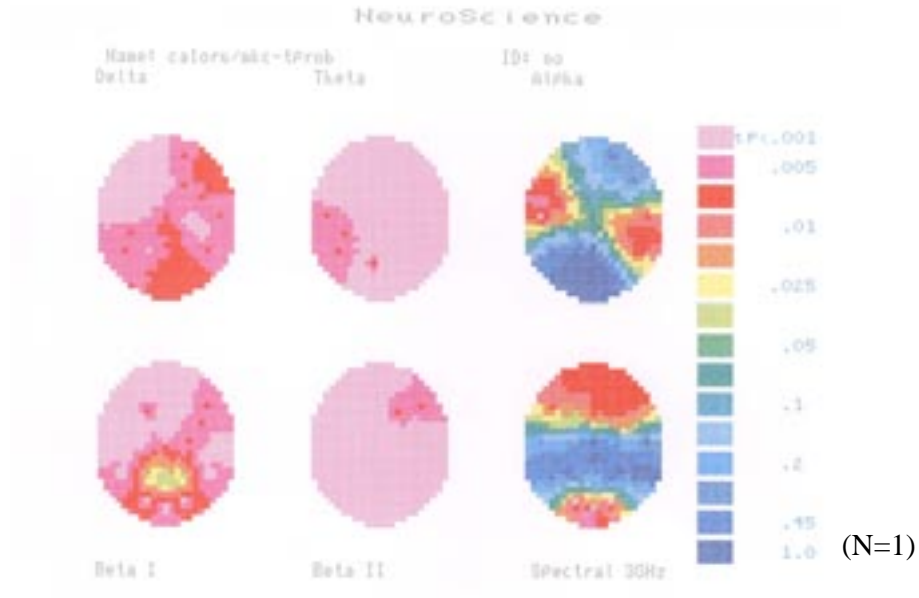


Significant changes ($p < 0.001$) with 3 subjects marked the onset of drug action and listening to the first piece of music in the pre/post-Comparison from pre-THC-music to the first post-THC- Music average. This picture shows the significance mapping of the EEG Changes for one subject from pre- to post music listening over the first piece of music. Anyhow, significance decreased with the second and third piece of music.

T-probabilities EEG-Changes Rest to Music

Reference: pre-THC-Rest-IndAvg

Comparison: post-THC-Music-IndAvg



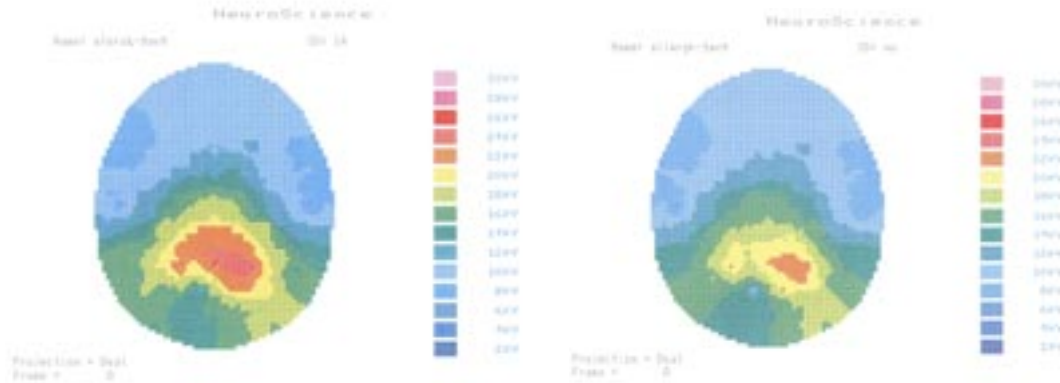
Next Map shows high significant changes from Pre-THC-Rest to the post-THC-Music EEG of the first piece in the row. As we could observe before, this T-Test again shows α -changes over the temporal regions. This might indicate Changes in auditory cerebral processing.

However, α -Mapping showed remarkable changes in Amplitude levels, as we can observe in the next slide.

Rest Alpha Changes

Pre-THC-Gavg

Post-THC-Gavg



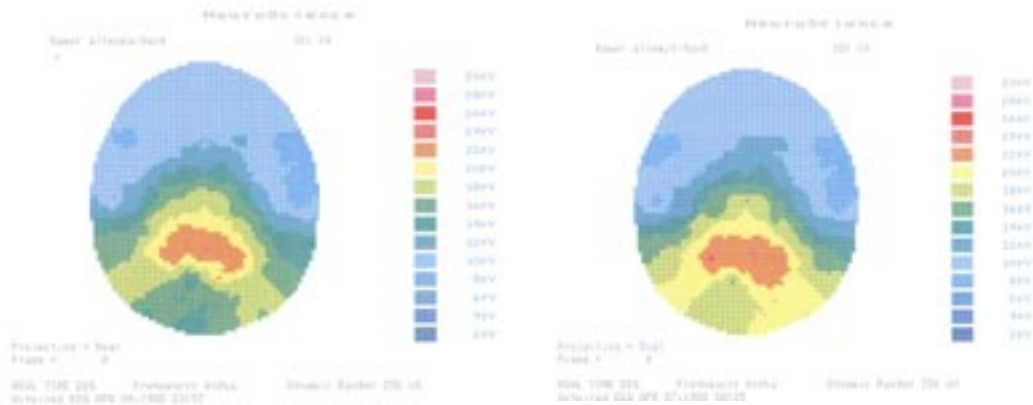
N=4; 30 μV Scale; DR 256 μV ;

These are the α -GA over four subjects for the rest condition. The 16 colours of the 30 μV Scale represent a 2 μV step on a dynamic range of 256 μV . Comparing pre/post rest visually a decrease of α -Percentage and amplitude in the Post-THC-Rest-EEG has been observed with all four subjects. The amplitude decrease showed an individual range from 6-10 μV . The group average over four subjects seen here shows a difference 2 μV .

Music Alpha Changes

Pre-THC-Gavg

Post-THC-Gavg



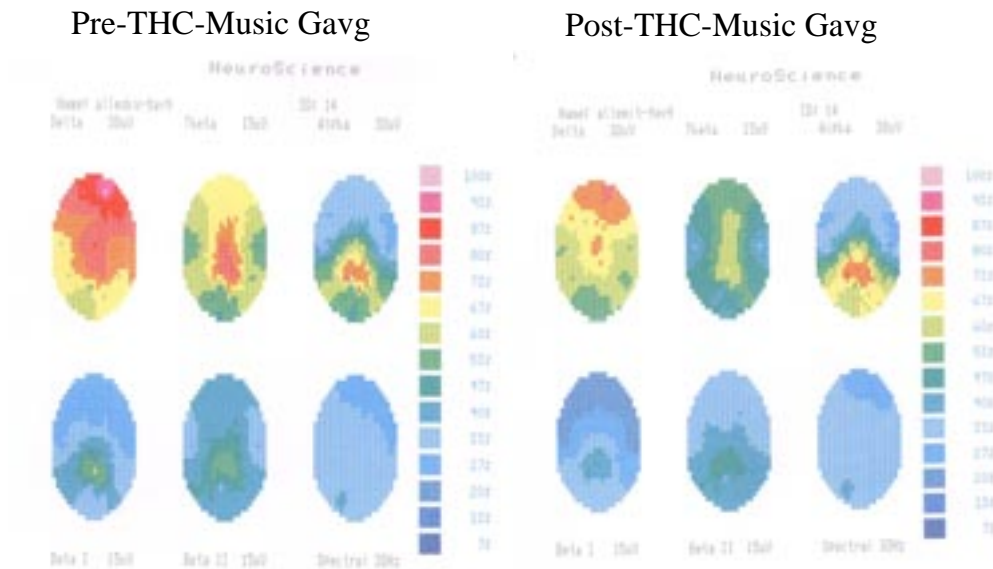
N=4; 30 μ V Scale; DR 256 μ V;

Here we see the pre/post α -GAs of listening to music. An increase of relative α -percentage in parietal regions was observed in the post-THC-Music Group Average for all four subjects. Compared to the pre-THC-music EEG the individual increase of amplitudes ranged from 2 - 4 μ V. Alpha amplitude changes remind on 'reverse Alpha' findings in studies with gifted individuals. Jausovec associated higher α -scores with a more efficient information processing strategy, less mental workload and flow (Jausovec, 1997a; Jausovec, 1997b; Jausovec, 1998).

Due to the fact that we look at an average of four persons we can see the *different individual α -gestalts* here. Intra-individual stability of the whole EEG-Gestalt in rest and activation replicated findings on personality and situational sensitivity of the EEG. The α -focus in parietal regions showed individual topographic shapes of receptive activity and the α -Range even indicated changes on higher and lower frequency ranges, Mapping of α -standard deviance showed highest deviance in the parietal regions.

A decrease of α -Amplitudes in post-THC-Rest and an increase in the post-THC-Music EEG has been observed with all subjects, as well as a decrease of percentage and power on the other frequency ranges

Pre/post THC Music Changes



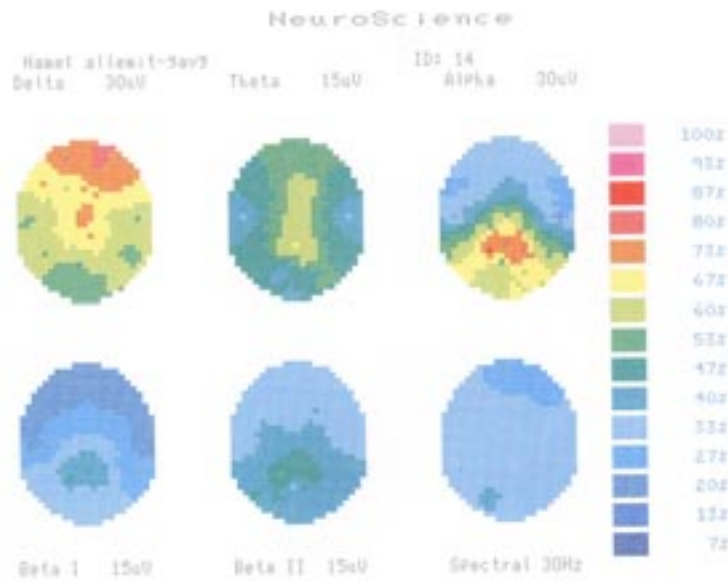
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N=4; DR 256 μ V

This picture shows the pre/post cannabis music changes in the group average mappings for the four subjects. Decrease of δ -, θ -, and β -amplitudes was a constant observation throughout the individual averages of the four subjects and was observed in GA of the four persons, too. THC is known to decrease the cell firing rates. Maybe this amplitude-decrease of is due to decreased cell firing rates. Comparing the left with the right mapping, in the left higher amplitudes, especially on δ - and θ - range in the upper row, but also on centro-parietal β -areas in the below, can be observed. In temporal areas the θ -decrease is remarkable, so let us take a closer look on the post-Cannabis Music GA.

Post-THC-Music Gavg



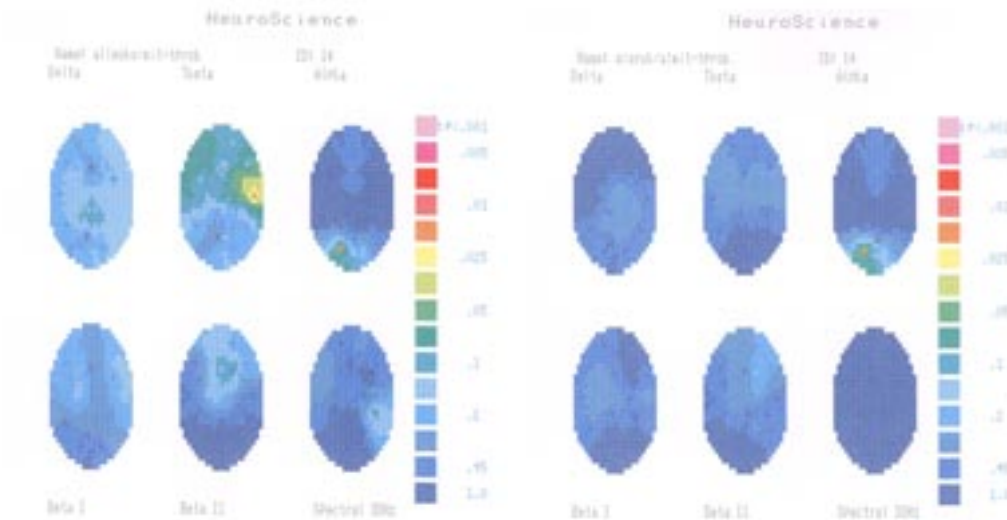
N=4; DR 256 μ V;

Pre-THC-Music listening caused an increase of θ -percentage compared to rest. In the post-THC-Music-Mapping the percentage decreased on central and frontal regions more than in rest condition but most decreases appear in both temporal regions. It seems as if Cannabis blocks θ -waves over the temporal lobe during stoned listening to music.

T-Probabilities

Refer: Pre-THC-Music
Comp: Post-THC-Music

Refer: Pre-THC-Rest
Comp: Post-THC-Music



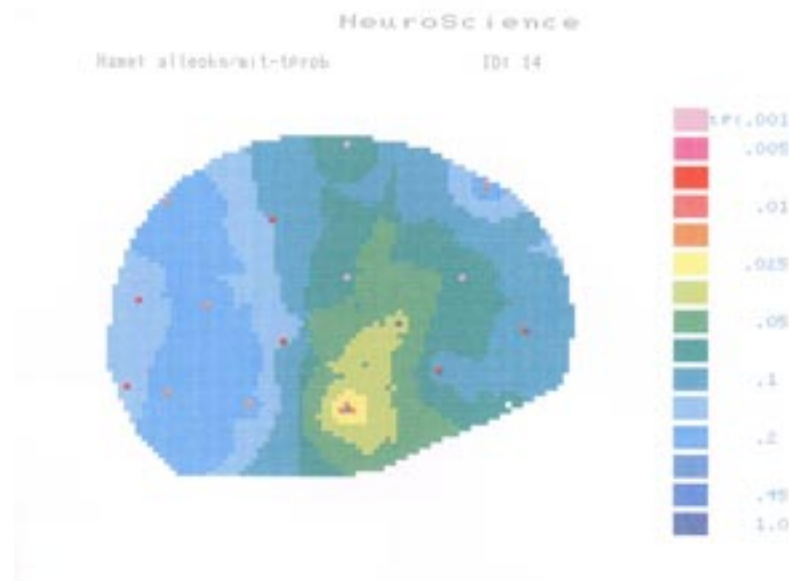
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N=4

As seen before significance mapping of individuals showed high significant changes between pre-THC rest, pre-THC-music and Post-THC-Music. Comparing the GA of the 4 subjects a significance of $p < 0.025$ on α -range for the left occipital region has been detected. Pre-THC-Rest compared to Post-THC-Music showed a low change in the left *occipital* as well as the comparison of pre/post GA of music listening. This particular region around O1 showed a faster frequency in the spectral map. The occipital region is known to change under the influence of music as Petsche, Kononov and Walker described (Kononov & Otmakhova, 1984; Petsche, 1994; Walker, 1977). In this context the change of occipital α could indicate changes in visual association linked to music. This region should be regarded in further investigations.

Right Hemisphere Theta Change ($p < 0.025$)



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N=4

Comparing pre/post music listening over four Subjects a significant change of ($p < 0.025$) at electrode T4 was observed in the right temporal cortex. It seems as if the above reported θ -Blocking over temporal lobe acts more on the right hemisphere. Comparing post-THC Rest and post-THC-Music GA a low change in this temporal area was observed on β_1 , too. This region seems to change constantly with all four subjects and should be regarded as a region of interest with combined methods like PET and EEG. Duffy, Petsche, Bruggenwerth, Auzou and David also observed changes in the right temporal fronto-temporal lobe, but with varying frequency ranges (Auzou et al., 1995; Bruggenwerth, Gutjahr, Kulka & Machleidt, 1994; David, 1989; Duffy, Bartels & Burchfiel, 1981; Petsche, 1987b; Petsche, 1993; Petsche, Pockberger & Rappelsberger, 1986; Petsche, Pockberger & Rappelsberger, 1987a). Even results of dichotic listening report changes in the right hemisphere (David, Finkenzeller, Kallert & Keidel, 1969; Davidson & Hugdahl, 1996; Kimura, 1967). Changes in the temporal lobe EEG might represent changes in the hippocampus region, too. The hippocampus is found to host cannabinoid receptors.

Summary and Conclusion

This pilot study gives promising insights into EEG changes of pre/post THC Music listening. Compared to pre-THC-rest and pre-THC-Music in the post-THC-Music-EEG a rise of Alpha percentage and power was observed in the parietal cortex on four subjects, while other frequencies decreased in power. Alpha amplitude changes remind on 'reverse Alpha' findings in studies with gifted individuals. Decreased amplitudes could represent a decreased cell-firing mode caused by cannabinoid receptor mechanism. Comparing pre/post music EEGs, differences ($p < 0.025$) were found in the right fronto-temporal cortex on Theta and on Alpha in the left occipital cortex.

Changes in temporal and occipital areas and increasing α -signal strength in parietal association cortex seem to represent a neural correlate of altered music perception and hyperfocusing on the musical time-space.

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**FORMS OF EXPRESSION IN COMMON TO MOVEMENT AND TO THE
PRODUCTION OF SOUND AND MUSIC**

PAPER PRESENTED

**IN THE WORLD CONGRESS OF MUSICTHERAPY, WASHINGTON - 1999
INCLUDED IN THE PRESENTATIONS RELATED TO BENENZON'S MODEL
SESSION ABOUT THE "ROLE OF MUSIC"**

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FOREWORD

The aim of this paper, presented by a dance therapist in a convention of music therapy, is that of explaining the reasons why certain elements of Dance Therapy have been included in the courses of the Anni Verdi School directed by R. Berenzon in Rome.

- I will formulate the basic assumptions contained in the Berenzonian theory, in development psychology theories and in Dance Therapy itself.
- I will introduce the concepts of Dance Therapy employed and the way in which they may be useful for the training of a music therapist.
- I will suggest the training objectives and the kind of experience through which these may be achieved.

Assumptions of the Berenzon Model

The core of Berenzon's Music Therapy is in the integrated work with a *gestalt* of body, sound and musical phenomena. The baseline of the discipline, the backbone of the training, is what he calls "the non-verbal context", which on one side is made up of the innumerable factors that stimulate the human experience and, on the other, of a "global" perceptive system that is seen as the union of different sensorial systems (sight, hearing, touch, smell, taste, proprioceptors, kinesthetic sense). Furthermore, he considers the underlying genetic trend towards dynamic perception, that is, towards experiences that engender a predisposition to have other experiences, and so forth.

According to Berenzon, our total perception is rooted in the prenatal period, during which the stimuli reach the fetus via a "vibrational system" that involves its entire body, the all-perceptive organ before any other specific sense is developed.

Therefore, this concept implies the idea that the musical experience comes from the same sensorial-perceptive and logical patterns we use to

build our general experience. Considering this, we may better understand why music therapists need to be trained in the practices that would help them:

- to recover their total perception abilities, which are often forgotten;
- to make their creative process more flexible, being allowed to express themselves in different languages (movement and music, for instance) both as an alternative and as an integration.

The Body and Non-Modal Perception

These principles are confirmed by the empirical research carried out by infant development psychologists. Some of the concepts developed by these studies are now essential to analyze the relationships between musical experience and body-motor experience.

The well-known works of D. Stern have evidenced that the perception of infants during their first months of life transcends individual sensorial channels and picks up **the general qualities of experience** (its intensity, duration, movement, number, shape). (Stern 1989, page 69) This research has also proved that the perception of these general qualities becomes what he calls "vital affects": total affective states that sum up all these general qualities into a comprehensive gestalt, and involve the whole experience of oneself. For example, by saying that a certain gesture is "evanescent", we are defining a comprehensive experience, that has in itself a given degree of intensity and speed and a given shape.

Artists in general, and especially those who make use of the body as an expressive medium, are well aware that this perceptive potential is due to variations in the body's general conditions and particularly to variations in its muscular tone. Therefore, the main source is the body, that in a certain sense "vibrates" with every single perceptive act. From careful self-observations we may perceive tone intensity, its modulation in time and the circulation of energy from one part of our body to another.

This perceptive "readiness", however, depends on the general conditions of the body. We know that in adults, many of these body reflections linked to every perceptive act are usually split from conscious experience. According to Stern, the language may lead to organize experiences into discrete categories, giving priority to the perceptions from specific sensorial channels. Also, defense mechanisms need to be separated from body experiences to survive. Conflicts and repressed emotions affect the tension flow and condition non-modal perception abilities.

If trainees are to become acquainted with the non-verbal context, the training should focus on:

- the recovery of a deep knowledge of the body;
- the creation of a flexible tension balance, open to tone fluctuations due to perceptive events;
- the strengthening of a state of consciousness that may observe and tolerate these fluctuations.

The Resources of Dance Therapy

The Effort-Shape System

Dance Therapy has certain theoretical and methodological resources that may serve as a foundation for recovering non-verbal experience. The Laban Movement Analysis is a powerful movement-observation and training tool, adopted by most US and European Dance Therapy schools, and also by the Association I belong to, Art Therapy Italiana. Irmgard Barthenieff, Judit Kestenberg and Penny Lewis are a few of the authors who have studied in further detail the implications of the Effort-Shape System in the therapeutic field. **This system was created by Rudolf Laban and is a complex model that studies qualitative patterns as well as the space organization patterns that may be detected in a way that transcends the individual movements.**

Even though Effort and Shape are closely intertwined, my paper will only briefly analyze the former factor, fundamental for non-modal

perception and more easily comparable to musical parameters. **Laban's model develops through two levels of analysis, each of which can be a perspective from which to see different aspects of non-modal perception.**

TABLE 1

Effort Elements Continuum
(Bartenieff, I. 1983, page 51)

<u>Effort</u>	<u>Indulging</u>	<u>Fighting</u>
Space	Indirect	Direct
Weight	Light	Strong
Time	Sustained	Sudden
Flow	Free	Bound

1st Level of Analysis

1) Effort

The word "effort" is the translation for *antrieb*, that in German means "the organism's urge to make itself known" (Bartenieff, 1983, page 51). **Efforts are the different attitudes a mover can have towards the environmental factors or weight/gravity, time and space.** Flow is a fourth element referred to the modulation of muscular tone that, independently on whether the body is moving or still, is always between two extremes: Bound and Free.

Human attitudes towards each of these effort elements vary within a range going from the quality of Indulgence (letting it go) to the quality of Fighting (struggling against). **What I would like to underline here is that, as we see in the Table, words such as Strong, Indirect, Sudden, etc. define general categories of experience.**

2nd Level of Analysis

2) Effort Combinations

The motivation or the intent of our movement are expressed in a given combination of effort elements. These combinations produce inner drives of

action that Laban identified as **Basic Effort Actions**. (Bartenieff, 1983, page 57).

TABLE 2
(U. Preston-Dunlop, 1977, page 67)

Weight	Space	Time	Action
Light	Indirect	Sustained	FLOATING
Strong	Direct	Sudden	PUNCHING
Light	Direct	Sustained	GLIDING
Strong	Indirect	Sudden	SLASHING
Light	Direct	Sudden	DABBING
Strong	Indirect	Sustained	WRINGING
Light	Indirect	Sudden	FLICKING
Strong	Direct	Sustained	PRESSING

As we may see, the words used in this table are those types of words used to express "vital affects". According to Stern, terms indicating dynamism and movement are the ones that would best define these qualities (Stern, 1987, pag. 53).

Here as well, every category represents a polarity in a range within which we may recognize movement in all of its innumerable nuances. For instance, "smoothing", "smearing" and "smudging" may be considered as derivatives of "gliding" (Laban, 1974, page 38). If we look at this carefully we may see that words have in their very sound a specific dynamic quality (Dogana, 1983).

Incomplete combinations of effort elements that imply neutral or passive attitudes towards some of the factors of Weight, Time, Space or Flow are seen as expressions of many other mood-like states, but also of discrete emotions or even of states of consciousness.

The following table reports a few examples.

TABLE 3
(North 1972, pages 246, 255)

Compositions of 2 Elements = Inner Attitudes

Weight/Flow = Dreamlike, creative or doubling,
 restrictive

Ex.: Light/Bound = Delicate, with great care

Space/Flow = Remote

Ex.: Direct/Bound = Controlled, obsessive

Time/Flow = Adaptability, mobility

Ex.: Sustained/Bound = Cautious

Space/Time = Awake

Ex.: Direct/Sustained = Smooth

Weight/Time = Earthiness

Ex.: Strong/Sustained = Powerful, perceiving

Weight/Space = Stability

Ex.: Strong/Indirect = Sinuous, striving

Combinations of 3 Elements = Externalized Drives

Action (Weight/Time/Space)

Ex.: Strong/Quick/Direct = Punch

Passion (Weight/Time/Flow)

Ex.: Strong/Quick/Free = Uncontrolled, wild

Vision (Space/Time/Flow)

Ex.: Direct/Slow/Free = Continued pursuance of clear aim
Indirect/Quick/Free = Sudden imaginative ideas

Spell-Timeless (Space/Weight/Flow)

Ex.: Direct/Strong/Bound = Concentration
Indirect/Light/Bound =

The Tension Flow

The Flow category requires a further consideration. Speaking of Flow, we refer to the way in which human beings organize their energy drives, expressed through the body's muscular tone variations. The development of the Laban model implemented by Kestenberg has introduced an opportunity to perceive the tension flow as a simple flow of energy, seen independently from the movement within which it takes place. The restrictions I have imposed to my present work prevent me from analyzing the method by which Kestenberg describes the tension flow. I will only mention that, just like in acoustics, she uses wave charts to indicate the degree of intensity or the rhythm of the oscillations between Bound or Free conditions.

Before going on, I would like to mention Barenzon's concept of ISO, that he defines as the "infinite whole of sound, acoustic and movement energies characterizing an individual". The tension flow is the first environment where ISO-generated energies emerge and the place where the resonances of perceptive encounters with the external world and with other individuals occur. As long as our consciousness of tension flow fluctuations grows, we start to become aware of our "incipient" (Dosamantes Alperson, 1984, page 145) movements, that is, the still pre-conscious impulses that struggle to be manifested and are the emerging matter of our expressive patterns, be they in gestures, music, visual arts. Our own creative process is thus made clearer, also in that inner environment where it comes to life.

It is not easy to recover the perception of the tension flow in its subtler aspects, linked to the mere flowing of vital energies and to perceptive resonances. For many people this would entail a substantial change in their state of consciousness, that has often remained deaf to this aspect for years. A gradual approach must then be achieved.

The hypothesis of my training work that a methodical exploration of how our movements are related to gravity, time and space (effort elements) would provide the required gradual approach. By constantly observing our movements, we may:

- discover the basic characteristics in common to body, sound and music creative production and the vital affects connected to them;
- be able to gradually strengthen the lucid observer inside us that we need to restore our original perception, using it in our job as therapists.

Why Dance Therapy Basics Should be Introduced

- To recover an original form of perception as a tool for a new awareness, starting from self-knowledge.
- To discover the profile of non-modal qualities that characterize the own body-sound-music production, that are the results of ISO-based dynamic structures.
- To improve the ability to express by making use of music and movements in an integrated form.
- To improve the ability to attune with other individuals. The opportunity to use the own body as a resource to tune up the own sounds produced with the movements and the inner state of those who do not express themselves with sounds is particularly important for a music therapist.

● To be more available to get the own affections involved, and hence more ready to experience counter-transferences.

● To learn how to become aware of counter-transference factors detected by the body but not captured by the mind.

● To improve the ability to observe the movements occurring during the therapy session, especially those that are scarcely visible and only detectable through tension flow resources.

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COMING TOGETHER: THE HEALING PROCESS OF MUSIC THERAPY GROUPS

Gary Hara

Abstract

This presentation will examine the elements and therapeutic processes that make music therapy groups unique and effective as group therapy modality. We will examine how improvisational music by clients not only reflect their development as group members but, can be the primary modality from which feelings and problematic issues can be worked upon. The music therapist's role as group leader will be examined in terms of possible transference and countertransference issues. Challenges of time limited group work will be discussed. It is hoped that further examination of music therapy group work and outcome research on groups will be stimulated. Much of the materials presented are based upon the presenter's clinical group experience in adult psychiatry. Personal experiences and observations in leading music therapy groups will be shared. Video excerpts of a music therapy session will be viewed and examined.

Group therapy has become more prevalent within various health care settings than ever before. Group work is a common treatment modality particularly within the United States, due to financial and staffing limitations. Therefore, music therapy work within groups has become the common practice for many music therapists.

At my hospital facility for example, groups are the major treatment modality in mental health. All clinical staff lead groups within the outpatient and inpatient settings. This is to serve a greater number of patients and increase the number of patient visits to the hospital. The hospital also encourages a high number of admissions, shorter hospital stay for each patient, and greater patient involvement in treatment while within the inpatient units.

This trend (which is becoming more common for all hospitals under the managed care system) calls for the greater use of groups in treatment.

Group work will continue to become more important and prevalent as a treatment modality for the foreseeable future.

The current health care system also brings less than ideal work conditions to conduct clinical groups particularly within inpatient psychiatric units. This is due to ever-changing group membership, having reduced number of sessions to work with patients and working with people who are non-compliant or less motivated towards treatment. Nevertheless, effective group work can be accomplished despite these work conditions if the work is approached in a spontaneous, flexible manner that is process oriented.

Why groups work as therapy- Yalom's principles (1970) *The Theory and Practice of Group Psychotherapy*

Irvin Yalom wrote about 11 core therapeutic factors that make group therapy work regardless of the therapeutic approach used to lead a group. These principles apply to music therapy groups as well:

1. Instillation of Hope
2. Universality
3. Imparting of Information
4. Altruism
5. The corrective recapitulation of the primary family group
6. Development of socializing techniques
7. Imitative behavior
8. Catharsis
9. Existential factors
10. Cohesiveness
11. Interpersonal Learning

(Yalom relied upon three assumptions of interpersonal theory (1) one's character is shaped by one's interpersonal relationships- group therapy is to focused upon disordered interpersonal relationships; (2) the group as a

social microcosm-one behaves similarly as one's outside environment; (3) the here-and-now - little need for the patient to provide group with detailed past history - "living data" emerge from the observation of a group member's interpersonal behavior in the here-and-now group. Can correct maladapted interpersonal patterns while risk new behaviors to learn new behaviors that would transfer to outside lives. (Yalom, p.3-33)

Here and now focus: To be effective, the group needs to experience itself in the here-and-now. This allows the group to perform a self-reflective loop and members can examine what has just occurred.

Yalom considered the here-and-now focus as crucial in group therapy functioning. The core assumption is that there is an interpersonal component in all symptomatology. The therapist treats not the manifesting symptom but, the underlying interpersonal pathology. (Interpersonal theory of psychopathology).

UNIQUE FACTORS OF MUSIC THERAPY GROUPS

Yalom's theoretical framework is quite applicable for music therapy groups. However, music therapy groups differ from verbal group therapy from which Yalom based his theory upon. Music therapy groups have the following factors that distinguishes them from verbal group therapy:

1. All music therapy groups have the musical elements of rhythm, melody, harmony, texture, musical form, timbre, & dynamics to use in addition to verbal language to achieve Yalom's principles.
2. Music therapy groups establish their own unique experiences while making music. Members can develop meaningful roles in the group regardless of their capabilities and language skill. All group members can engage in developing and making the group's music.

3. Music therapy groups involve creativity-- group members are in a creative process. In doing so, they are creating their own solutions.
4. Music therapy groups undergo an aesthetic experience- developing music that is artistic and musical on its own terms that engages and becomes relevant to the group members.
5. In using music, music therapy groups undergo a different experiential process from verbal group therapies.

PROCESS OF MUSIC THERAPY GROUPS WITHIN A SESSION In using the Yalom's theoretical framework of working while utilizing the unique factors that music offers, I tend to use improvisational music and adapt popular songs within sessions. I like to work on a spontaneous and flexible manner based upon whatever members in the group initiate. The following is a general outline of the process a music therapy group often seems to display. I have described a music therapy session in developmental terms from which the group members display certain behaviors and stances at particular times. I also describe the music therapist's possible leadership role within the group during its development during a session. Much of this derives from my group experience working with adult psychiatric patients. This outline parallels work with other creative arts therapies such as psychodrama and movement therapy.

WARM UP. A period that the group members establish orientation to the group's structure and purpose, establish rapport with therapist (and among the other group members where relationships may be weak). This period often reveals tension and anxiety among the group members. Conflicts among members may be present and open. Pathological symptoms are often displayed. Defensive behaviors are common. Therapist's role: To activate the group members into the music, assess the immediate situation, and focus upon an arising theme present in the here-and-now. Establish

rapport with members and among themselves through the music. Therapist may need to become directive in order to facilitate the group.

THEMATIC DEVELOPMENT: Group members further development relationship with therapist and show more willingness to share feelings/ give input and/or take risks with therapist's support. Feelings are revealed through musical playing with group displaying more noticeable listening and responding. Group development of group norms. A particular theme (issue/ feeling) may arise from a group member or the group as a whole through the nature of the music being played which later can be focused upon later. Therapist's role: Become more like a participating group member to be with the group members while in the music. Share group leadership by allowing group members to initiate and lead the group into musical experiences. Try to allow more space within the music for group members to develop their own musical materials/themes.

THEME FOCUSED: Group members may develop noticeable relationships among themselves. Group members may develop more autonomy from therapist and might even divert from former preferred musical structures. Group may focus upon a shared feeling, problem and/or issue that is expressed through the music. Therapist's role: Varies from being passive to active with interventions made in order to focus/ work upon the theme presented during the session.

CLOSURE: Reflect on what had occurred in the group during the session. Sharing among group members on feelings / issues that were expressed or what group members had done. Sharing by members can be musical, verbal, or both. Therapist's role: Directive as in warm-up. Promote sharing including sharing own personal experience from session, thoughts, observations, and feelings related to the group. These can be done through a musical experience to conclude the session.

These stages are related to the functional level and emotional level of the group members and therefore, not always occurring in every session.

TRANSFERENCE IN MUSIC THERAPY GROUPS The active involvement of the music therapist to engage and participate with the group members leads towards the development of transference by the group members onto the music therapist. The therapist's own musical input will lead to group members to form personal feelings, emotional reactions, and fantasies towards the therapist. Group members develop feelings onto music therapist as an authority figure (negative & positive) related to their prior past experiences with significant authority figures they had in their lives which is known as transference. Transference can allow group members to work with the therapist through feelings and issues stemming from significant others. In music therapy groups, I often had found transference develops within group members more quickly than in verbal group settings due to musical experience.

COUNTERTRANSFERENCE FOR MUSIC THERAPISTS

The active musical involvement of the music therapist during improvisations can lead to countertransference issues for the music therapist in reacting musically towards the group/ or individual group members from a personal emotional place rather than a clinical objective perspective. For example, the music therapists playing and directing the group towards music the therapist prefers or divert group away from musical playing that the therapist finds uncomfortable with. Every musical intervention can reflect the music therapist's own personal preferences. It is therefore critical that the music therapist is aware of his/ her own personal issues relating to music making and musical preferences. Particularly important is how the music therapist tends to project his/ her musical involvement onto the group members. A music therapist needs to know whether his/ her musical interventions are clinically objective or based upon personal reactions that are not related to the immediate clinical situation.

Transference and countertransference are natural occurrences. They can be valuable clinical tools while working with clients. Countertransference when noticed by the therapist, can be viewed as a clinical indicator for the therapist on the interaction dynamic between therapist and group/ or individual group members.

CHALLENGES OF WORKING WITHIN SHORT-TERM SETTINGS

Doing group work within short-term settings poses special challenges. The major challenges one faces working within short-term settings:

1. Time limited. Often have few sessions to work with group members. It is common to have only one session contact with an individual.
2. Constant changing membership. Group membership is always in flux due to the steady turnover of patients on the unit.
3. "Unmotivated" patients- noncompliance with treatment. Patients are often involuntarily admitted to the hospital and are not initially willing to be involved in their treatment. Many patients often display resistance towards being in treatment.
4. Little benefit from insight oriented treatment. Patients are not receptive towards interpretative interventions and have little knowledge about therapeutic process. The limited time also constricts the usual insight oriented treatment.
5. Patients with acute symptoms- Patients have acute symptoms such as restless, short attention span, impulsive behaviors, withdrawn, paranoia, disorganization, etc that makes it difficult for such patients to be and stay in group sessions.

PROCESS OF SHORT-TERM GROUPS Process described previously applies to short-term music therapy groups. One needs to be adaptable as group leader and more directing at times to create structure in order to facilitate the session. Each session is viewed as a complete therapy experience.

The transference and countertransference become more magnified. Therefore, the music therapist could benefit from gaining ongoing clinical supervision and engage in their own therapy to deal with the personal issues that may interfere with effective clinical work.

RESEARCH ON GROUPS Research on groups has been relatively limited due to the complex factors in studying the therapeutic process within groups (e.g. effect of psychotropic medications, other available therapies). However, certain types of studies can be done.

1. Survey on group participation. Group members can be given questionnaires about their experiences in the group. One study (Morton Lieberman, 1983-Comparative Analyses of Change Mechanisms in Groups) noted that group members highly rated their group experiences in terms of feeling more understood by others, knowing others have similar problems, feeling supported by others. Patient satisfaction surveys has become highly regarded tool within managed care health care systems to gauge patient perspectives on their treatment.

2. Therapy Outcome-qualitative studies. Studies that can describe and examine the factors that promote the therapeutic process are needed. Qualitative studies have become more popular despite the difficulties in doing such studies due to limitations of doing quantitative research on groups. Therapy outcome studies on the effectiveness of treatments are highly regarded within hospital systems.

3. Effect of groups on patient hospital length of stay & treatment compliance. These areas are of special interest to health care systems.

Currently, little research on music therapy groups in influencing better hospital treatment outcomes exists.

CONCLUSION: I hope that this presentation has increased awareness of the therapeutic process that is involved within music therapy groups. Becoming aware of this process greatly enhances one's sensitivity and flexibility while leading sessions to meet the needs of the group members. Music therapy groups have group experiences that are unique to both the patients and music therapist. It is different from verbal group therapy. Currently, psychological theories on groups are based upon verbal group work and may not fully address the process that occurs within a music therapy group setting. As limited research has been done on group therapy, even less has been done exploring on the effectiveness of music therapy groups. The need for outcome studies of music therapy groups is greatly needed to validate music therapy within today's managed care health care system. I hope that you can demonstrate the effectiveness of music therapy groups in your workplace and take the time to develop yourself as an effective group therapist.

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The Influence of Soft Music on Newborns in Indonesia

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I dedicate this work to someone whom I love deeply.

Thanks for coloring my life beautifully, SMA...

AND

*Special thanks, of course, to my dearest brother, my best friend,
my best teacher, and my spiritual director through this writing also.*

Thanks for filling my life with love and wisdom, FAH, O.C. ...

Abstract. The effects of soft music on the emotional responses of newborns are examined. 60 newborns are divided into experimental and control groups. The experimental group of 30 Ss receives soft music for 2 days continuously. The control group of 30 Ss receives no music. Each group is observed for 2 days. Results reveal that there are no significant differences in heart rate, respiration rate, weight, and sleep pattern between the experimental group and control groups. However, the mean crying pattern is significantly different between the two groups. It seems that there are differences in heart rate and respiration rate more detailed research is needed. The subjective impressions of mothers, nurses, doctors, and the researcher are also taken into account in forming the general conclusion that the emotions of the experimental group appeared to be calmer than the control group.

From our adult perspective, birth must be a difficult experience not just for the mother, but also for the baby. Think of all the newborn has lost: a warm, safe environment with free and constant supply of food,

and nothing to estrange him or her from the world. Suddenly the newborn must breathe, eat, and suffer separation from his or her environment.

According to the theories of many personality experts, these extreme changes could cause serious and long term psychological injury (*Kartono, 1979*). Birth is the most traumatic event in life. Therefore, it is very important to know everything related to birth to help the newborn. Not just to understand about the physiology, but, more than this, how to give the best treatment during and after birth so that they can adapt to their new environment better (*Jonxie, Visser, & Troelstra, 1964*).

One of the things the newborn has lost is the sound of the mother's body: the rush of blood and fluid, the heartbeat, breathing. This music accompanied the foetus continuously since before it could sense sounds. Suddenly it is gone, replaced by the unmediated tumult of the world. Is it possible that the newborn would be comforted by playing some kind of appropriate music?

The first years in a child's life are critical in developing his personality, including emotion. A baby's emotions can be seen as his or her means of communication with others. He or she expresses his or her feelings, needs, and wants through his or her emotions (*Hetherington & Parke, 1983*). Feeling is an important thing for a baby (*Nordoff & Robbins, 1985*). Communication of emotion occurs through facial expression and sound (*Carlson, 1986*).

In addition, Worthman (*Keasey, 1981*) suggests that an array of physiological signals including: vascular changes, hormonal changes, respiratory changes, circulatory changes, visual changes, sweat gland changes, and muscular changes can also communicate needs or emotions.

The development of the newborn depends on interaction between biological predisposition and experience that is prepared by environment (*Atkinson, R. L., Atkinson, R.C., & Hilgard, E.R., 1987*). Newborns receive many new stimulations. These new stimulations are checked against experiences they have had, including their experiences in the womb. According to Piaget, he or she is assimilating, which is one part of his or her adaptation process (*Tedjasukmana, 1987*).

Newborns can hear very well (*Butler & Golding, 1986*). According to Meredith, by the second trimester, the development of the foetus is nearly complete. The heartbeat strengthens and its sensory receptors begin functioning. The foetus is sensitive to touch and will react to it with muscular movement. The foetus' sense of hearing also functions, and it will react to loud sounds in the mother's environment (*Hurlock, 1985*). Melson & McCall (*Deutsch, 1982*) found that the heartbeat of babies changed when they played a melody. A study by Salk (*Leach, 1981*) shows that newborn's crying decreases when a record of a heartbeat was played. The researcher assumed that the babies found the recording comforting because it reminded them of the womb. According to Brackbill, Adams, Crowell, & Gray, other rhythmic sounds like lullabies seem to have the same enjoyable function as a heartbeat (*Leach, 1981*).

Shuter, Dyson, & Gabriel (*1982*) suppose that children are interested in beautiful sounds since the very beginning of life. But apparently they do not like Rock Music, as evidenced by hard kicks that the baby made in the womb when Rock Music was played (*Verny & Kelly, 1981*).

This research investigates the possibility of maintaining the "music" even after babies are born. It is hoped that the taped music played to newborns could be associated with the "beautiful music" of the womb. So, they could be calmer because the music reminds them of a very enjoyable place that gave them enjoyable feelings. It could make their adaptation to the new environment better.

Method

The independent variable of this research is presence or absence of soft music and the dependent variable is emotion or degree of calmness.

Soft music is music contained in the *Sleep Gently in the Womb Programme 2 (EMI)* cassette. The music was played for two days continuously.

Degree of calmness is the baby's general emotion reaction pattern which should be stable when he or she feels happy and comfortable in the

environment. This is able to be measured from: (a) heart rate: count of heartbeats per minute which is taken every six hours, (b) respiration rate: count of respiration per minute which is taken every six hours, (c) difference in weight: difference in weight between the first and second days after birth, (d) crying pattern: duration of crying per day in minutes, (e) sleep pattern: duration of sleeping per day in minutes.

The population for this research is normal newborns with an Apgar score between 7-9. The sample for this research is 60 newborns 0-2 days old which separate into 30 newborns for the control group and 30 newborns for the experimental group.

This research uses observation techniques to gather data. Observation was carried out for two days. The mothers themselves noted every time their baby started and finished crying. The same was also done for when their baby went to sleep and woke up. Beside this, subjective opinions from the mothers, doctors, nurses, and researcher gave added information about the newborns' emotions.

The design of this research is randomized to the extent that whenever a baby happened to be born and the experimental room was empty, that subject joined the experimental group, and vice versa for the controls. The data in this research were analyzed using a *t-test*.

Results and Discussion

Results of the data analysis for indicators of degree of calmness in newborns in Dr. Soetomo Surabaya General Hospital appear in the table below:

Indicator	Control's Mean	Experiment's Mean	t	p
Heart rate	111.205	109.258	1.045	0.151

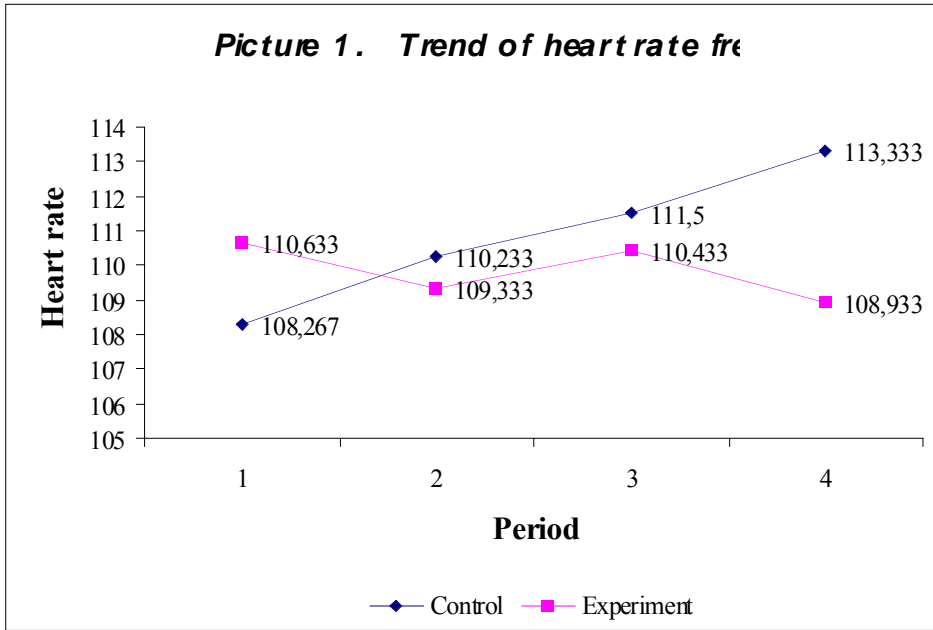
Respiration		48.701	47.669	0.663
0.258				
Weight I	-	0.039	- 0.041	0.206
0.416				
Weight II	-	0.078	- 0.076	- 0.153
0.437				
Crying pattern		79.533	54.233	1.936
0.028				
Sleep pattern		911.500	986.300	- 1.218
0.113				

Detailed interpretation of each indicator is shown below:

Heart rate

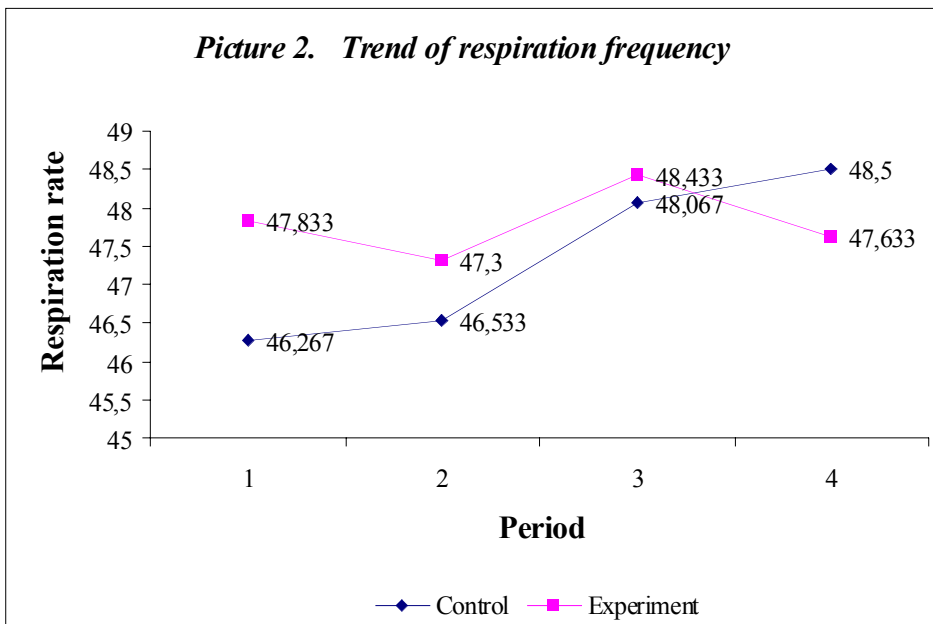
Data analysis showed that there was no significant difference in heart rate between newborns with soft music and no music. Probably this is because the newborn was still in a transition phase from full dependence on their mother. In this condition newborns pay more attention to adaptation to internal physical activity. So added stimulation from outside seems not to influence their internal physical activity very much.

In spite of that, if we look in more detail at picture 1, we can see that there is a slight visual trend, though not statistically significant, in the direction of greater calmness for the experimental group.



Respiration

As with the heart rate, there was no significant difference between newborns with soft music and no music. This time, even if we judge only visually from the graph (picture 2), it is hard to see any difference. This result tends to indicate that music had little or no effect.



Weight

Another indicator of newborn's emotion is good and fast physical growth. If a newborn's emotion is good he or she would drink more. This

physical growth is shown by an increase of weight ((*Mazie, 1992*). There is no significant difference between newborns with music and no music in weight. It is possible that weight changes could be seen during a longer period, whereas this research is only during a short period.

Crying pattern

The principle form of negative verbal communication between the baby and others is through crying (*Hurlock, 1988*). When they wet the bed, they cry; to call their mother because they need something, they cry.

This research supports that theory. There is a significant difference between babies with music and no music ($t = 1.936$, $p = 0.028$, one tail). Newborns given no music cry more than those who hear continuous, soft music.

Thus the research supports the idea that newborns gain some comfort from listening to music.

Sleep pattern

A baby will sleep more soundly if he feels comfortable (*Gunarsa & Gunarsa, 1989*). Results show that there is no significant difference in sleep patterns between newborns with soft music and no music. Though the lack of difference does not support the hypothesis about the usefulness of soft music, note that it is possible for the babies to be perfectly calm, or calmer, and not actually sleep. Thus the result does not invalidate the hypothesis either.

Calm emotion in general

In general, it could be said that soft music tends to affect the emotions of newborns who are in an adaptation period. The degree of calmness of newborns with soft music tends to be higher than those with no music.

In fact, statistical analysis shows that there is a positive influence of soft music on an indicator related to emotions (crying pattern). Moreover, from qualitative analysis based on subjective impressions of their mothers,

nurses, doctors, and the researcher it was found that soft music seems to make newborns sleep more soundly and in some cases drink more. If observation time and number of samples were added, the differences between two group would probably be more striking.

From this research, it is hoped that everyone who takes care of babies directly could give soft music to them, especially to the newborn. Thus, the environment would be easier and have a positive influence to them.

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Music Therapy in Brain Injury Rehabilitation: A Pilot Study^{1,2}

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¹ The research described in this presentation was sponsored by the Center for Research in Complementary Medicine, which is funded by the National Institutes of Health, National Center for Complementary and Alternative Medicine (NCCAM), formerly the Office of Alternative Medicine (OAM).

² This research study is published in *Rehabilitation Psychology* (in press) and readers interested in results not included in this paper should consult that publication.

³ Dr. Nayak and Dr. Shiflett are no longer employed at Kessler. Dr. Nayak is employed at NJ Medical School, UMDNJ, and Dr. Shiflett is employed at Beth Israel Hospital in New York City. Dr. Wheeler is now employed at the University of Louisville.

⁴ Barbara L. Wheeler presented this paper at the World Congress of Music Therapy.

**Office of Alternative Medicine and
National Center for Complementary
and Alternative Medicine**

The annual budgets for research funding for complementary therapies for the National Center for Complementary and Alternative Medicine (NCCAM) are as follows:

\$2 million in FY 1992 and FY 1993

\$3.5 million in FY 1994

\$5.4 million in FY 1995

\$7.4 million in FY 1996

\$12 million in FY 1997

\$20 million in FY 1998

\$50 million in FY 1999 (as NCCAM)

Office of Alternative Medicine (OAM) Research Centers include:

<u>Center</u>	<u>Population</u>
Kessler Institute for Rehabilitation and University of Medicine and Dentistry of New Jersey	Stroke, SCI, TBI and Neurological Conditions
University of Virginia	Pain
Columbia University	Women's Health
University of Texas, Houston	Cancer
Harvard Medical School	Cardiovascular and Lower Back Pain
University of California, Davis	Asthma, Allergy, Immunology
Stanford University	Aging
Univ. of Maryland, Baltimore	Pain
Palmer School of Chiropractic, IA (consortium)	Chiropractic

OAM Research Centers (begun in 1998) include:

<u>Center</u>	<u>Population</u>
University of Michigan	Cardiovascular Disease
University of Arizona	Pediatrics
Minneapolis Medical Research Center	Addictions

Other research projects that have been conducted at Kessler/ UMDNJ include:

<u>Project</u>	<u>Population</u>
Ginkgo biloba	Stroke, TBI
Acupuncture	Stroke (2)
Acupuncture	SCI pain(2)
EEG Light Stimulation	TBI
Reiki	Stroke
Neural Org. Technique	TBI
Trager	SCI; MS

MUSIC THERAPY IN BRAIN INJURY REHABILITATION: A PILOT STUDY

Purpose

To evaluate whether music therapy is effective as an aid to enhance a patient's mood, social interaction and ability to be more actively involved in therapy (physical and occupational) during acute rehabilitation.

Related Literature

Social and Emotional Effects of Music Therapy

Descriptive and Anecdotal Reports and Case Studies

*Helped people with strokes and TBI:

express frustration and depression
facilitate emotional expression and communication

Controlled Research Studies

Effects of Music Therapy on Social-Emotional Functioning Following TBI and Stroke

*Significant improvement in emotional empathy as reported by family members and friends, but not by participants

*Reduction in depression (not statistically significant)

Eslinger, P., Stauffer, J. W., Rohrbacher, M., & Grattan, L. M. (1993). Music therapy and brain injury. *Report to the Office of Alternative Medicine at the NIH.*

*Orientation and agitation improved with music therapy

Baker, F. A. (1999). *Effects of Live and Taped Music on Orientation and Agitation with People Experiencing Post-Traumatic Amnesia After TBI.* Unpublished thesis, University of Melbourne, Melbourne, Victoria, AU.

Effects of Music Therapy on Mood with People Who Have Had Strokes

*Less depression and anxiety

*More emotional stability

Purdie, cited in Marwick, C. (1996). Leaving concert hall for clinic, therapists now test music's 'charms.' *Journal of the American Medical Association*, 275(4), 267-268.

Clinical Perspective of Study

Addresses needs of people with stroke and TBI to:

* Decrease depression

- * Relearn skills for social interaction

There is a lack of effective methods for dealing with these problems

Literature suggests that music therapy helps problems

There is a lack of research on music therapy to decrease depression and increase social interaction in this population

Uses of Music Therapy with Stroke and TBI

Rehabilitating people with stroke and TBI

- to facilitate movement, gait, improve muscular control
 - to improve attention and information processing
 - to aid in initiating tasks, sequencing, and motor planning
- to rehabilitate speech and communication problems

Goals

- * Improve mood
- * Improve social interaction

Method

Design

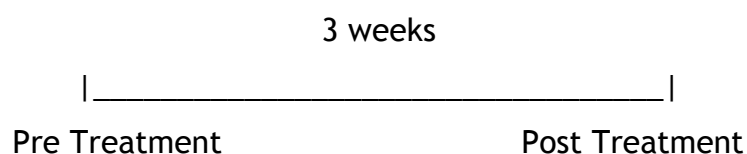
Between groups, repeated measures design

Included 18 participants with traumatic brain injuries or stroke

*Music therapy group - n =10

*Control group - n = 8

Music Therapy Group



Assessment

Assessment

Up to 10 treatments

3 times a week

45 minute sessions

Outcome Measures

Self-report - Faces Scale

A seven-point scale consisting of stylized faces

Family rating of participant's mood

Last 24 hours and Past week

Therapist rating of participant's mood

Family member's rating of social interaction

Staff rating of participation in therapy. The items addressed cooperation, motivation and how actively involved the participant was in therapy

Music Therapy Treatment Protocol

- Variety of music therapy procedures utilized
- Based on interests and abilities of the participants, and ability to address the goals

- Opening song/activity
 - Usually an instrumental improvisation

- Core or main activities
 - One or two additional music therapy activities
 - Included:
 - Single pitched instruments played on cue
 - Composition through substitution of words
 - Singing
 - All included verbal processing, with some focus on mood

Results

Results revealed significant improvements in family members' assessments of participants' mood and social interaction in the music therapy group compared with the control group. The staff rated participants in the music therapy group as more actively involved and cooperative in therapy than those in the control group. Please consult the article in *Rehabilitation Psychology* for more detailed results.

Clinical Implications/Importance

Music therapy was effective in improving mood and social interaction following stroke and TBI

Results are preliminary

Social interaction and mood important areas to research

Clinical implication:

Incorporation of music therapy into acute rehabilitation programs

Methodological Problems/Hurdles in Implementing Design

Problems in conducting clinical research, without the ability to control many aspects of patient involvement and treatment

Small sample size

Irregular attendance

Variable number of people in music sessions due to visitors or poor health

Random assignment not fully achieved

No comparison intervention (i.e., art therapy) to control for attention and group effects

Inconsistent group structure (some sessions held with individuals)

Early discharge from hospital

EFFECTS OF HEALING MUSIC ON ENDOCRINOLOGICAL CHANGES

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ABSTRACT

It has been reported that music has physiological effects in Japan, which includes changes of electroencephalography (EEG) and the autonomic nervous system. However, there have been few studies that investigate endocrinological changes during music therapy. Therefore, we investigated effects of music therapy on changes of stress-related hormones. We studied 10 healthy subjects (5 women and 5 men; mean age, 22.9 years; range, 18 to 29 years). After a 15-minute period of rest, they listened to five kinds of music continuously (the duration of each music was a 3-minute period). The five kinds of music that we used included Japanese traditional music played with vertical bamboo flutes, a Gregorian chant, a piece of harmonic music that reminded us of woods covered with the light of the sun, a piece of music with repeated African rhythms, and a piece of harmonic music repeated rhythms. Pre-psychological research about these music pieces with factor analysis had drawn 3 factors, "relaxation," "vivid" and "evaluation." Blood samples for measurement of adrenaline (AD), noradrenaline (NA), dopamine (DA), corticotropin (ACTH), and cortisol were collected just before and after the music session, and after a 15-minute period of rest after the music session. There were significant decreases of NE during the music session, although there was no significant change of AD and DA during the music session. Therefore, music therapy may influence endocrinological changes by a nonadrenaline-related mechanism. Moreover, plasma levels of ACTH and those of cortisol significantly decreased during the music session. Therefore, music therapy may also have relaxative effects through the hypothalamus-pituitary-adrenal axis, although circadian rhythms of these hormones should be considered. In conclusion, there may be some effects of music therapy on endocrinological changes toward a relaxation state.

1 DEFINITION OF HEALING MUSIC

As a result of reviewing various resources from within and outside of Japan, a scientific definition of "healing music" could not be found. In "The Overview of Sound Healing Practices," Crowe and Scovel state that a definition of sound healing is not clear, but terms such as music therapy, healing, curing, and health are loosely grouped and are included within the meaning of sound healing 1).

"Heal" is a derivation of the Indo-European word "holy". Words such as "holy", "heal", "health", "hallow", and "whole" all have these same roots. Keeping this in mind, Nuki connected the word "heal" with "holistic medicine". In other words, being healthy means to have a balanced functioning of the mental and physical as a whole. "Healing music" can be seen from the spiritual and physical point of view and is defined in this paper in the following manner. From the mental point of view, "healing" is the release, comfort, or easing of distress and fatigue, and music which functions to do so is called "healing music". From the physical point of view, "healing music" is referred to as music that functions as a physiological index to reduce stress through emotional responses while listening of music.

2 PURPOSE

To view healing music from an academic perspective, a psychological investigation and an endocrinological experiment were conducted. In the past, in order to investigate the psychological response to music, Nuki conducted experiments using the heartbeat, respiration, and Galvanic skin reflex responses from the autonomic nervous system, and an electroencepharography (EEG) from the central nervous system as indexes. However, because endocrinological research is extremely rare in Japan, the effects of music therapy on the changes of stress-related hormones in the blood stream were investigated. In addition, the correspondence between psychological evaluations and endocrinological changes was examined.

3 METHOD

3-1 Procedure of selecting music

Since the 1970s, Nuki has researched the composition characteristics of sedative and active music through experiments using a polygraph and EEG tests. The results of these experiments showed that sedative music includes the following characteristics:

- (1) harmonic music with soft or floating consonant tones
- (2) music with relaxed, slow and beautiful melodies
- (3) minimal music with repeated, simple rhythms

Based on these results and on other references, the following eight pieces considered to be "healing" were selected after listening to a number of music pieces from around the world.

Table 1: Music used

(1) Magic found within ethnic music	African drum rhythms
(2) The eternal world	Mongolian lullaby
(3) The roots of the Japanese	Japanese shakuhachi (vertical bamboo flute) "Movement of Wind"
(4) The origins of Western music	Gregorian chant
(5) Harmonic music with beautiful tones	Background music "Sunlight and Forest"
(6) Repeated rhythms	Background music "Ivory Tower"
(7) A two-part composition	Background music "Dream / Illusion" (a combination of nos. 5 & 6)
(8) Stimulative music (This piece was chosen to determine the validity of the questionnaire.)	Bartok, sonata for piano and percussion, 3rd movement

3-2 Subjects

- (1) Based on the hypothesis that there is an "age difference" regarding "healing music", 31 healthy men and women in their twenties and fifties who

have not had musical training were chosen at random as subjects for the psychological investigation.

Subjects in their 20s: 20 Waseda University undergraduates and graduates (10 women, 10 men; average age 23.7, SD 2.56) Subjects in their 50s: 11 office workers and housewives (6 women, 5 men: average age: 52.7, SD 3.41)

(2) For the endocrinological experiment, 10 healthy men and women with no musical training were chosen at random. The five women and five men are Waseda University undergraduates and graduates between the ages of 19 and 28 (average age 22.9). All of them understood the purpose of the research before agreeing to participate in the experiment.

3-3 Psychological Investigation

A psychological investigation was carried out after the subjects listened to each piece of music. According to the semantic differential method, a rating scale of seven levels composed of the 18 pairs of adjectives, such as "energetic/dispirited", "sickly/healthy", "painful/healing", "irritating/soothing", etc. was used.

After listening to the eighth piece of music, an inquiry was made about the following topics: "the most healing piece", "music in one's daily life", "health condition", "favorite music genre", and "experience performing with music instruments".

3-4 Endocrinological Experiment

We measured plasma levels of noradrenaline (NA), adrenaline (AD), dopamine (DA), corticotropin (ACTH), and cortisol to investigate endocrinological changes induced by healing music. The experiment (Figure 1) was started at 9:00 a.m. in an air-conditioned laboratory. An indwelling catheter was inserted into a cubital vein of the left arm for blood sampling. The music session was started after a 15-min period of rest. Blood samples for measurement of NA, AD, DA, ACTH, and cortisol were collected just before and after the music session, and after a 15-min period of rest after the music session. In the music session, the subjects listened to five

kinds of music continuously (the duration of each music was a 3-min period). The five kinds of music were (1) "Forest and Sunlight", (2) Japanese shakuhachi, (3) Gregorian chant, (4) , (5) , which were rated among the most relaxing pieces of music in the psychological evaluation. Analysis of variance was conducted on endocrinological parameters.

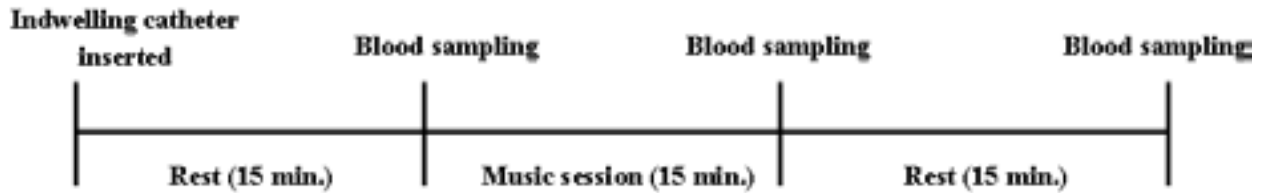


Figure 1 Test Protocol

The Tukey test for post hoc comparisons was then conducted. A p value < .05 was considered significant.

4 RESULTS

4-1 Endocrinological experiment (Figure 2-6)

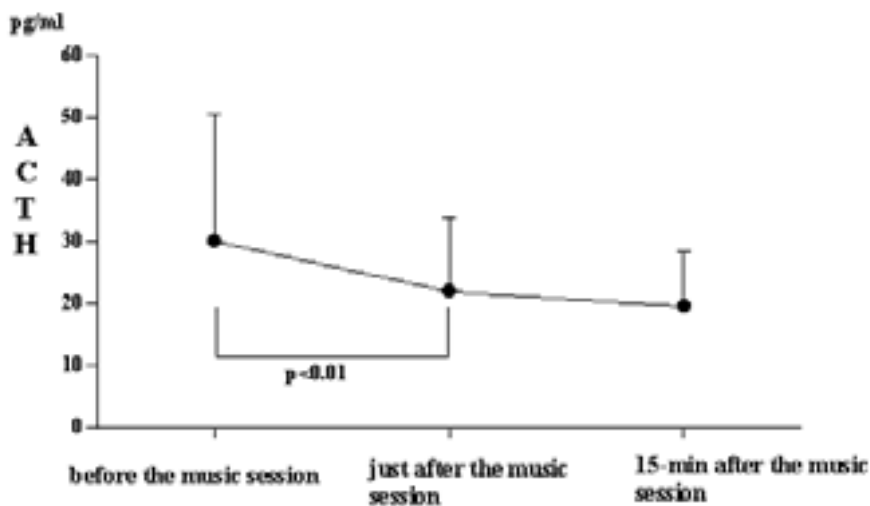


Figure 2 Changes of ACTH

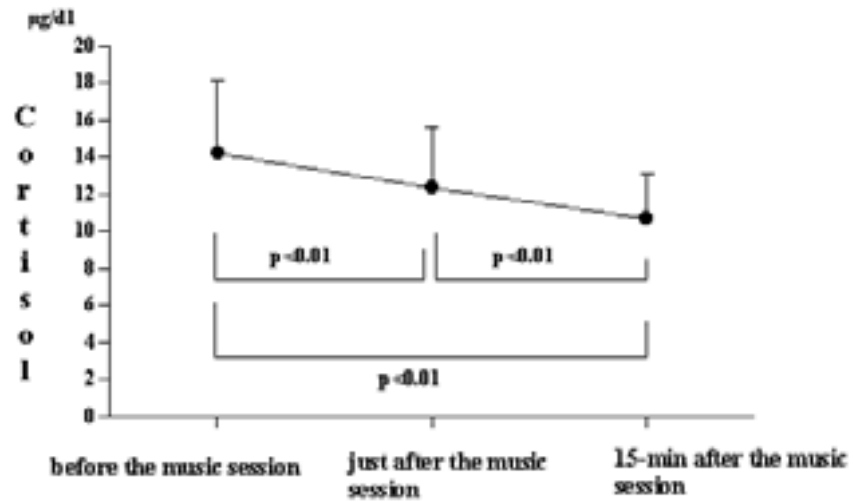


Figure 3 Changes of Cortisol

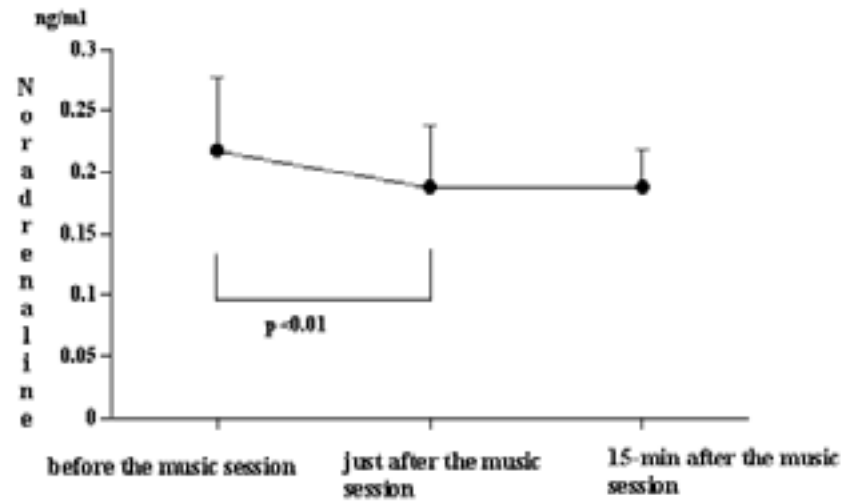


Figure 4 Changes of Noradrenaline

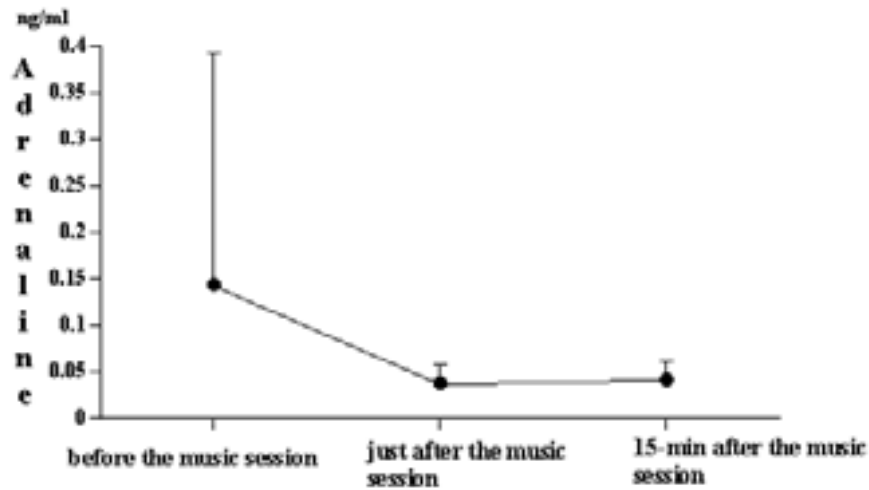


Figure 5 Changes of Adrenaline

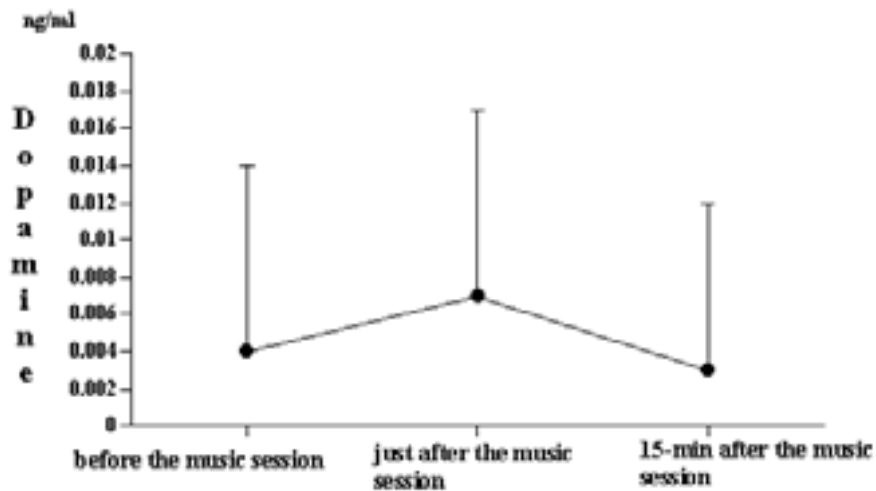


Figure 6 Changes of Dopamine

There were significant decreases of NA during the music session ($p < .01$), although there was no significant change of AD and DA during the music session. Plasma levels of ACTH significantly decreased during the music session ($p < .01$). Moreover, plasma levels of cortisol just after the music session and after a 15-min period of rest after the music session were significantly lower than those of cortisol just before the music session ($p < .01$ and $p < .01$, respectively).

4-2 Psychological Evaluation

Concerning the factor analysis of the adjective pairs (semantic differential method)

A factor analysis was carried out using the rating values for all eight pieces. Rotation was conducted according to the varimax method. Three factors were chosen according to the principal factor solution.

The first factor includes the eight adjective pairs "calm", "serene", "graceful", "static", "at ease", "healing", and "comforting", and "able to concentrate", and considering these characteristics it was labeled "relaxation".

The second factor was labeled "vivid", and includes the five adjective pairs "bright", "healthy", "light", "spacious", and "energetic".

The third factor was labeled "evaluation", and includes the five adjectives "fondness", "profound", "distinguished", "interesting", and "natural".

Gender: A different criterion could be seen for the African drum rhythms, the Bartok sonata, and "Sunlight and Forest" according to gender. Regarding the second factor "vivid" for the African drum rhythms, the men's score of -0.10 was significantly lower than the women's score of 0.92 ($p = < 0.01$). The women evaluated this piece as being more vivid. Regarding the second factor "vivid" for the Bartok piece, the men's score of 0.13 was significantly lower than the women's score of 0.79 ($p = < 0.05$).

Regarding the first factor "relaxation" for the piece entitled "Sunlight and Forest", the men's score of 0.41 was significantly lower than the women's score of 1.20 ($p = < 0.01$). The women evaluated it as being more tranquil. For the second factor of the same piece, the men's score of 0.41 was significantly lower than the women's score of 1.00 ($p = < 0.01$). The women evaluated it as being livelier. (See Table 1)

* Characteristics of "relaxing" pieces

- a) Soft and beautiful harmony Å 19 people
- b) Beautiful melody Å 8 people
- c) Exotic Å 2 people
- d) Repeated rhythms Å 1 person

e) Misc. Å 4 people

f) Unanswered Å 2 people

? Familiarity of pieces

Very familiar Å 11 people

First time listening Å 10 people

Both Å 10 people

Age difference (subjects in their twenties and fifties)

The five pieces that received a different evaluation according to age difference are the African drum rhythms, "Ivory Tower", the Bartok sonata, the Mongolian lullaby, and the Gregorian chant. Regarding the second factor "vivid" for the African drum rhythms, the score of -0.12 for the subjects in their fifties was significantly lower than the score of 0.72 for those in their twenties ($p = < 0.05$). The subjects in their twenties evaluated this piece as being more "lively".

5 DISCUSSION

5-1 Endocrinological experiment

In this study, we measured endocrinological changes during the music session. Plasma levels of ACTH significantly decreased during the music session in this study. Hassler (Hassler M, 1992) has been reported that ACTH is significantly associated with music and space perception. Therefore, the results about ACTH in this study suggest positive effects of healing music. There were significant decreases of NA during the music session in this study. NA, which is associated with the peripheral sympathetic nervous system, increases under psychosocial stress. Therefore, it is suggested that healing music may have some relaxative effects. Plasma levels of cortisol significantly decreased during the music session in this study. Cortisol, which is associated with hypothalamus-pituitary-adrenal (HPA) axis, is a

representative stress-related hormone and increases under psychological and physical stress. Therefore, our findings also suggest that healing music may have relaxative effects. There are some limitations in this study. First, ACTH and cortisol have circadian rhythms. Therefore, a further case-control study is needed in order to confirm effects of healing music on HPA axis. Moreover, effects of healing music as music therapy on illness could not be established in this study because the subjects were healthy. Therefore, it is necessary to carry out studies in which subjects are in high levels of tension and anxiety.

5-2 psychological experiment

In regards to language evaluation, focusing on the eight adjective pairs included in the first factor "relaxation" ("calm", "serene", "graceful", "static", "at ease", "healing", and "comforting", and "able to concentrate") which is thought to be connected with "healing", 50% of the subjects tended to give a positive evaluation. This shows that the music to which was listened was evaluated as being "tranquil".

The subjects both in their twenties and fifties evaluated "Sunlight and Forest" as being the most "healing". This evaluation accounts for approximately half of the subjects in their fifties and 30% of the subjects in their twenties. The Gregorian chant received the second highest score among subjects in their twenties. However, because this piece was included on a CD that was popular in 1996, this score may be a result of this piece's familiarity to the younger generation that is sensitive to what kind of music is popular. In opposition to this, the shakuhachi piece "Movement of Wind" received the second highest score among the subjects in their fifties. This score may be a result of possibility that the simple sounds of the Japanese traditional instrument shakuhachi raise nostalgic feelings of the Japanese and make them feel as if their "soul is healed".

"Ethnic music" such as the Mongolian lullaby and African drum rhythms was felt by the younger generation to be "healing music". The detailed repeated rhythms (as in that of minimal music) in the two pieces

"Dream / Illusion" and "Ivory Tower" was also felt to be psychologically "healing" or "relaxing".

In regards to gender, even though it is difficult to generalize, according to the results of the impressionistic evaluation of this research, women tended to give a higher absolute value than men did, and seemed to be more emotional in their responses. In other words, they considered "vivid" pieces of music more "vivid" and "tranquil" pieces as more "tranquil" than the men did. On contrary

to this, the men tended to give a score close to "neither" for either of the criterion. However, there was no difference in scoring between genders for the third factor "evaluation". Because of this, it can be said that the women tend to respond more sensitively to evaluations dealing with the emotions. Future research concerning the difference of emotions between genders would be of great interest.

5-3 Results

Healing music can be thought of on two ways. The first is that it has a particular sound for each individual person, and the second is that many people can feel in common "healing" through the music. The latter case was dealt with in this research. Music that is slow and has beautiful, clear tones was evaluated as "healing", but this does not necessarily mean "sedative" music. It must be kept in mind that the characteristics of the type of music and compositional structure change according to the listener's psychological condition at that particular time. For example, when one is relieved from a highly stressful situation, music with a repeated rhythmic structure is best suited for continuous listening.

The uses of healing music vary, but as "spirituality" is included in the original meaning of healing, it can be expected that palliative care (hospice) can gain the most from the effects of healing music. It is gradually being used more in connection with other medical care such as in the reduction of anxiety before surgery, countermeasures against insomnia, artificial dialysis, pain reduction during medical treatment, and the physical and mental control in the inpatients' ward.

Due to the high expenses necessary to conduct the research, it was not possible to make a comparison with a control group for this endocrinological experiment. Because of this, this research has limitations. However, because it was possible to investigate blood samples from the subjects, this research can be considered a beginning of endocrinological research on human beings concerning

music listening. At the next step of this research, the number of subjects will be increased. The authors hope to find scientific support and to develop physiological functions and mental activity for music therapy and background music.

CITATION

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QUALITATIVE RESEARCH

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Ladies and Gentlemen,

I am very happy to be here and have the opportunity of speaking of the research work that has engaged us since the beginning of the music therapy treatment.

I think that it is important to point out that the research was done in the "Istituto Ospedaliero di Sospiro" (Sospiro, Cremona, Italia).

This institution has also financed the project which was planned out by a Music Therapy team consisting of two music therapists (Alfredo Raglio, Fiorenzo Puerrari), a psychiatrist (Maria Elisabetta Galizzi) under the supervision of Dr. Rolando O. Benenzon.

TABLE I

THEORETICAL FRAMEWORK

- The theoretical principles for this type of treatment are based on R.O. Benenzon's and on D. Sterne's theories.
- Use of sound-music improvisation (active Music Therapy) in a non-verbal context.
- The sound-music element is seen as the expression of the sound identity (ISO).
- The sound-music element is used as an expressive way in the framework of communication in the relationship (in this case the sound and the sound object turn into intermediary objects).

- The Music Therapy treatment wants to create a relationship and start a communicative process which have to be obtained through watching and listening without any direct action on the part of the therapist.
- The tuning-in processes which start the intersubjective relationship are obtained with specific sound-music material.
- The connection between Benenzon's and Sterne's theories is to be found in the similarities between the ISO features and the Self features of Stern's; psychological theory.
(ISO is unconscious and it has dynamic features. It derives from global perceptive experiences of one's body and the other's body as producers of sounds and principally of heart, breathing and entrails rhythms. Both the functions of the SELF described by Stern and the ISO principle described by Benazon are organizing principles of the emotional and cognitive development and particularly of the abilities to establish a relationship).

TABLE II

MEANING AND REASONS OF A RESEARCH IN MUSIC THERAPY

- " Leaving behind romanticism and pioneering in order to ask oneself the reason for causes and results (R.O.Benenzon)
- To give scientific endorsement to the important therapeutic and rehabilitating results achieved by the Music Therapy Treatment.
- To stress the connection SOUND/RELATIONSHIP.
- To show that the sound-music element has an intrinsic and specific value, which can be contextualized in a relationship.
- To focus on the most important elements in the therapeutic process and the most effective technique.

- To improve the music therapy treatment from a methodological point of view.
- To define consistent and common theoretical and methodological criteria which can be used in every music-therapeutic treatment similar to the one we are considering.

TABLE III

FUNDAMENTAL QUESTIONS

- How important is the sound-music element in a relationship?
- How is the relationship influenced by the setting and the action and presence of the music therapist?
- Is it possible to outline universally shared and applicable treatment methodologies when starting from common theories?
- What are the main behavioral and sound-music replies of patients when faced with specific stimulations suggested by the music therapist?
- How do patients and mentally-sound people use musical instruments under the same conditions?

These and other questions have been the driving force of the research which has been complex and articulated since the beginning.

The first difficulty we found was to try to eliminate the greatest possible number of variables linked to the methodology we used and to the creation of the Music Therapy setting. The whole work was supposed to be done with a criterion of uniformity and invariability, which would favor the objectivity of what took place. The sessions would be held in the same setting and with the same method. The consequence of this was a series of difficulties linked

to the carrying out of the sessions and the stiffness of the methodology rules.

There have been problems connected with continuity, anxiety about possible results and the conditioning of the inexorable methodological inflexibility.

There is a macroscopic difference between the structuring of sessions with therapeutic objectives and those with research objectives; in the latter the music therapist is just watching and is consequently "neutral" and should limit his gestures to the minimum. Any variation added by him would alter the results and the objectivity of observation and evaluation.

Another important aspect was the criterion for collecting data; we outlined observation protocols to quantify data related to the relationship and production, at the same time trying to safeguard that amount of non quantifiable emotions which are of primary importance to every therapy and to every artistic-creative process. We did not want to achieve a technicality at the expense of the most emotional and inner responses because they are, probably, the most meaningful aspects in a therapeutic process.

That is why it is necessary to find a technique more effective from a therapeutic point of view, and also to deepen the knowledge linked to the sound/relationship correlation and to improve the methodology of the Music Therapy treatment.

The goal of the first phase of the research (with patients) was to establish a comparison between Music Therapy and other techniques of non-verbal communication by emphasizing the specific use of the sound-music element in the music -therapeutic context.

In the second phase of the research (with patients and a control group of healthy people) we studied the body-sound-music expressive possibilities in different music therapeutic settings. This showed a significant variation of replies depending on the different settings.

The research work will be continued by a third phase (with patients and a control group of healthy people) aimed to analyze the influence of the presence and action of the music therapist in the setting.

The initial assumption is that the non-invasive music therapist's presence favored by the use of sound-music instruments as intermediary objects plays a fundamental role in the musictherapeutic relationship.

THE PROTOCOLS

TABLE IV
Protocol A

3					
2					
1					
	0	5	10	15	20
				25	30
	TIME (min.)				

DESCRIPTION

A = bodily separation

T = direct relationship with the music therapist

T1 (LOW) = visual contact with the therapist

T2 (MEDIUM) = physical approach (proximity, open postural attitude)

T3 (HIGH) = interaction with the therapist in order to establish communication

I/O = relation with objects and instruments

I/O1 (LOW) = visual contact with instruments/objects

I/O2 (MEDIUM) = listening or exploration of instruments/objects

I/O3 (HIGH) = use of instruments/objects in order to establish communication

We have developed a watching protocol (Protocol A) in order to quantify the moments identified by Stern as part of the intersubjective relationship (co-participation of attention, intentions and emotions) and to analyze these moments from the point of view of the direct relationship of the patient with the therapist (T) or the relationship of the patient through the instruments (I).

The co-participation of the attention may be considered as a first-intensity level of the direct relationship with the music therapist (T1) and/or through the instruments (I1): this implies a visual contact of the patient with the instruments and/or the music therapist; the co-participation of the intentions is equivalent to a second intensity level (T2, I2) and it means a bodily approach to the music therapist and/or listening or exploring the instruments; the co-participation of the emotions (precisely with the tuning-in) is considered as a third-intensity level and it assumes an interaction with the aim of communicating with the therapist and/or the use of instruments with a communication purpose.

During the sessions we collected numeric data, for each patient, and we quantified the moments of relationship T and I based on their intensity.

The Protocols B, C and D put in evidence the sound-music data.

**TABLE V:
PROTOCOL B**

Patient..... setting:..... session No.....
 date..... time duration.....

First gesture of the patient faced with the instruments: indifference watching
 immediate attention use

J = productions with instruments in the setting ĵ = productions with other elements which are not part of the group of instruments

* = pause

J																									
ĵ																									
m	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22			

**TABLE VI
PROTOCOL C**

ĵ / J	Instruments	Use	Rhythm	m
1				
2				
3				
4				

5				
6				
7				
8				
9				
10				

COMMENTS:.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

TABLE VII

PROTOCOL D

Productions significantly repeated by the patient and by the music therapist
(sound-music elements which appear at least three times during the session):

PT. :

MT. :

PT. :

MT. :

PT. :

MT. :

In the research we used another protocol (Protocol E) suggested by Dr. Benenzon, which showed the data related to the session, the setting, the music therapist and the patient.

TABLE VIII

Protocol E

Name of the patient:

Session No:

Music therapist:

Type of session:

Time:

Data regarding the session and the setting

- Particular features of the Music Therapy room:

Light:

Smells:

Temperature:

External sounds:

- Used instruments:

How many?

Which?

- Position

- Description:

● Eventual changes of the instruments:

● Strategy used for the session

Why?

● Instrument used as intermediary object:

● Instrument used as cathartic object:

● Instrument used as encapsulated object:

Others:

● Strategy for the next session:

- How does the music therapist end the session (verbally, with a rhythm, with a melody, in another way, etc.)?
- How does the patient end the session?
- Duration
-

Data regarding the music therapist

- State of mind before the session (in good spirits, happy, cheerful, indifferent, anguished, anxious, worried, frightened, sad, afraid, others):
- The music therapist thinks of himself, of the patient, of another thing:
- Other comments:
- First feeling of the music therapist when facing the patient (indifference, rejection, charm, others):
- Does this feeling coincide with the feeling during the preparation phase of the session?
- Does the music therapist use instructions (verbal, non-verbal, directive, non directive, partially directive, others)?
- Which instrument does the music therapist choose? Why? How does he use it?
- At the end of the session the music therapist feels (satisfied, disappointed, indifferent, confused, others):
- Why?

Data regarding the patient

- Attitude of the patient (body, gestures, movements, position in the space, etc.):
- Choice of instrument (immediate, doubtful, decisive, previous to observation, others):

● Which instrument?

● How was it used? In a conventional way? In a non-conventional way?

Description:

● Sound production of the patient (rhythmic, melodic, random, etc.):

Description:

● How does the patient react to stimulation (what body-sound-music associations, what rhythms, and what movements)?

● Has the patient shown any change? Which? (bodily modifications, body-sound-music associations, new musical elements, etc.):

TABLE IX

PROTOCOL F

Data regarding the music therapist

• State of mind of the music therapist before the session

- indifferent

- disappointed

- gratified

• State of mind of the music therapist during the session:

- repulsion - tenderness

- scorn - empathy

- fear/rejection - enthusiasm

- anxiety/doubt - pleasure/enjoyment

• State of mind of the music therapist after the session:

- indifferent

- disappointed

- gratified

- Prevailing tonic state (of the patient)
 - tension
 - relaxed

- Prevailing tonic state (of the music therapist)
 - tension
 - relaxed

Protocol F also included the state of mind of the music therapist before, during and after the session and the prevailing tonic state of the music therapist and the patient or the volunteer.

The states of mind were individualized among the most frequent and defined in the context of the Music Therapy sessions: some negative such as repulsion, scorn, fear/rejection, anxiety/doubt, and others positive such as tenderness, empathy, enthusiasm, pleasure/enjoyment in decreasing order of intensity and of emotional importance.

The contribution of these Protocols (Protocols E and F) to the research was fundamental because they made it possible to find contact points between the "objective" data (the numerical and sound-music data) and the "subjective" ones (the emotional ones).

RESULTS

Table X

FIRST PHASE OF RESEARCH

COMPARISON BETWEEN THE NUMBER OF REPLIES IN THE MUSIC THERAPY SESSIONS AND IN THE CONTROL SESSIONS WITH SOUND AND WITH OBJECTS

Description: I= relation with instruments

O= relation with objects;

T= direct relationship with therapist

I/O IN THE MUSIC THERAPY SESSIONS +38%

T IN THE MUSIC THERAPY SESSIONS + 3%

Table XI

COMPARISON BETWEEN THE NUMBER OF REPLIES IN THE MUSIC THERAPY SESSIONS AND IN THE CONTROL SESSIONS WITH SOUND AND WITH OBJECTS

Description: I= relation with instruments

O= relation with objects

T= relationship with therapist

I/O+T IN THE MUSIC THERAPY SESSIONS + 22%

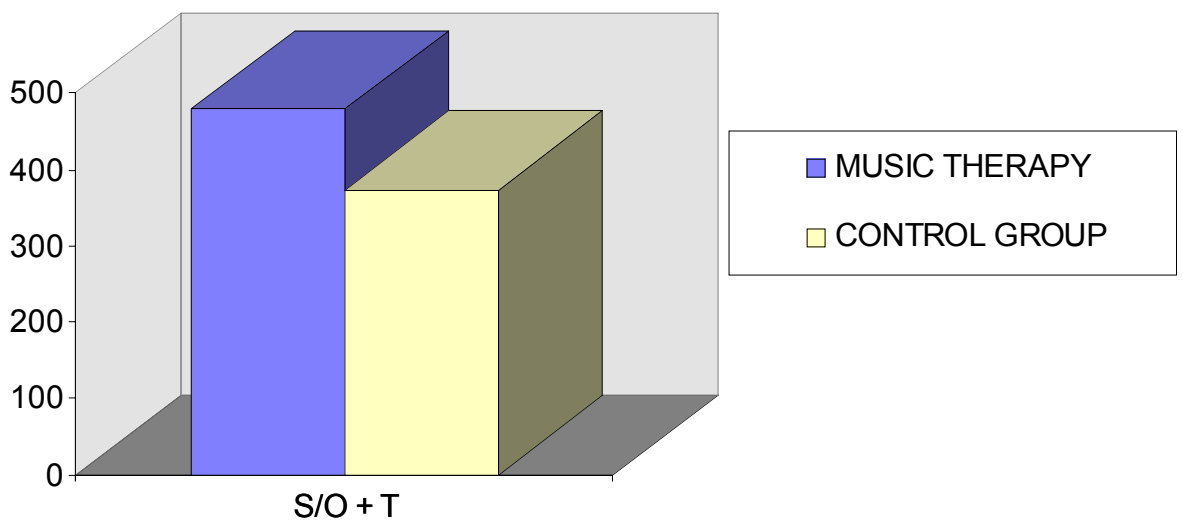
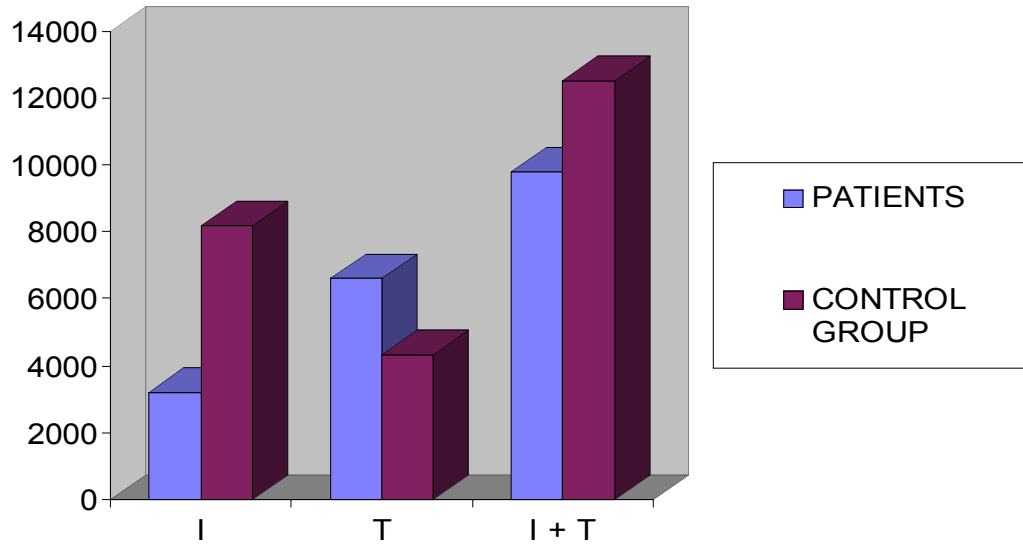


Table XII

SECOND PHASE OF RESEARCH

NUMBER OF "I" AND "T" MOMENTS IN THE SESSIONS WITH PATIENTS AND WITH THE CONTROL GROUP



PRODUCTIONS OF THE PATIENTS AND OF THE CONTROL GROUP

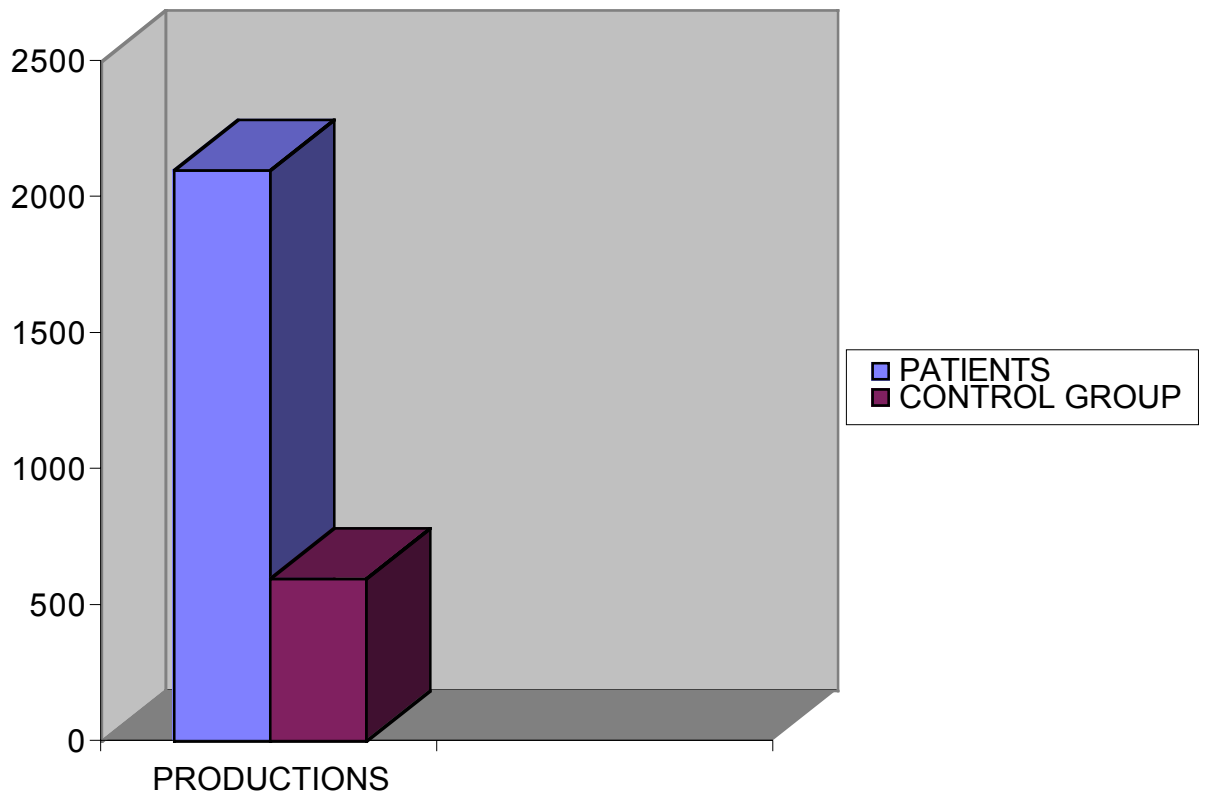


Table XIII

PRODUCTIONS WITH INSTRUMENTS OF THE SETTING (IC) AND WITH INSTRUMENTS THAT ARE NOT PART OF THE SETTING (FC) AND CONVENTIONAL (C) AND NON-CONVENTIONAL (NC) PRODUCTIONS IN THE SESSIONS WITH PATIENTS AND WITH THE CONTROL GROUP

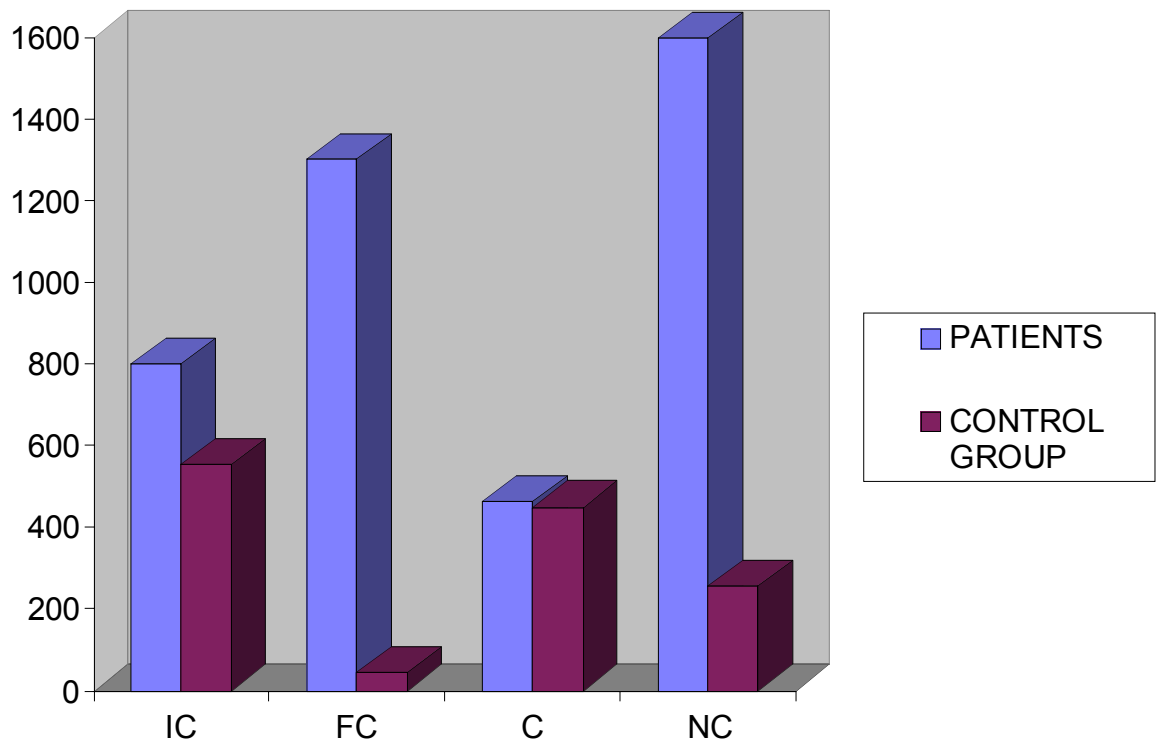


Table XIV

BINARY (B), IRREGULAR (I) AND TERNARY (T) RHYTHMS PRODUCED BY THE PATIENTS AND BY THE CONTROL GROUP

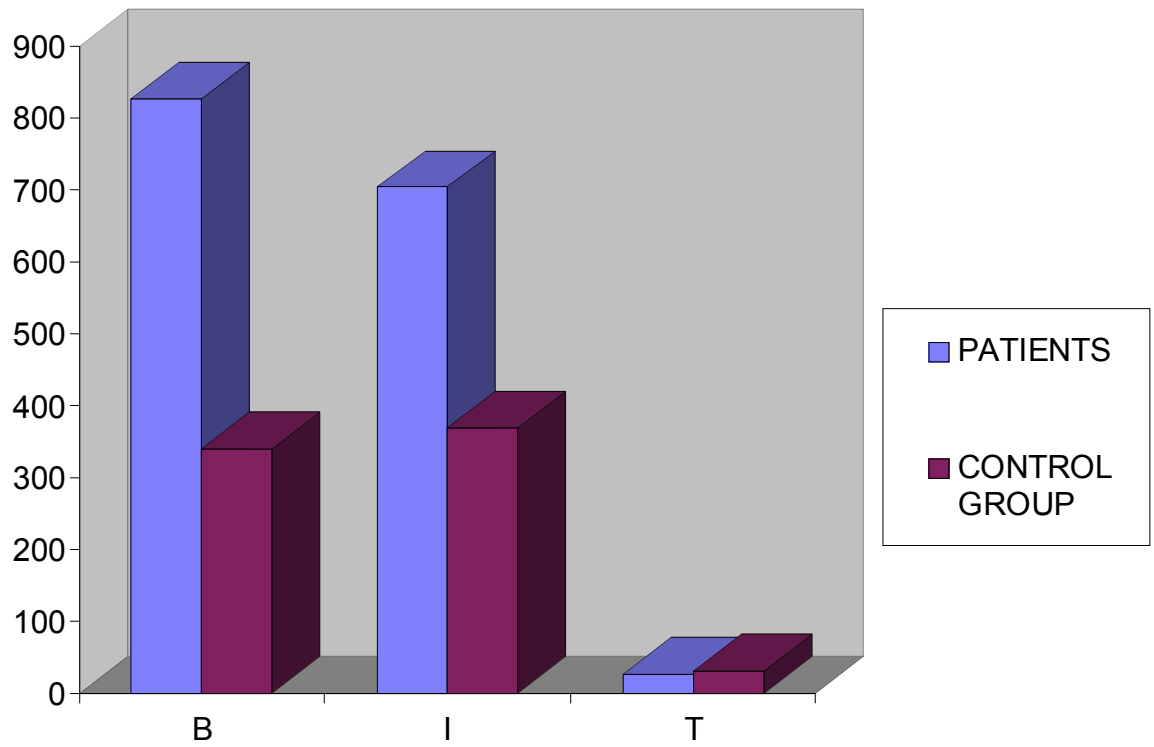
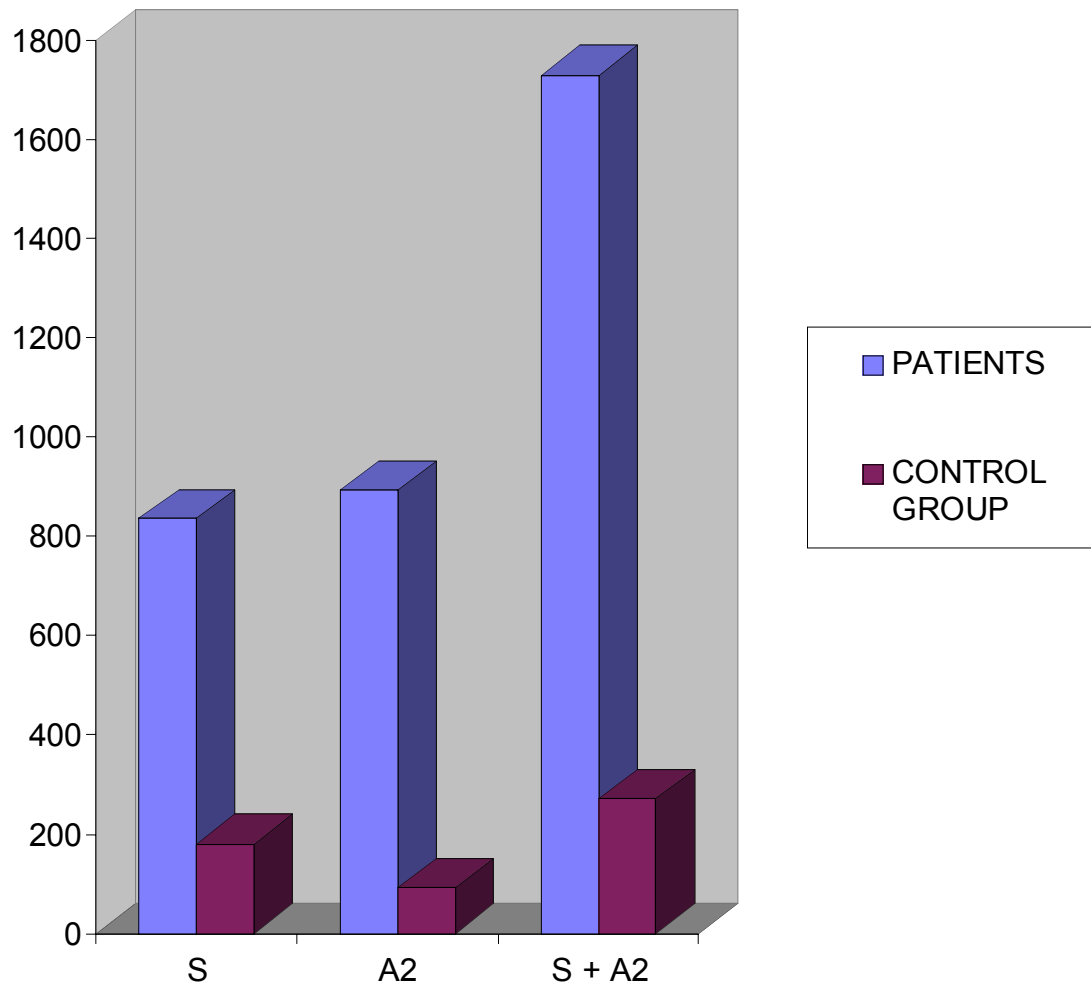


Table XV

DATA REGARDING THE MOVEMENT OF PATIENTS AND OF THE CONTROL GROUP DURING THE MUSIC THERAPY SESSIONS (S = separation, A2 = approach, open postural attitude):



CONSIDERATIONS

Research in Music Therapy is a complex subject full of correlative problems and factors, which overlap and influence one another.

Let us think of a series of concentric circles with the smallest one in the center. Here we place the Music Therapy team (in our case, two music therapists and a psychiatrist).

In the other circles we insert the other factors, which are part of the research in the following order:

- Theory, project, method
- Setting and formulation of instructions
- Music Therapy sessions
- Viewing of the sessions, protocols
- Internal supervision of the Music Therapy team
- Institution
- External supervision

I think that the good result of a research will be directly proportional to the coherence and harmony in and among the circles. Every area which does not work properly and coherently will hinder and condition the realization of the work.

The figure of the music therapist is the central and so the most complex and influenceable. He plays a double role as consultant, therapist-researcher, observer-observed, as part of both the intervention group and the supervision one. The situations of anxiety that is (respect of times, rigidity of tasks, fear of judgement, desire to get results and the constant presence of a telecamera) influence his position a lot.

The research and the supervision have taught us a lot especially as regards consistency, and task performance in the music therapeutic work; the space-time element and the rigid and essential setting helped us to understand the events and the discrimination between the ISO of the therapist and the ISO of the patient.

As Benenzon has said ,the first objective is the music therapist and his VISSUTO CORPOREO-SONORO-MUSICALE.

The field of the research is made up of the global non-verbal context and the reading of the events is analogicus;the body dimension has a fundamental importance on the expressive-communicative level,but also on the interpretation of the data above all in the second phase of the research. Considering the complexity and the high number of variables in this research,I think that the quantitative value of the data will not come from one single experience but from the sum of many experiences:thus it will be possible to verify the possibility of extending the method of the research and the application of the Observation Protocols.

To sum it up the results of our research are general and non dogmatic or categorical;however they can back up the scientific presuppositions of the discipline and improve the quality and efficacy of therapeutic interventions. To conclude I would like to quote a sentence by Starobinski (1960) which can be applied to research both in psychotherapy and even better in music therapy.: "Scientific maturity means accepting imprecision,when it cannot be rationally dominated,and rejecting false precision."

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THE PROCESS OF EVALUATION IN MUSIC THERAPY CLINICAL PRACTICE

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INTRODUCTION: LITERATURE REVIEW

The last ten years, have seen a tremendous increase in the theoretical background of music therapy. The work between researchers and music therapists has generated significant contributions for theoretical-methodological development of the discipline and there have been useful contributions about clinical work.

Despite the progress that has been made, bibliographical review shows that there has been, relatively, not too much written in music therapy literature dealing specifically with evaluative process as a methodological phase of music therapy clinical work. Literature reviewed about evaluation can be organised in categories:

A. GENERAL INFORMATION

1. *In case analysis describing treatment process*: Aldridge, 1999; Benenzon, 1998; Di Franco y Facchini, 1995; Hoskyns 1995; Martín, 1998; Magee, 1995; Muller & Warwick, 1995; Olfield, 1995; Smeijsters & Van del Hurk, 1993; Wagner 1996a.
2. *Describing the musical process in music therapy*: Aldridge, 1999; Bergstrom-Nielsen 1993, 1999; Gainza, 1997a,b; Lee, 1989, 1990, 1995, 1996; Pavlicevic, 1990, 1995a, 1995b; Rodríguez Espada, 1988; Towse, 1997.

3. *Information about music evaluation related to music therapy*: Blasco, 1996; Sikstrom y Skille, 1995; Smeijsters, 1995; Gainza, 1982, 1996a,b.
4. *Supervision in music therapy*: Brown, 1997; Benenzon, 1998a; Bruscia, 1998; Di Franco, 1996; Dvorkin, 1998; Frhone-Hagemann, 1999.

B. SPECIFIC INFORMATION

1. *Describing methodological information that includes references about assessment and evaluation in music therapy*: Andsell, 1991; Benenzon, 1971, 1998; Blasco, 1999; Bruscia, 1987; Davis y col., 1992; Griggs-Drane y Wheeler, 1997; Hanser, 1987; Isenberg-Grezda, 1988; Loureiro, 1998; Maranto, 1993; Olfield, 1993; Oliveira Curz, 1998; Poch, 1999; Rejane, 1999; Sabbatella, 1988a, 1998b, 1999; Wigram, 1997.
2. *Describing assessment and evaluation procedures in music therapy clinical practice*: Andsell 1991; Bruscia, 1991; Benenzon, 1998; Cassity y Cassity, 1991; Ferragina, 1999; Galizzi y col., 1996; Gfeller & Baumann, 1988; Grant 1995; Griggs-Drane y Wheeler, 1997; Krouth, 1986; Nordoff & Robbins, 1977, 1982; Olfield & Adams, 1995; Poch, 1999; Sabbatella, 1993; Sagasti y Bernaola, 1998; Van Colle & Williams, 1995; Wagner, 1996b, 1998; Wigram, 1995, 1996.

Literature analysis shows that in comparison with other professions (medical, paramedical and education), the specific area of evaluation in music therapy is still weak. Most of the information is related to assessment and evaluation of clients as part of treatment processes; procedures of assessment and evaluation vary according to the area of work, the clinical population, the needs of the client, the treatment goals, the level of therapy, institutional needs, theoretical orientation of the therapist and vary from more formal to less formal approaches. Authors did not specifically address on music therapy evaluation methodological processes (data collection, data categories, reports, areas of evaluation, relationships between assessment and evaluation, evaluation of treatment effectiveness, etc).

About the precedence of the music therapists writing about evaluation, literature analysis shows a sharp contrast with reference to production of information between on the one hand, the Latin-American Spanish and Portugal professional context, and on the other the North American and Western European context.

As in different disciplines, a complete overview of evaluation as a systematic process, remarks the importance of evaluation process in music therapy. Evaluation is not the mere accumulation and summarising of data, the field of evaluation includes many substantial and well-recognised subareas such as product evaluation, personnel evaluation, program evaluation and so forth (Scriven, 1991). In opinion of the author a complete and global process of evaluation in music therapy includes different aspects, not only related to assessment and evaluation of clients (table 1).



🌐 Supervision of clinical practice: includes evaluation of client, music therapist, and music therapy treatment process.

META-EVALUATION OF MUSIC THERAPY

🌐 Evaluation designs of music therapy applications (programme evaluation, evaluation of the processes of evaluation in music therapy, institutional satisfaction, etc.)

Table 1: Areas of music therapy evaluation

PURPOSE OF THE STUDY

The development of music therapy around the world has been linked with a number of factors unique to each country. Literature review about evaluation in music therapy shows a sharp contrast with reference to production of information between Latin-American Spanish and Portugal professional context and the North American and Western European context.

In the words of Ruud (1998): "*European music therapists have lately been more concerned with doing research on their own clinical work... and research is understood in a broad sense as a way of finding knowledge*". If we paraphrase the stated idea we can say that: music therapists from Latin American countries, Spain and Portugal have been more concerned with their clinical work than with research. This can be corroborated by a bibliographical study on specific music therapy's topics where the majority of the specific publications belong to authors from North-America, Western-

Europe. These differences are basically a result of the unequal development in the area of clinical practice research and the diffusion of the results in both professional contexts, which influence the quality and quantity of the bibliographical productions currently in the editorial market. Eventhough the socio-economic situation of Latin America countries does not allow the financing of research projects or the presentation of the results obtained in clinical work by publications, this fact does not imply that in the daily clinical work of music therapy data or information about clinical practice is produced.

Contrary to the reasons presented above, we believe that clinical work in music therapy in Latin American countries, Spain and Portugal can contribute considerably to the theoretical development of music therapy.

The impetus of this study came from my own experience as music therapist and university teacher of music therapy. The relationship of the University of Cadiz with Latin-American Universities through educational and political cooperation agreements programmes create an important opportunity to exchange information and research in music therapy. The participation in these exchange experiences since 1995, enriched the teaching and increased the interest of both the author of this article, as well as her students about the practice of music therapy in Latin-America. The poor information available about the topic, can be found in reports of associations in stands at international congresses, in articles in journals or prologues of books, sometimes in papers at congresses or round tables which somewhat superficially offer some information in this sense. There is an absence of specific literature and studies about evaluation in clinical practice in those countries. In order to search for information the objective of this study is *to describe assessment and evaluation procedures used in clinical practice in Latin America countries , Spain and Portugal.*

METHODOLOGY

1. Research Design

In the words of Bruscia (1995:73) "*music therapy is too broad and complex to be defined, contained or limited by one research approach*". Wheeler (1995:3) corroborates this idea when she says " *the methods of music therapy research are generally part of a larger conception of research with particular adaptations to the needs of music and music therapy*". It is fundamental to take the above-mentioned into consideration when developing a research plan, as well as, to combine specific music therapy knowledge with current research strategies and techniques with the aim of adapting the latter to the specific needs of the research object. To formalise the research design the suggestions of Fox (1981) concerning the underlying dimensions that can be used to structure or classify the research ideas in order to select their orientation or approach should be taken into account. Following these ideas, the answers to our questions and the needs of our research study can best be found somewhere *in the present*, amongst the music therapists who are working anonymously, in everyday clinical music therapy practice. Based upon a *Survey Design* the object of this research is to *describe the current situation about evaluation in music therapy clinical practice* based on the information given for this study by the music therapists. For this purpose the descriptive study is based on a survey/questionnaire which will make it possible to gather the necessary data taken from the "*Cuestionario sobre Practica Profesional de la Musicoterapia*" designed by the author of this work.

2.- Data Collection: Survey of Music Therapy Clinical Practice

The *general objective* of the *Survey of Music Therapy Clinical Practice* is to gather data about music therapy clinical work focus on methodology and evaluation of clients in different areas and levels of practice. The survey consists of 24 open and closed questions organised in three sections: *Professional Issues, Methodology of Clinical Practice, Assessment and Evaluation of Clients* (Table 2).

The reliability and validity of the Survey was tested through External Peer Review (Fox, 1981), and for this purpose a Validation Survey was developed. The criterion applied in the selection of the external peers was to take

outstanding music therapists of the participating countries and from other countries⁵.

Topic	Nº of questions	Information Collected
Professional Issues	4	Area of work, Type of clients and pathology Level of clinical practice
Methodology of Clinical Practice	7	Music therapy approach and theoretical orientation, Treatment procedures and techniques. Media and roles, Session format, Role of the therapists, Dynamic of the process
Assessment and Evaluation	13	Model of assessment and evaluation of clients, Instruments of data collection and analysis, Evaluation criteria, Areas of evaluation, Supervision of clinical practice

Table 2: Description Survey of Music Therapy Clinical Practice

⁵ The music therapists invited were: Gianluigi di Franco (President of the European of Music Therapy Confederation), Silvia Jensen (Konsulent Handicap Norjyllands, Denmark), Diego Schapira (Chair of the Commission on Ethics and Research of the World Federation of Music Therapy), Amelia Ferragina (past-co-ordinator of Music Therapy Training Course at the University of Buenos Aires), Lia Rejane Mendes Barcellos (Lecturer Curso de Formação de Musicoterapeutas do Conservatorio Brasileiro de Musica), Esperanza Alzamendi, Amparo Alonso and Myriam Blanco (Members of the Commission of Research Asociacion Uruguay de Musicoterapia).

The questionnaire was translated into Portuguese to facilitate the datagathering of colleagues in Portugal and Brazil.

3. Target Audience and Participants

In order to limit the population of the study the criterion used in selecting the participating countries was the inclusion of those countries members of the Latin American Committee of Music Therapy: Argentina, Brazil, Uruguay, Columbia, Chile, Cuba, Mexico, Peru and Venezuela. It was decided to include Spain and Portugal to offer an overall view of Music Therapy Clinical Practice in the Spanish and Portuguese speaking languages.

The data gathering process was begun with the collaboration of Music Therapy Associations in the participants countries, delegates of the Comité Latinoamericano de Musicoterapia, Commission on Etichs and Research of the World Federation of Music Therapy, University of Cadiz. The questionnaires were distributed through normal mail and email. The respondents of the questionnaire were certificate music therapist.

The research project was introduced at the V Foro Rioplatense de Musicoterapia (Montevideo, August 1998) and at the II Encuentro Latinoamericano de Musicoterapia (Rio de Janeiro, November 1998). The questionnaire was sent by post and email during July - December 1998. Follows up letter were sent in September and December 1998, and the closing date was May 1999.

RESULTS

1. Demographic Data: Professional Issues

There were 119 respondents to the questionnaire: *Argentine* 74; *Brazil* 15; *Columbia* 3; *Chile* 1; *Peru* 6; *Uruguay* 5; *Portugal* 2; *Spain* 13. There were no responses from *Cuba*, *Mexico* and *Venezuela*. 89 respondents were female (75.4%) and 29 (24.6%) male. The *age-range* of responses is between 21 and 66 years old. The 26-30 age group represents the highest concentration of respondents with 32 (29.9%) and the 36-40 age group with 20 (18.8%). The average of respondents was 33.9 years. Data for respondents' *years of experience* reveals that the 0-5 years category

represents the highest concentration of respondents with 48 (43.2%). Table 3 summarises data for *client groups* respondents worked with.

CLIENT GROUP	N° of Respondents	%
Autism	35	29.4
Disability	18	15.1
Mental Health	13	11
Communication disorder	11	9.2
Neurotic	10	8.4
Elderly		
Medicine	9	7.6
Neurology	9	5.9
Sensory impairment	7	4.2
Total	119	100

Table 3: Client groups respondents worked with

2. Methodology of Clinical Practice

About *session format*, 84.9% of respondents work in *group sessions*; 65.3% in *individual sessions*; 14.4% in *family sessions* and 8.5% in *dyadic sessions*.

The main *media* used are percussion instruments, voice, and body. More frequently *techniques* used are *listening to music* (78.5%), *instrumental improvisation* (70.5%), *body movement with music* (65.2%), *combined listening with verbalisation* (61.6%) and *vocal improvisation* (58.5%).

Theoretical orientation vary according the country, in *Argentina, Brazil, Colombia, Chile, Peru, Portugal and Uruguay*, *Psychoanalytic* approach and *Existential* and *Humanistic* schools are most frequently. In *Spain* there is not unifying school of practice.

3. Assessment and Evaluation

● **Areas of assessment and evaluation of clients:** Taking the first two agreeing categories together participants thought that the *more important* general areas are: *sensorimotor* (90.6%), *emotional* (94%), *cognitive* (55.6%) and *communication-social* (94.8%).

● **Assessment information collected:** Taking the first two agreeing categories together, participants thought that the *more frequent* aspects to assess, beside diagnosis are *musical state of the client* (70.5%), *musical responses skills* (71.7%), *use of musical instruments* (61.2%), *improvisation skills with instruments* (71.8%), *voice abilities* (66.1%), *expression through voice* (75.2%), *movement-sound* (83.8%), *feelings communication through music* (91.4%), *skills on communication through music* (81.3%), *participation in musical activities* (80.5%).

● **Models of evaluation used:** Taking the first two agreeing and not agreeing categories together, 50% of respondents use *standardise model of assessment* and 34% *don't use standardise model of assessment*. About *evaluation* 39.8% use *standardise model of evaluation* and 51.6% *don't use standardise model of evaluation*.

● **Record methods used to collect and to preserve data:** Taking the first two agreeing together participants used *audio tape record* (60%), *video tape record* (16.5%), *written notes* (85%), *music notations* (37.4%), *behavioural checklists* (30%).

● **Evaluation reports:** Taking the first two agreeing categories together, music therapists use *descriptive reports* (80.9%) rather than *check list reports* (57.3%).

● **Importance of assessment:** Taking the first two agreeing categories together, 98.3 % of respondents *strongly agree* with its importance as it is an *useful tool to find out the client's problems; to set up the objectives/goals* (93.8%) and *treatment procedures* (96.5%) and *to decide the admission of the client to music therapy* (94.5%).

● **Importance of evaluation:** Taking the first two agreeing categories together, 94.1 % of respondents *strongly agree* with its importance because *it serves to determine the progress of the client; the*

achievement of treatment goals (80.8%), reliability of treatment plan (85%) and to obtain data to finish music therapy treatment (87.2%).

DISCUSSION

The number of responses received, could be considered a "representative number" if we take in account the international nature of the study, its scope of research, the lack of tradition on research, and participation on research designs within the countries participants cause problems in data gathering which at times resulted slow and wearisome. The data for *age* and *years of experience* of respondents would seem to verify the notion that music therapy is a "young and in evolution profession".

The alliance to a particular model of working and theoretical orientation have profound effects on goals, the process of course of treatment and procedures for assessment and evaluation of clients (Bruscia, 1987). Responses give about theoretical orientation, techniques used in clinical practice and assessment and evaluation of clients confirm the relationship between a more free orientation in clinical practice (improvisation techniques and psychoanalytic, existential and humanistic approaches) and the use of no-standardise models of evaluation and descriptive reports to inform about evaluation of clients. A more ambivalent attitude emerges with regard to the use of standardise model of assessment.

Literature analysis shows that in comparison with other professions the area of assessment and evaluation in music therapy is still in developing. As a profession in evolution, results of this study suggest that participants strongly agree with its importance and consider it an useful tool in treatment plan organisation. It's important make links between music therapists' opinion and research in the area of assessment and evaluation in order to develop instruments adapted to clinical practice needs.

CONCLUSION

The results of this research design allow to gather, organise and update information on music therapy clinical practice within the participant

countries. This results will serve as a basis and contribute useful data to future studies on the field.

There are implication for future research into assessment and evaluation of clinical practice and about theoretical orientation of music therapy whitin countries particiopants on this study. Assessment and evaluation of clients are not the mere accumulation and summarising of data. They are important tools to give credibility to music therapy and a new an emerging area of research.

The diffusion of the results will make the way of working of music therapists in the countries studied known to other professional groups and music therapists in other regions of the world.

Acknowledgements

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When Aggressiveness is Disturbed.....

Lony Schiltz-Ludwig

Abstract

Analytically orientated music therapy has shown to be a good therapeutic mediation in various cases of disturbance of aggressiveness, related to an underlying borderline personality organization in adolescence. By stimulating the emergence of fantasies, of repressed drives and negative feelings, by allowing their elaboration and integration in a non-anxiogenic atmosphere, it is especially effective in weakly mentalized structures and in conduct disorders related to a borderline organization.

Recent developments in French, German and Anglosaxon literature concerning the concept of borderline personality structure in adolescence are analyzed. As these young people risk developing a lasting personality pathology in adulthood, tertiary prevention, i.e. treating those showing the first symptoms of an evolution towards an abnormal personality is essential.

Case studies illustrating different forms of disturbance of aggressiveness, ranging from inhibition, interiorisation of aggressive drives and somatization to disinhibition and antisocial behavior, follow the different stages of the therapeutic process in long lasting individual and group therapies.

The effects of musicotherapy have been evaluated thanks to a methodology both quantitative and qualitative, especially developed for the needs of this research, and on the basis of a quasi-experimental design using a control group.

The results of the phenomenological and statistical evaluation, based on psychometric tests, observational frames, rating scales and projectiv tests, have been conclusive, showing the joined action of music on narcissism and the capacity of objectal love and the restoration of the process of subjectivation in adolescents. They are discussed in reference to the unsolved question of the exact action of music therapy in the treatment of conduct disorders related to an underlying borderline personality organization, and on the basis of recent developments in psychopathology of adolescence.

1. Introduction

Adolescents presenting various forms of aggressivity problems - such as inhibition, heteroaggressive acting out or aggressivity directed against their own bodies- have been treated with the help of a psychotherapy using an artistic mediation, combining musical improvisation and the creation of written stories under musical induction. During the therapeutic process, the musical production and the imaginative production are complementary and interact to eventually lead to the imaginative and symbolic elaboration of the violent phantasms, to changes concerning the moral functions, to an

evolution towards an affective maturation and to a resumption of the subjectivation process.

During the last decade, psychiatrists and clinical psychologists have discovered that there is an increasing number of adolescents with a borderline organisation predisposed to act out their aggressive drives in a violent or suicidary way. This is the psychopathological explanation of the increasing number of bullying, of suicidal attempts or of drug addiction ; it reflects itself a deep modification in educational practice, in moral standards and in family structure.

These young people need a long lasting individual psychotherapeutic treatment, otherwise they risk to grow up towards a lasting character pathology at adult age; they could develop towards the antisocial, the narcissistic or the depressive personality organization described in the DSM IV among the abnormal personalities. During adolescence, we have the possibility to prevent this malign evolution.

As I worked with adolescents as a clinical psychologist and psychotherapist for nearly thirty years, I have often had the opportunity to deal with adolescents suffering from this type of personality disorder. With the traditional verbal therapy, they take a long time to evolve. As music therapy is likely to act both on the emergence of the personal desire and on the release and canalising of the aggressiveness, it seems to be an effective measure in case of predisposition to acting out. This hypothesis has been put to the test.

2. Clinical background

During the last decade, the clinical interest for borderline personality organisation in adolescents has continuously increased. The adult borderline personality has been described in a psychodynamic perspective with reference to the analyses of Kernberg and Kohut: because of difficulties in the primary objectal relations, the child has not been able to separate from his parents and to grow towards an autonomous personality. Even as an adolescent or an adult, he is utilising preferentially archaic defence mechanisms such as splitting, projective identification and primitive

idealisation. He has maintained a black and white view of reality and maintains a separation between the good and the bad aspects of himself and others. His feeling of identity and his perception of others lack stability and fluctuate from one moment to the other, according to the prevalent experience, leading towards a fundamental emotional instability. This condition is traditionally located between the psychosis and the neurosis and is sometimes covered by pseudo-neurotical symptoms.

In a descriptive nosographical perspective, the concept of borderline personality is included in the DSM IV among the personality disorders. However, the borderline personality organisation is often mentioned in a broader sense, reflecting the initial conception of Kernberg, as a lack of definite structure, a fragile, precarious organisation underlying a large number of fluctuating conduct disorders. In France, Bergeret⁶ has described this personality organisation for adults, but it can easily be transposed to adolescence. In his developmental perspective, there are three possible evolutions from borderline personality organisation: towards a psychotic structure, towards a normal or neurotic organisation or towards character pathology. In Germany, Dulz and Schneider⁷ have a similar conception, showing that under therapy there is a possible evolution from a low-level to a high-level borderline personality and a change in surface symptoms.

Recently, clinicians of many countries have noticed an increasing number of young people with a borderline personality organisation, resulting either in violent behaviour or in overadaptation and a false self, covering a stagnation of personal evolution and a blockade of pulsional and emotional functioning and authentic desire.

In the manuals of psychopathology of adolescence, there is a gap concerning the preliminary signs of personality disorders, except for the antisocial personality. The chapters devoted to conduct disorders include only a small

⁶ BERGERET J., *La personnalité normale et pathologique*, (3e éd) Paris: 1996, 330 p.

⁷ DULZ B., SCHNEIDER A., *Borderline Störungen. Theorie und Therapie*, (2e éd) Stuttgart: Schattauer, 1996, 186 p.

range of disturbed behaviour, omitting the pictures of banalization and inhibition.

One of the main clinical signs of conduct disorders related to an underlying personality organisation is the incapacity to dream and fantasise and to elaborate the tensions and conflicts of daily life in an imaginative and symbolic way. This blockade has been described by Sami-Ali⁸ for the psychosomatic personality. Since long, the poverty of imagination of their clients has struck the attention of social workers engaged in the rehabilitation of young offenders. The lack of imagination in adolescents presenting a false self has been studied through the utilisation of projective tests⁹.

Clinical experience has shown that for the treatment of conduct disorders related to an underlying borderline personality organization, an artistic mediation and especially a music therapy combined with verbal psychotherapy is often more effective than verbal psychotherapy alone.

Because of its action on the unconscious level of emotions and on archaic responses fixed in the bodily sphere, music therapy is likely to be especially effective in the so-called weakly mentalized structures.

3. Methodology

In the Psychology Service of our school, the adolescents have had weekly sessions of individual music therapy, receptive and above all active, consisting of listening sessions, of writing stories under musical induction, of solo and duo improvisations followed up by verbal elaboration. The therapeutic approach was inspired partly by the non-directive psychotherapy of Rogers, partly by psychoanalysis, but specially by Kohut's psychology of the Self, which underlines the importance of constituting a mature narcissism at adolescence.

In those sessions, the basic therapeutic attitude is the one of the non-directive psychotherapy, transposed from the verbal to the sound

⁸ SAMI-ALI Le banal. Paris: Gallimard, 1980, 222 p.

⁹ SCHILTZ L., Musique et élaboration imaginaire de l'agressivité à l'adolescence. Evaluation d'une expérience thérapeutique. Thèse de doctorat en psychologie clinique. Paris V, 1999, 499

communication, keeping the same availability and empathy, reacting to the client's problem by musical improvisation, by reassuring him or respectively confronting him, before moving to verbalisation. In this process I am attentive to the manifestations of the unconscious, to any transfer or counter-transfer, but I leave it up to the client to discover the sense of his behaviour, proposing an interpretation in exceptional cases only. Fragments of the past always end by emerging and are elaborated upon by means of imagination, artistic production and symbolisation. It is a process of questing the meaning of one's personal and family history. A large part of the work consists in the narcissistic restoration, in the elaboration of a new positioning in relation with the Ego ideal, in agreement with the personal gifts and abilities, and in the understanding and integration of aggressive drives.

A certain number of adolescents suffering from this type of personality disorder have been treated by this method over a period lasting from six months to two years. All have undergone a positive evolution. The changes obtained have been evaluated statistically with the help of observational frames, with projective tests and with rating scales referring to external criteria.

Summary of the experimental design

1. Tests used

Control group

Pretest	Posttest
AFS	AFS
FAF	FAF
MBI	MBI
Reactions to ethnical music	Reactions to ethnical music

Clinical group

Pretest	Posttest
AFS	AFS

FAF	FAF
MBI	MBI
Reactions to ethnical music	Reactions to ethnical music
TAT	TAT
Stories written under musical induction	Stories written under musical induction
Observational frames and rating scales	Observational frames and rating scales
	Autoevaluation of music therapy

Comparisons

- | |
|--|
| 1. Clinical group to control group in pretest and posttest situation |
| 2. Clinical group and control group to itself in pretest and posttest situation |
| 3. Clinical subgroups I and D, respectively Pat and -Pat, to each other in pretest and posttest situation |

4. Case studies

Case studies will illustrate the different stages of the therapeutic process. In the first case the repressed aggressiveness began to be exteriorated in violent tantrums, in the second case, it was directed inwardly.

4

Martha

Martha is a fifteen-year-old girl ; she has a seventeen-year-old sister. Her mother contacted the Psychology Service because her daughter had behaved violently towards her classmates in several occasions. Martha had been suffering from anxiety attacks at night since she was a child. During the last months, a vague feeling of anxiety has been invading her ; she shows various fears and phobias and expresses many hypochondriac complaints. She suffers from : concentration problems ; school results have deteriorated, she is quite inactive and spends a lot of time brooding over her fears, has no more hobby left, tries to read from time to time without being able to concentrate.

She was always a quiet child, playing in a persevering way ; she has always been afraid of the dark and was coming to her parents' bed until the age of ten. The light has to be left on, so that she can fall asleep. She has been pampered by her mother, spoiled by her older sister ; her father did not care much about his children's education. He has now a friendly attitude towards his daughters. Martha clings to her mother and suffers above all from separation anxiety ; she is very scared to lose the persons she loves ; she fears for instance that her father who has some micturation problems is suffering from a cancerous disease as her grandfather died from prostate cancer. The thought of death is haunting her. A feeling of oppression in her own chest is worrying her. There is a strong identification with her mother's fears. There is a lack of distance between her and her parents, she is unable to describe her family, nor can she criticise her parents.

The psychological examination, including projective tests, the Rorschach and the TAT, shows the archaic nature of her anxiety, she is trying to protect herself against it by using rationalisation and other defence mechanisms of an obsessional type. Her answers show her problems with frontiers and with intrusion ; her basic feeling is a sense of derealization of a complete lack of inner vitality, the fear of death is overwhelming her.

The blunt anatomical answer to plate II shows how she feels :

« A lung blackened by the smoke of cigarettes, the heart is bleeding ; I think it hurts and the person will die of it, blood is flowing out of the lungs »

The TAT shows persecutive anxiety recalling Melanie Klein's schizoparanoïd position.

There is however a possibility of humoristic elaboration, tingeing her macabre imagination with black humour.

Some conclusions of the psychological examination :

anxiety of a primary type ; weakness of ego, precarity of neurotic defences, risk of evolution towards a lasting pathological organisation of personality.

We shall now see some moments of therapeutic evolution :

Her improvisation moves from fusional regression through the expression and acting out of anger towards an integration of different musical parameters and a playful creativity.

In the beginning she preferred to play rhythmically, was unable to create a melody, needed repetition and monotony. She discovered the pleasure of playing at the gong. It was the beginning of a stage of fusional regression, during which she was delighted by the vibrations. I accompanied her by playing the chine-bars. It was like a presence at her side, she said.

She explored all the possibilities of the gong ; as she suffered from respiratory oppressions I suggested that she should sing with the gong ; she did it timidly and then with increasing pleasure and could breathe deeply while singing.

During the next sessions she always began by playing the gong, beating more and more strongly. « It's good for my anger ». She made a tremendous noise associated with the explosion of natural elements. « I shall deliver myself of my anger ». Was she trying out the stability of the internal object ? If she could discharge all her aggressiveness on it without destroying it, her anger could not be so terrifying.

The stories she wrote under musical induction showed now a diminution of archaic defence mechanisms such as denial and splitting, a beginning of integration of the good and the bad aspects of herself and the outer world and an emerging possibility of enjoying the drives coming from her body. She began to play melodies.

She could describe now how her mother was making her nervous by wanting to survey her schoolwork. Her mother, who attended psychological guidance too, tried to be less anxious about her daughter's success, but it was difficult for her to change her manner. Martha asked to have riding lessons and was delighted by them. Her mother was astonished about her achievement. Martha asked a keyboard instead of new clothes and played for herself at home. The manifestations of anxiety had become less frequent.

During the last two sessions of the year, Martha played little melodies on the balafon and the xylophone. She was developing more creativity, even if she was yet far from a real musical structure.

After discharging her anger, she was finally able to express more differentiated feelings through her music.

Claude :

Our second example shows a boy of 17, who under his overadapted surface suffered from deep depression. He had a sixty-year-old father who was rather tyrannical and had organised the whole life of his son in a directive manner and especially his leisure-time ; a sensitive mother, who had become an alcoholic because she could not bear the burden of a paralytic stepdaughter, who asked for continuous attention and who refused to seek professional attention outside the family. The father did not want to give her away and his wife had to do the whole assistance by herself. As the stepdaughter was very egocentric, there was a lasting latent conflict with repressed feelings of hatred, jealousy and guilt in that family.

Claude pitied his mother and was ashamed of her alcoholism, and several times he had tried to take a bottle of spirits out of her hands.

He is sent to the Psychology Service by his headmaster because he was drunk himself several times when coming to school. He accepts with relief the proposal of psychotherapy. He is unable to play rhythmically but is inventing sensitive melodic motives on the piano. I accompany him in the same manner giving however a rhythmical support. After some sessions, he says by himself : » My music is very sad ».

The text written when listening to music shows the depressive ground of his personality but also his evolution under music therapy.

Vivaldi. Lute concert

« Sadness (for instance funerals)

It's raining and it is cold.

It's oppressive

Makes you think of suicide

It's winter and the trees are bare of leaves.

Behind the bare trees, you see a cemetery.

You can hear the shouting of crows.

You are alone. »

After six months, he writes another text, which may show his evolution : things no longer are seen under their dark aspect alone but he is able to pass towards the lighted face of reality and to integrate the two aspects of life.

Dvorak : Symphony of the New World

« A landscape in winter. Sad. It's cold outside. The snow begins to fall. Little by little, a carpet of snow is spreading over the ground, becoming thicker and thicker. The wind is going to blow. The snow is falling more slowly. Finally there is a white landscape , completely transformed. »

At the same time, he is playing in a different manner bringing in more energy, producing variations of tempo and intensity, finally integrating rhythm and melody ; his improvisations are of a very good musical quality. Gradually he becomes able to speak of his family, to criticise his father's tendency of domination, to express his pity for his mother and his shame of having been on the point of becoming himself addicted to alcohol. He is able to show opposition towards his father, and instead of going on playing the trumpet in the music band where his father is a president, he founds a rock band with some of his friends. He plays the keyboard and writes music pieces for them.

His school results have improved very much.

Some results of the study

Some interesting results of the phenomenological and statistical evaluation, based on psychometric tests, observational frames, rating scales and projective tests are presented, with reference to the ongoing discussion about the effectiveness and the limits of music therapy and to the recent scientific progress in the psychopathology of adolescence.

The main hypothesis was confirmed as a whole: Psychoanalytically orientated music therapy is effective with conduct disorders related to an underlying borderline personality organization

Quantitative results

Significant differences were found on the following variables in the pretest-posttest comparison in the clinical group:

On *behavioural* and *psychological* variables

- expressing of feelings
- richness of fantasmatic activity
- authentic verbal expression
- affirmation of oneself and assertiveness

On *external criteria*

- school results
- creative leisure activities

On *musical production*

- integration of rhythm and melody
- musical formal structuration
- musical creativity
- personal playing style (differentiation of oneself) and diminution of fusional attitude

In the clinical group, the imaginary expression of aggression increased, while the tendency towards auto- or heteroaggressive acting out diminished. In the control group, there were few significant changes

In their general pattern of evolution, the similarity between the clinical subgroups was greater than the differences, in spite of quite opposite

surface symptoms, giving thus a support to the recent conception of the borderline personality organization.

Some qualitative observations

The following stages of the therapeutic process could be separated:

Stages of music therapeutic process

I	Stage of exploration and release
II	Stage of regression and fusional pleasure
III	Stage of individuation
IV	Stage of structuration and differentiated pleasure

In stage 1 and 3, the release of aggressive drives was maximal. In stage 4, there was noticed an striking progress in musical structuration and integration of different musical parameters, and, at the same time, an improvement in creativity and in the formal qualities of literary production.

To be efficient, instrumental and vocal improvisation needs the setting of the therapeutic relationship, thus permitting a discharge of aggressiveness that is not dangerous, offering a holding to anxiety, and allowing a fusional regression in a first stage; functioning afterwards as a mirror to the efforts of individuation and differentiation. Nevertheless, there seems to be also an intrinsic effect of music on the bodily level, making the establishment of the therapeutic relationship more easy.

Rhythm and melody were used to satisfy different emotional needs:

● Rhythm allows an emotional and physical discharge. Pure rhythm was chosen by those who had unfulfilled narcissistic needs.

● Pure melody was chosen by those who had a symptomatology of depression behind their surface of overadaptation. A melodious quest seemed to accompany the elaboration of the depressive position.

● The search of a stable basic pulsation, a rhythmic ostinato or merely a temporal link could be noticed with those who had to integrate the Law, to restore the paternal function and to develop an internal control over their chaotic feelings and drives.

Two types of pleasure could be distinguished:

● A fusional archaic pleasure accompanied the first stage of therapeutic regression close to the state of shared ecstasy appreciated by those who go to a rock concert.

● A more differentiated pleasure appeared in the final stage of therapy, close to the “flow” feeling identified by Csikszentmihalyi¹⁰, going on with intrinsic motivation, while discovering the possibility of improvising freely and of doing a work of musical composition. It was always a source of psychological growth. Pleasure is so important because the adolescents suffering from a blockade of pulsional functioning are often anhedonistic.

¹⁰ Csikszentmihalyi, M. Das Flow-Erlebnis, 1993

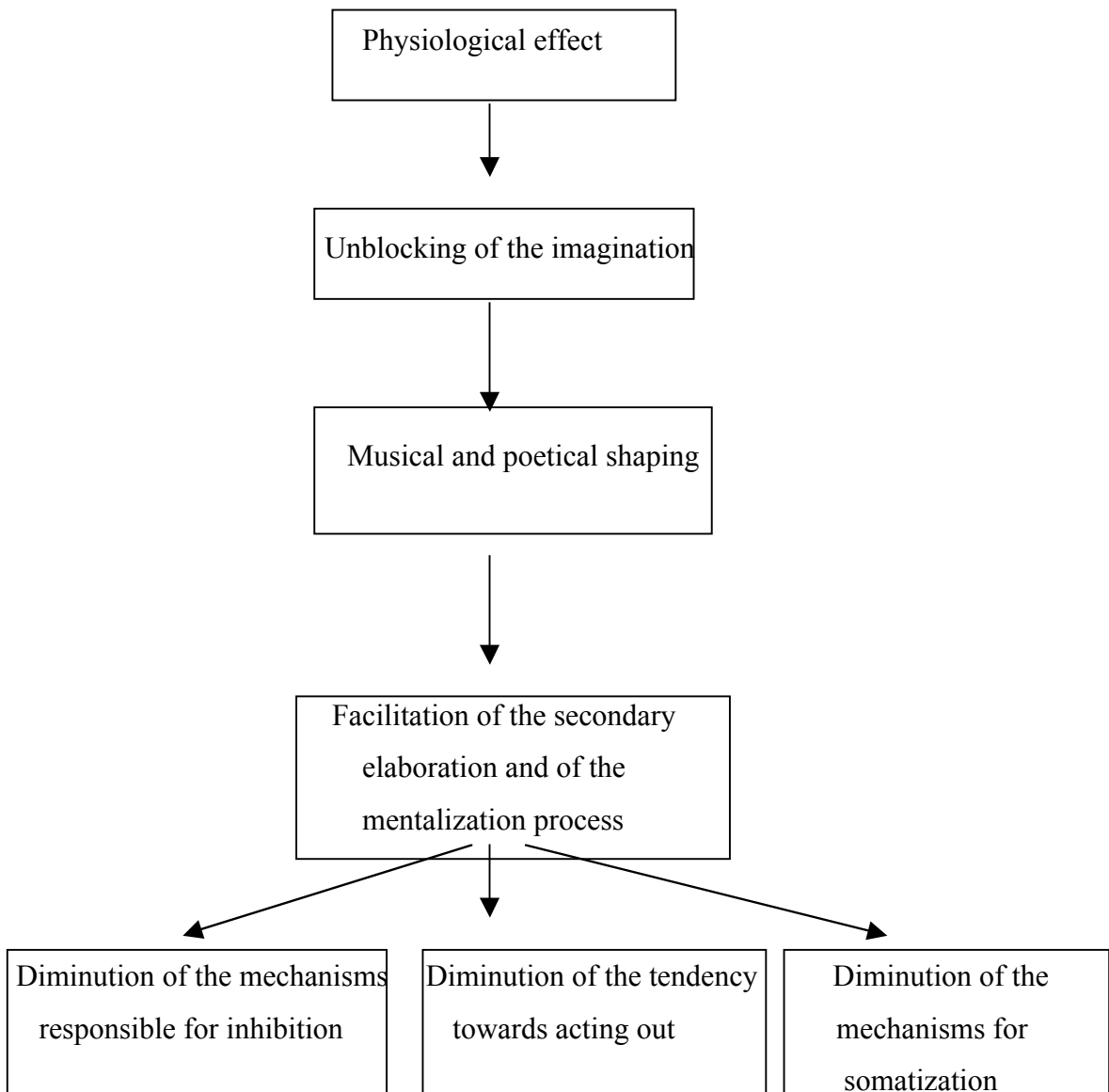
Music therapy had a marked effect on narcissism with adolescents who hated their own body. We often saw a restoration of the sense of personal worth.

There was an interaction of music and spoken language to set the fantasmatic activity free, an effect that is especially important with weakly mentalized structures, such as a tendency towards the psychosomatic personality or the antisocial personality. The stories written under musical induction were a dramatic expression of intrapsychic conflicts, as if the adolescents wanted to tell something about themselves without saying I and myself. Verbalisation in turn was often the beginning of a richer and better structured musical production.

The loosening of the pulsional and fantasmatic blockade was often favoured by an improvisation resembling rock music, as if ancient traumatic marks inscribed in the body had to be overcome by a strong bodily implication. This effect was remarkable with those who had overinvested their intellectual functioning and were split from their affectivity and their bodily self.

One of the most interesting results was the emergence of archetypal themes in the stories written under musical induction, towards the end of the therapy, such as themes related to death or birth, love, religion, the figure of the socerer, of the hero, of the alter ego and so on, linked with an astonishing progress in stylistic qualities and formal structure, as if the existential importance of this symbol drew together all imaginative and emotional forces, allowing the client to reach a nearly artistic performance. At the same time, the musical production reached a higher level of integration and individualization.

5. Understanding the action of music therapy



6. Conclusion

In case of borderline organization with adolescents, analytically oriented music therapy permits the emergence of personal desire, of authentic emotions, the canalisation and imaginative and symbolic elaboration of aggressive drives, towards an improved assertiveness and a regained possibility of personal choices. These positive results were produced by a long lasting individual and group therapy, which has been proved to be an

promising attempt of tertiary prevention of personality disorders, in the natural background of school itself.

E. Presentation

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Many Voices in One: Healing the Effects of Collective Transgenerational Trauma through the Bonny Method of Guided Imagery and Music, A GIM Case Study

Cecilia H. Schulberg, MT-BC, MM, MFT

GIM, developed during the 1970s by Helen Bonny at the Maryland Psychiatric Research Institute, is a music-centered, transformational process that allows an individual or group to work through issues in a safe arena provided by the music. This involves "conscious listening" to specially selected music in a deeply relaxed, dream-like state. Archetypal symbols and images expansive enough to hold collective as well as personal experiences are evoked by the music. The elements inherent in the music--pitch, rhythm, timbre, dynamics, tempo---allow the music to access and interact among various levels of consciousness while providing a container powerful enough to hold the experiences it evokes. Material is manifested in sensorial images (visual, auditory, olfactory and gustatory), feelings, memories, kinesthetic responses and transpersonal experiences. Processing these experiences through mandala drawings brings closure, reinforcement and a link between inner and outer reality.

Motivated by my own healing experiences with GIM as a child of survivors of the Nazi Holocaust, I began using GIM with other children of Holocaust survivors, individually and in group, with the focus of addressing the effects of the Nazi Holocaust. They ranged in ages from early twenties through late forties, mostly middle class, educated. They came from a broad spectrum of backgrounds and perspectives of how they live their lives as Jews, and how they experienced the impact of the war in their lives. Some did not even know that they were Jewish (much less that a parent was a survivor of the Holocaust) until their teens or early adulthood. Some have reached the peak in their professions; others struggled. Some are married, some have children, some are single. Some grew up and live in Germany;

some were born in Europe but eventually came to the United States; some have been in the United States their entire life.

INDIVIDUAL GIM

The individual GIM session is different in several ways from a group GIM experience. An individual session has four components:

- (1) the pre-session, or checking in;
- (2) the induction;
- (3) listening to the music; and,
- (4) the post-session, or processing (Bonny, 1978, #1, p. 16).

Choosing the music for an individual session is based on the "iso" principle of matching the current mood of the traveler. This is done in the pre-session by listening to verbal metaphors used by the traveler, watching the traveler's body language, and having the traveler check within for how emotions are being expressed within the body, e.g., muscle tension.

For these sessions, Dr. Bonny developed a series of taped music programs reflecting various mood experiences. These programs were based on "a natural affective contour" she observed in "a typical hallucinogenic drug trip" during her research at the Maryland Psychiatric Research Center. This contour had six stages, or three sections: pre-onset/onset, build to peak/peak, stabilization/return. She used dynamic, western classical music, believing that the tension in this type of music evoked hidden psychodynamic material, while the musical resolutions allowed the material to be released, resolved and integrated within the psyche (ibid, #2, pp. 11-12). She found one piece of music for each stage (or section) to represent and define it, totalling three to six pieces per program (ibid, #2, p. 39).

The induction is similar to those used for a group GIM experience except that it can be more tailored to the individual, based on the information acquired during the pre-session. The traveler may lie on a couch or recline in a comfortable chair. It is preferable for the traveler's eyes to be closed to facilitate easier access to his/her inner world. The music begins once the

traveler is relaxed and given a focus, following the intervention: "...let the music join you [with the focus] and take you wherever it is you need to go." As soon as the traveler experiences something with the music, it is verbally shared. A regular dialogue between the traveler and guide is essential to the individual session. Guiding techniques incorporate "reflection, introjection, Gestalt, and empathy to more deeply involve the [traveler] in what is being experienced" (Bonny). I will present a brief case study which demonstrates how powerful this type of music therapy can be.

Following a powerful group GIM experience (3/7/95), a female child of Holocaust survivors in her mid-forties was intrigued to try an individual session. In that first group meeting, she had shared her life long struggle to have a Jewish identity that was based on strength and optimism vs. that of victimhood. She appeared to be someone who achieved this persona, but the group noticed in her mandala that this struggle still existed (slide 1 - "Then, The Middle, and Now"). She acknowledged that the marked up arm pointed down with no hand and the Jewish arm band Jews were forced to wear represented the victim side she was trying to disown; and, the upraised arm with the yellow Jewish star represented the strong, proud Jewish identity she wanted to experience.

(3/14/95) As I do in all first sessions, I took a brief history of the issue on which she wanted to work. Her parents' escape from a transport to a concentration camp had a major impact on her life. There were no survivors on either side and she has only a brother. As a female Jew who grew up in an American community where there were no Jews (and where she felt they had to be keep their Jewishness a secret), she "fought" to be her own person, to be strong in all respects, and to be the best at whatever she did. She was the one in her family to ask questions; but, like the rest of her family, she had difficulty getting too close to her feelings, and was very guarded in the group. However, she was very open to whatever would surface in the privacy and safety of the individual GIM sessions. From her group GIM experience she was hoping she could access strong feelings she

had learned to push away as a way of coping. She now felt that this was getting in the way of current relationships and in enjoying life.

I used the "Explorations" program, diagnostic in that the pieces are varied in mood, giving a good overview for where someone is at who has intact ego strength. In this early version, the first selection began with Ravel's "Daphne and Chloe."

#1 - [Pause] *it feels very heavenly - there are butterflies in the sky - I_m on top of a mountain, it's serene - [pause] what_s down there is not so good - (tell more) what_s in life is sad - I_m rising above it - I have a feeling of rising - (how is that for you?) it's sunshine (let yourself experience that)- [pause, crying] sounds like voices of Jews crying out, singing out -(what are they saying?) they_re lifting you up - things are good, smooth, light - (where?) from the beginning the music was rising to the top of the mountain, to another level - (how is it to be there?) like death, going up, it_s not where I want to be but it_s ok - there are voices - [tears](what are you feeling?) sad, like my whole family's up there - [pause] feels like a very collective group, the voices - there_s a peacefulness -(feeling that inside?) no, I feel sadness - (where?) my gut -*

#2 - [Brahm's Symphony #1, Allegretto] *I_m getting the message to live your life, do it well, be merry and light - (are you experiencing that?) no - 'cause I_m not a light person, I want to but I actually feel heavy - (where?) my whole backside, it_s weighted - I'm feeling the quickness of life, it_s intense at times - (how is that for you?) I can get very intense, I don_t like it - [pause] the music feels powerful - I like it that way - drama, stimulation - not abstract, black and white - I like powerful - (feeling that inside?) just swept up in it - I can tell I_m holding my breath [puts hand on chest] - it_s dramatic - brought back the stuff I_m carrying from the war - (where?) in my stomach area - I_m just going with the music, now I_m nowhere with it - [pause] it_s a little better in the music, was trapped, now opening up -*

#3 - [excerpt from Respighi's "Pines of Rome - Gianicola"] *I like dramatic stuff more than light - (tell more) I_m drawn to drama in life, I want peaceful and easy, but drama attracts and stimulates me - but it can get too much and the peace in the music is good at that time - but lots of time it_s nothingness - or I have both, I would like not to have drama -now I could be sitting by a lake doing nothing (let yourself do that) - I_m drawn to nature, most pure thing, gives peace - (are you feeling that?) I think it_s the goodness in life - [pause] I much prefer that to drama at this point - I_m in a high state, nothing but a feeling of floating - it_s what I aspire to - [pause] this brings up the feeling about how wonderful life is, how incredible the world is - how lucky I am to be alive - I_m gifted by my lot in life - I_m aware how lucky I am - [pause] but at times I want to keep it growing rather than take the selfish, easy way - I have a tendency to do that - [pause] I see flowers in an open field - I have an image of an incredibly beautiful spot, it_s a sunny day, contrast of killing and blood with nature, weird concept - seems at times nothing can be done about it -*

#4 - [Debussy's "Nocturnes - Sirenes"] *getting voices of Jews up there - [deep breath, long pause] lot of the pain of their dying is worse for the people on earth, the people who survived - the message is you must make the most of life, 'cause you get to live [tears] (you get to live) - [pause] grab as much gusto as you can (grab as much gusto as you can) - grab as much life as you can, experience as much as you can, 'cause it_ll come to a close too - [another long pause] my hands are cold [moves hands] there_s some fear in what I'm talking about, or nervousness - (have a sense of what the fear_s about?) tapping inner stuff, death, about having cancer [tears] - it happened so fast I didn_t know what happened [deep breath] - this isn_t related to the music but I didn_t tell my mother I had it, I couldn_t tell her - and she was in town at the time - [pause] I_m getting the message the world_s a wonderful place - (feeling) I know that, it_s a shame to waste time in your muck, stupid - I see green leaves, beautiful forest - the souls are talking back again - (how is it to be connected with them?) interesting*

concept, I've never done that, with voices, even with family, I never did at that level - I have a feeling of my aunts [tears] they_re the collective -

#5- [Chesnokov's "Salvation is Created," pause] my father had two sons killed in the war, I just got an image of them, not knowing them [tears] - there_s no justice (there_s no justice) - [tears continue] (what are you feeling?) sadness over all those people who I would have loved to know and know me (can you let yourself feel the sadness?) [tears] - I 'm feeling a circle of people putting their arms around me - (how is that for you?) comforting - I started feeling my father_s presence - [pause, deep breath] I never experienced the other side - (what's that like?) just very different, a collective thing, such a new experience, it_s comforting (let yourself experience it) - it_s like a little bit of a past is there -

#6- [Pachelbel's "Canon," tears] back to the beauty of life - and just how lucky I am - and that I don_t want to blow it with my junk inside, what I_m carrying, would be letting Hitler win, through osmosis - [pause] life_s just incredible (life_s just incredible) [smiles] yeah - I just want to reach to the highest point and go - (can you let yourself do that?) yeah, my hands are tingly, I_m flying, light - I_m feeling a lot of energy in my hands (feel that energy) - my whole body feels energized - refreshed - [pause] I often massage to this music - I basically feel very happy at this moment (let yourself feel the happiness) - a soaring feeling - like I got in touch with something deep inside, feeling cleansed - I got a glimpse of something deep in my soul that I never did - a message to grab life and enjoy it - I've always known this but I got stuck a little, it doesn_t mean I_ll do it - I want to put my arms around my mother - (can you do that?) [puts arms around herself] I'm sad, I didn_t give her pleasure with a grandchild, it would have given her pleasure, me too, there_s a pain in my stomach, a big burden and pain I have - she doesn_t think I_m really happy and at that level I_m not - I fake it and she knows it [arms still around herself].

(Slide 2: "In The Middle"- *where at now, between the two places, mixed feelings [mouth]: action! drama/gusto [red line] and peaceful, G-d connection (only with nature)*)

(3/28/95) In her second session she shared how she left the last time "*flying high to let out thoughts, feeling a lightness, feeling something opened up a little.*" She was able to read a couple of books sent, and written, by survivor friends of her parents about their experiences in the camps, and was able to experience the sadness. She felt a big release physically as well in her gut/stomach with a bug she got since her group GIM experience a couple of weeks earlier. It was tough for her to let herself experience all the feelings she had blocked her whole life, but she felt it was important to continue.

Her second individual GIM experience began with her expressing her life long need to protect her mother, her feelings of helplessness at not being able to do so, and her awareness of how her attempts shut down her own feelings/needs. To match her mood, I used Helen Bonny's "Nurturing" program. I'll begin with the 3rd. selection of the program, the "Shepherd's Farewell" from Berlioz's L'Enfance du Christ, where her journey changed dramatically in the middle of the piece.

I'm getting an image of German soldiers - pushing bayonets down into the ground - I'm feeling their power, their force as they're walking, pushing their bayonets down into the ground, I'm seeing the metal in their helmets, no faces - (I ask her how that is for her) feels like I'm a victim - like I'm helpless, that they can do whatever they want - (I ask her where she's feeling that inside her) in my gut - it's tightening up - they want to kick me in the face, I want to take their bayonet, I don't know if I'm capable -

[The 4th. Selection is the "Humming Chorus" from Puccini's Madame Butterfly] *I feel I should be diplomatic to get through it, I do that in my life - now I see the soldiers singing to this music angelically - (I ask her how that makes her feel) enraged that they can do this and then do the cruel things they do, be so nasty - I guess it's about being a victim, they kiss their dogs*

and children and then they do nasty things - (I ask her where she's feeling the rage inside her) in my stomach - tightening - I feel I could burst! - I feel like I'm carrying a lot of rage! - I feel I could blow them up! - these "sweet, wonderful" people - [I encourage her to stay with her experience, pause] I still can't imagine how these Germans get into hunting people - guess that's the duality - so I see them singing sweetly, and I don't buy it, 'cause I know about the other side of their actions - the thought of being like my parents, the victims of their actions, I don't know what I'd do with that rage, guess I have it too, it's poisonous! - I'm getting the image of a neck, that I could crack it! - (I ask her if she's doing that) yeah, I could kick and do a lot of damage! (I ask her to bring those feelings into her hands and feet)

- [to facilitate the release of her rage the music was changed at this point to Helen's "Affect Release" program, which begins with "Mars" from Holst's The Planets] -

(I encourage her to bring the music inside her) I'm feeling a lot of rage! - I feel I could punch and take a knife and stick it to them! - I feel I could kill them with a rifle! [positions hands as if holding a rifle] - (I ask her what it feels like to hold the rifle) actually light, and powerful, I'm feeling more power than anger now! - I want them to sweat a little, I see them begging, but no faces - (I ask her if she can let herself see their faces) I see their cold blue eyes, blond hair and smirks on their faces it makes me angry, I want to kick them, step on them! (I encourage her to bring her feelings into her feet) [she moves down to kick and step on the end of the couch] I'm stepping on their stomachs, their [genitals], their faces, I'm jumping up and down on them - (I ask her if she has anything to say to them) "[Screw] you! See what it feels like?!" - now they're cowering - (I ask her how she feels) I don't like it, this isn't me, I'm not violent - I wish I could stay with the anger and let it out more but it just isn't me -

[The 2nd. Selection is Bach's "Toccatina and Fugue in Dm"] *I think the pain eats me, not knowing what to do with it - the Nazis are now standing around a pit and they have rifles this time - I'm standing, watching - I'm going to be one of the people now with no power, I know what's up ahead and I can't believe it, I have no say - makes me feel in my life I have a lot of say, I don't like authority, I don't want anyone holding anything over me....I live life the way I do so I don't let the system affect me - (I ask her if the Nazis are still there) a little bit, I just try to remain anonymous....I'm*

trapped, there's no way out - (I ask her where she feels that inside) in my stomach and chest - it's hard to breathe, hard to be shot - how could I get caught like this?!...better to be a cat with no religion than a Jew from Europe - [pause] the Germans are just eating and laughing, living life, and the Jews are cowered, helpless - and the Germans are hungry, strong with their power, and I feel that in my stomach, the people with power, the upper hand, the authority - I'm not used to the feeling - I am and not, it's a horrible feeling of being trapped and caught, would rather be free - (I ask her if she has an image of that) staying on the periphery of things, interested but not involved - feels like I can never get away, I'm not good at committing to things, and it's about trust, trusting myself - I see myself running away from the pit, everyone else is busy doing their own thing, and I'm running as fast as I can, feeling it in my legs, and arms, feeling powerful! (I encourage her to bring her feelings into her legs and arms) [she moves them as if she's running] - I'm not looking back, I don't know why I'm running, it's bright and sunny -

[Here I switch the music back to the Nurturing program with the 5th. selection, from Massenet's Scenes Alsaciennes] *I'm catching my breath, smiling I did it again, I beat the system, I'm walking but I don't know where - I'm crying for the people who fell into the pit, 'cause it's over - I have an image of going behind the Germans with a gun and shooting them all - and telling everyone to run - it's just a thought, I'm not doing it, I'm just taking care of myself, just wandering in the forest, I'm free, and alone - getting in tune with the people who were just killed and going up - and they can't believe it either, the souls, going up to another level, and I'm waving goodbye, and I'm standing with my eyes closed.*

(Slide 3: "Killing vs. Freedom" - Germans are black, she's red, souls are yellow on green grass, all around empty circle, happening outside, can't get to feelings, safer, struggle between being the victim and being the aggressor, neither good, wants to feel feelings and stop analyzing)

This was the first time she was able to feel and express her suppressed rage and fears: that was a scary thing for her to do. She experienced her inner struggle between being the victim and being the aggressor, not wanting to be either. She was aware of how she tried to be safe by being on the

“periphery” of life; and she also realized how this prevented her from living life fully.

She wasn't able to attend the 2nd. 2nd. generation GIM group meeting. In the 3rd. individual session, she expressed a great deal of sadness over not being able to have children due to having uterine cancer 3 _ years earlier. This is a double-edged sword being the child of Holocaust survivors and not being able to regenerate what was lost, and this produces guilt as well. Now she's with a partner who wants to adopt a child and she's ambivalent. She took all these feelings into her 3rd. and final GIM experience. At this time, I had been experimenting with the soundtrack to “Schindler's List,” and felt the 2nd. selection, “krakow Ghetto” matched her mood.

#1 - [Pause] *it feels like I'm going down into the layers of my soul - (What do you notice there?) it's pretty heavy - dark - it's wants to be held and nurtured - (what?) my soul, my child, my core - (can you do that?) yeah, I can do it - my core feels very vulnerable, the music_s deep and heavy and melancholy - my soul feels very fragile, not real strong - it_s real sad - limp - [pause] I also hate that image - (what do you hate about it?) want to see myself as strong and tough, maybe I_m not, think my mother wants me to be that kind of person and I try to be for her, I admire that she_s that way, I_m softer (be with that softness) - yeah, I think I am, I had a killer nature in competition but I_m really a push-over and I don_t want anyone to know that, learned that from my mother, not let anyone hurt you, but that_s not who I am, I like that warmth, think that_s neat -*

#2 - [“With Our Lives, We Give Life”] *I have the memory of my mother saying, you make your own life and world, and I guess that_s what she did - and I haven_t done that [tears] - part of being a Jew is family, education, pointed out by non-Jewish friend, realizing how important family is - at some level I felt I wasn_t going to do it but I_m getting in touch with that now - part of the culture, having a family - always really wanted to have relationships with friends, can_t have the same thing - maybe looking in the wrong places - my mother said to me, “You_ll be sorry one day,” could hear that - (what about now?) you_re nothing without a family (let yourself be with that) - [pause] I don_t think it has to be that way, that_s more my mother_s voice (doesn_t have to be that way) -*

#3 - ["Remembrances"] *I'm loaded with stuff to give and I don't want to end up lonely and bitter, my partner can't accept it, doesn't need as much - makes me feel good, that heart connection - feel have a lot to give (feel that heart connection) - my friend sees my just surviving, not like I used to be, think I was more under my mother's guidance, what the world thought was truly amazing - when I think more of who I am, not my mother, I'm not who she is - (how is that for you?) I'm nurturing with people, I like that, but it's not very satisfying, I want to go deep, I expect a lot - sometimes I'm just content to just be and she said that's not who you were - maybe it's just change, in a big search for peace, don't want conflict any more, don't have to prove anything any more -*

#4 - ["Schindler's Workforce"] *I achieved a lot - I don't just want a filler - (what do you want?) think I'm looking for a certain intimacy I don't have with my partner - had that with my first partner (where feeling that?) in my pelvic area - it's feeling of wanting to just hold someone close in that full body position, and have them join in - not been paying attention to the music, been in my head - this music makes me want to run out in nature, not be in my head - (can you do that?) yeah, the free part of me likes to do that, not follow rules - my partner doesn't let me do that, I'm a free spirit, that's my gift, I'm not bizarre, I'm fun (let yourself experience that with the music) [moves arms] I like to run among the flowers - makes my soul feel better, I like to be child-like, that's a big part of myself, I like to make fun of the rules - (feeling that now?) yeah - I'm feeling the adventurous part of myself, the part that likes to be free, to explore, to really experience the world with wonder, with open eyes, what I really want to get, the music's uplifting me (let the music lift you up) - makes me want to drive into different villages and ask questions and grasp it (grasp it) [makes grasping motions with hands/arms] it's very awakening - I feel my soul, my heart opening up (feel them opening up) - I like the little stuff, that I can be curious about - [pause] it's nice to feel that good feeling inside (feel that good feeling) - I just really want to be happy a lot, I know that I'm lucky, it's a shame to not be in that state - [pause] some of the music reminds me of the Jewish joke that's the twist, the joke is onus, we can be whatever G-d wants us to be, and I know that, certainly my child knows that (your child knows that) - in that child state I feel tremendous amount of energy and I want that back - obviously it's up to me.*

(Slide 4: "Calm") Through GIM, she was able to get in touch with her vulnerability, her child state. Here, she could now allow herself to be nurtured as well as nurturing, integrating this wonderful quality with her strength. The message from beyond about living life fully allowed her to have all her feelings: she could grieve and release and experience the joys of life as well. This was beautifully expressed in a poem she wrote at the last GIM group meeting before summer break a year from this session, and in her mandala of the prior GIM experience

(Slide 5: "Loss" - grandmother and her with arms around each other):

A different world, different time, different era, thank G-d.

But I'm caught up in the past - it is my future - on some level.

It haunts me. It doesn't leave me.

If I think about it there is no peace so I don't want to think about it - too painful.

*I will try to live better - because it's the **best revenge**.*

I still can't believe it, I wish it wasn't true, but it is.

BEYOND THE ORDINARY

Julie Sutton

This paper is about perspective.

The core of the paper stems from the perspectives with which we all view psychological trauma. This has a direct relation to how we work, where we work and who we work with. Society's attitude to the impact of traumatic events changes, as does our theoretical understanding of the processes within traumatic experience. Amongst those of us here today a number will have had direct contact with a traumatic event. Others will have known or worked with someone who has encountered the impact of trauma. The efficiency of news-gathering agencies has made traumatic events rapidly accessible to us and this in itself will have an impact at the individual and personal level. Events 'beyond the ordinary' are - paradoxically - part of common human experience.

As well as including the collective experience of trauma and the ways in which ideas have changed over time, this paper also links the stories of some of the children and young people I have met in Belfast and Bosnia. I am grateful to them for agreeing that their stories could become part of this paper and I have changed names and some geographical details to respect their privacy.

I will be concentrating on four main areas, or "perspectives". My position is that in this work it is essential to inform ourselves by using an integrated approach. More recent developments in thinking about trauma cover a wide span of literature, yet nonetheless clear theoretical links can be found between disciplines. With such multi-disciplinary awareness we become familiar with posttraumatic processes from different places. As well as increasing our understanding of trauma, this also enables us to identify a rationale for offering the musical medium in the clinical setting.

1. Of these four main perspectives, the first relates to personal narrative and is linked to environment across three areas. My paper has evolved from professional and personal experiences of working as a music therapist in Northern Ireland for the past twelve years. There is a perspective in which events have affected community response to change and the awareness that I have been part of this community. I have also experienced the impact of visiting Bosnia three times since December 1996. I currently work as clinical supervisor with therapists working in Mostar.
2. A second perspective takes into account the ways in which there have been changes in approach to the effects of psychological stress or trauma. These changes have had roots in psychology and psychoanalytic thinking leading to the development in 1980 of a definition of posttraumatic stress disorder (PTSD)¹¹. From this point thinking has refined further in relation to increased clinical observation, clinical experience and research. Earlier writers had hypothesised that PTSD was as a result of 'normal' (we might say "ordinary"), adaptive response to trauma. Yet literature suggested that of those exposed to trauma, while experiencing the effects of this exposure, surprisingly few developed PTSD¹². What seemed to be critical in relation to the development of PTSD was the perceived severity of threat to survival and personal impact of the shock¹³.

¹¹ Andreasen, N. C. (1980) "Posttraumatic stress disorder" In: H. Kaplan, A.M. Freedman, B. J. Sadock (eds) Comprehensive Textbook of Psychiatry, 3rd Edition, Vol. 2 Baltimore, Williams & Williams pp1517-1525

¹² This can range from 10%-30% in most studies. See:

Davidson, J. R. T., Hughes, D., Blazer, D., George, L. K. (1991) "Posttraumatic stress disorder in the community: an epidemiological study" *Psychol. Med.*, 21, pp1-9

Helzer, J.E., Robins, L. N., McEvoy, L. (1987) "Posttraumatic stress disorder in the general population" *New England Journal of Medicine*, 317, pp1630-4

¹³ Van der Kolk, B. A., van der Hart, O., Burbridge, J. (1998) "Approaches to the Treatment of PTSD"

Ursano, R. J., McCaughley, B. G., Fullerton, C. S. (eds) (1994) Individual and community responses to trauma and disaster London, Cambridge University Press

3. A third perspective draws upon the fields of neurobiology and neuropsychology, where increasingly more research looking at the neurochemical processes relating to trauma has been undertaken. These processes include normative stress responses, the developmental perspective and the symptomatology of PTSD itself¹⁴.
4. A fourth and final perspective relates to where music therapy might have a specific role within the support and treatment of those who have experienced psychological trauma either originating in a single, overwhelming event, or as a result of living in a community where violent conflict has taken place.

It is useful to first consider defining trauma and I will do this before expanding on the four perspectives I have outlined.

Trauma in general

I would like to begin with an excerpt from a music therapy session of one 8 year-old boy, who I will call "Jerry". Jerry lives in Northern Ireland:

e.g. "Big Bomb 1"

AUDIO 1a - OHP

I think this demonstrates the impact of trauma. We will pick up Jerry's story in a while; at this stage it is important to consider briefly basic definitions of trauma.

TRAUMA (basic definitions)

OHP

¹⁴ van der Kolk, B. A. (1994) "The body keeps the score: memory and the evolving psychobiology of post traumatic stress" *Harvard Review of Psychiatry*, 1, pp253-65
Davidson, J. R. T., Nemeroff, C. B.. (1989) "Pharmacotherapy in PTSD: Historical and clinical considerations and future directions" *Psychopharmac. Bulletin* L, pp422-425

"diseased condition of the body produced by a wound or injury; emotional shock, often leading to neurosis" ¹⁵

● "a powerful shock that may have long-lasting effects"¹⁶

● "a wound; damage to the tissues by any physical agency; emotional upset as a cause of mental illness"¹⁷

To take the definition a step further we now look at the Diagnostic and Statistical Manual terms of reference for posttraumatic conditions:

POSTTRAUMATIC STRESS (definitions) OHP

1. POSTTRAUMATIC STRESS DISORDER (DSM-IV)¹⁸

Follows exposure to an extreme traumatic stressor involving direct personal experience of:

- Actual or threatened death or serious injury, or other threat to one's physical integrity, or -
- Witnessing an event that involves death, injury, or a threat to the physical integrity of another person, or -
- Learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a close family member or other close associate

Person's response to the event must involve intense fear, helplessness or horror.

Characteristic symptoms resulting include:

- Persistent re-experiencing of the traumatic event

¹⁵ Hornby, A. S. (1974) Oxford Advanced Learner's Dictionary of Current English Oxford University Press

¹⁶ Collins English Dictionary (1998) UK Harper Collins

¹⁷ Wingate, P. (1972) The Penguin Medical Encyclopedia UK, Penguin Books

¹⁸ Diagnostic & Statistical Manual of Mental Disorders (4th edition) (1994) Washington DC, American Psychiatric Association

- Persistent avoidance of stimuli associated with trauma
- Numbing of general responsiveness
- Persistent symptoms of increased arousal

Disturbance must cause clinically significant distress / impairment in social, occupational or other important areas of functioning.

SYMPTOMS MUST BE PRESENT FOR MORE THAN ONE MONTH.

The Diagnostic and Statistical Manual more recently included an expanded definition, including associated features, of which Acute Stress Disorder is a disaster-related diagnosis¹⁹.

2. ACUTE STRESS DISORDER²⁰

Now included in DSM-IV and recognises:

- The potentially high level of distress that an individual can experience in the acute trauma phase;
- The potential for this distress to predict PTSD (shows a potential process leading to PTSD);
- 3 symptoms of dissociation (e.g. sense of numbing or detachment; reduced awareness or surroundings; de-realisation; de-personalisation; dissociative amnesia)
- 1 re-experiencing symptom
- marked avoidance
- marked anxiety
- evidence of significant distress / impairment

SYMPTOMS OCCUR WITHIN 4 WEEKS OF EVENT AND RESOLVE WITHIN THAT 4-WEEK PERIOD.

¹⁹ Associated features also include: organic mental disorders (as a result of head injury, toxic exposure, etc.); adjustment disorder; substance use disorders; major depression; generalised anxiety disorder, as well as grief reactions and other normal responses to an abnormal event.

²⁰ DSM-IV as before

SYMPTOMS LAST FOR AT LEAST 2 DAYS AND NOT AFTER 4 WEEKS.

In relation to these descriptions of psychiatric disorders, for many exposed to a traumatic event there follows a period of 48 hours during which there is experience of symptoms such as flashbacks, anxiety states, numbing and arousal. The key feature is that these symptoms are transitory and *decrease* after this point.

In a recent publication²¹, Caroline Garland, clinical psychologist, psychoanalyst and head of the Unit for the *UK Study of Trauma and Its Aftermath*, described trauma as "a kind of wound". She thinks of a traumatic event as one where the protective filtering processes we use to feel safe in the world become overwhelmed and useless. Exposure to a traumatic event will connect with events and experiences from the past. This is the viewpoint from which I will be considering trauma. While the paper is related to traumatic events, I feel that the underlying issues impact on many aspects of life, both for us and for the clients we work with.

I will now return to expand on the four perspectives I outlined earlier.

The environmental perspective

In the UK over the past few years, news media and documentary programmes have more consciously recognised the psychological impact of traumatic events. Those affected include not only the injured, those who witnessed others being killed or injured or who witnessed the event without injury to themselves, but also those who were part of the rescue services, or part of the news teams reporting the event. Family members visiting survivors can become traumatised by the extent of injury to a relative and what they see in hospital wards where there are other survivors. Hospital and support staff are, of course, also deeply affected. For those of us not directly affected by an event any single traumatic event reported by news

²¹ Garland, C. (ed) (1998) Understanding Trauma. A psychoanalytical approach London, Tavistock Clinic Series

media can also impinge powerfully and this is particularly so if we have a similar, previous experience.

We have had a recent example of this in Northern Ireland with television coverage of the deaths of three young brothers as a result of the fire caused by a petrol bomb thrown into their house last year. The impact upon the mother, father and remaining brother of these boys is impossible to imagine. Both parents escaped the blaze, having first tried to rescue the children. The older brother was not in the house, even more powerless. The rest of the family has had to deal with the event as well as the strain of supporting the survivors, including dealing with news media. The impact of the event upon those living on that housing estate was obvious. The impact on those living throughout N. Ireland was strong enough to put a great deal of pressure on those demonstrating at Drumcree²². This should be seen in the perspective of many previous traumatic events. To broaden the perspective further I know of one family living in England, for whom these deaths had a particularly powerful effect, because ten years ago this family had lost their only two children in a house fire.

If we summarise the ways in which any single event can have an impact we are thinking about what often has been called the "ripple effect":

The ripple effect of a traumatic event

OHP

- Those present who survived (whether physically injured or not)
- Those witnessing the event (related/friends/passers by)
- Close family members who were not there
- Rescue services

²² The Drumcree demonstration was started after Orange Order marchers (protestant) were prevented from walking down the Garvagh Road in Portadown. Drumcree is the name of the church where the march starts. Members of the Orange Order believe that because they have always marched down the road they should do so now. The catholic Garvagh Road residents believed this was provocative. The Parades Commission agreed with the residents and banned the march, leading to violent protests from Orangemen and their supporters.

- Media (film crew reporting the event)
- Hospital staff (including porters, cleaners)
- The immediate community (the street/area)
- The broader community (county/country/beyond)
- Impact on those with previous/similar experience of traumatic event
- Those seeing TV reports/reading newspaper
- Longer-term impact on survivors (physical/psychological)
- Longer-term impact on ongoing support services/family/friends
- Longer-term effect on the community (ability of survivors to contribute to community; future relationships, etc.)
- The impact on us here today

I have used this example of the house fire to show the widespread affect a traumatic event can have. It vividly exposes the many levels at which a single event affects all of us in some way, at a number of different levels. We do not have to be present to be affected, and *how* we are affected depends on who we are and on our life experiences from birth onwards. To return to Garland, who wrote about the importance of these individual, unique life histories:

"However precisely we might be able to identify and quantify the nature of the stressor, it is not sufficient as a way of understanding the impact on the individual. The individual has a constitution and a history which have shaped his internal world; hence a character and a personality. He also has a culture. So he is someone who is more or less vulnerable to that particular event in his developmental history. That vulnerability is a function of the inevitable interplay between

objective and subjective, external and internal reality. In practice it is a complex business."²³

Following on from this I would like to return to Jerry and continue with his story about the big bomb. If I now add some of *his* own history you will hear the following excerpt (the concluding part of the first example) knowing that Jerry's Dad was in the army and that Jerry was used to checking under his father's car "for lunchboxes"²⁴. In addition, just before Jerry began music therapy the huge bomb in Enniskillen had exploded, killing and injuring many who had been attending the Remembrance Day parade.

e.g. "Big Bomb 2"

AUDIO 1b - OHP

Following increasingly aggressive outbursts at school, Jerry had begun his therapy with explosive drumming that was frequently fragmented and chaotic. He presented a continuous, sounded musical narrative that either blocked out or left little space for anything else. This "wall of sound" is strikingly similar to the music of a number of children my colleagues in Mostar are working with. From the Bosnian perspective the therapists sometimes describe how they make links with their clients' music and the constant mortar attack that families in Mostar experienced while taking refuge in their cellars.

Back in Belfast one of the ways that the community coped with the violent events taking place was to keep silent. Silence was a major coping mechanism during the seventies and eighties. Associated and inextricably linked with the silence was denial, yet now these mechanisms have to be seen in the changed context of increased information exchange and

²³ Garland, C. (1998) as before, pp23

²⁴ "Lunchboxes" = car bombs

documentation of many aspects of the conflict²⁵. What worked during the seventies will not be so effective now.

In 1988, withdrawn from mainstream education to a school for children with complex speech and language impairment, Jerry had such a severe non-fluency that rendered him at times speech-less. He was in effect silenced. In sessions over several months Jerry began to whisper what appeared to be a narrative about what he was doing with the instruments. This narrative eventually evolved into the "big bomb" story. This story took four sessions to tell and Jerry eventually called it "The Trap".

I think this is a useful example of how the individual's history (as Garland termed it) enables a perspective.

At this point we can add a further perspective, relating to the impact of psychological trauma upon ourselves as clinicians with our own histories. This is an emotive area of work and we should of course be aware of our personal responses to the material. It is difficult not to respond emotionally to the stories of those who have lived through events so overwhelming that physical survival is at threat. Traumatic narrative is traumatic. We need to be able to think about these stories within the personal as well as the broader perspective.

We should take care with the effect upon us of such traumatic narrative. If we become overwhelmed, we are unable to function usefully or even adequately in the work setting. Having lived through experiences beyond the norm, clients need to know that it is safe to talk and that they can tell their story without damaging the therapist.

²⁵ Smyth, M., Fay, M-T. (2000) Irretrievable Losses: Personal Accounts from Northern Ireland's Troubles London, Pluto Press

Smyth, M. (1999) "The Effect of the Troubles on Children" *Journal of Childcare Research*, Vol. 3, no. 2

Finally, we must be able to come to awareness of how, as individuals, we respond to hearing about traumatic events. We know that our own histories contain experiences of feeling traumatised. We know of the impact of this at both conscious and unconscious levels upon our work with vulnerable clients and several authors have written about the necessity of this awareness in therapists. Sedgewick, a Jungian analyst, reviewed some of this literature from a range of theoretical frameworks and used examples of his own clinical practice to explore countertransference at different levels²⁶. Considering the area in general he commented,

*"Not just the patient but the therapist brings his entire "self" - neuroses, wounds, needs, soul, etc. - to the analysis."*²⁷

This is, of course, central to all therapy work. However, in working with and thinking about those who have lived through events where survival has been at threat, our own histories can be particularly exposed. As clinicians we know that we should become aware of this in order to safeguard our clients and ourselves. As Sedgewick wrote,

*"the analyst should note both how he is interpreting and where he is interpreting from."*²⁸

As therapists we cannot separate ourselves from the communities we work within, in the same way as those in therapy are affected by the outside world. This is seen very clearly when considering the ripple effect of a traumatic event. In terms of Northern Ireland there has been a series of traumatic events that range from actual to perceived threat to life. The nature of the violence has also changed over time, for instance, from the individualising to the generalising of the campaigns. Individual targets were

Smyth, M., Morrissey, M., Fay, M-T. (1999) Northern Ireland's Troubles. The Human Costs London, Pluto Press, pp180-200

²⁶ Sedgewick, D. (1994) The Wounded Healer. Countertransference from a Jungian Perspective London, Routledge

²⁷ Sedgewick, D. (1994) pp42

sought out during the "tit-for-tat" deaths both within the paramilitaries and the security forces. This is contrasted with the bombing campaigns such as Enniskillen or more recently, Omagh. It suggests that people have had to adjust to this, yet evidence leads us to believe that this is not an easy process. In spite of their redundancy, ways of coping set up during the seventies have carried through to the present day where there has been an upsurge in sectarian and criminal activity. Current research is showing that levels of stress are higher in men than in women, with alcohol use and prescribed medication commonplace in the more vulnerable population²⁹. It is not simply a picture of religious or political divide, but with far more complex social and economic factors. The situation is constantly changing, but one consistent element seems to be the marginalising effects of deprivation in relation to the conflict. It is really more commonly a case of *chronic re-traumatisation* rather than single events resulting in posttraumatic stress responses.

We could consider this area of complex overall environmental perspective much further, but this would be outside the remit of the paper. I will now move on to the second area, of theoretical approaches to trauma. Much of this material is included in the handouts.

Trauma and psychological thinking

Trauma literature has changed considerably in the past decade and reflects the developing approaches and changing attitudes to those who have experienced psychological trauma. More recently there has emerged an integrated or eclectic perspective, where a range of theoretical ideas are held in mind when thinking about the impact of trauma.

We find literature from applied and developmental psychology that explored the ways in which the earliest life experiences produce acute fear relating

²⁸ Sedgewick, D. (1994) pp37

²⁹ Smyth, M. in press

to threat to survival. Theoretical perspectives vary but all contain the lasting effects of these early life stages.

Experiences of real or perceived threat to survival have roots in our ability as a species to survive. These experiences link with our early perceptions of feeling safe or not safe. As infants we depend on our primary caregivers for our physical and emotional security and these first relationships colour all subsequent relationships. Conflicting ideas have emerged within literature concerning this area, yet the impact of these early experiences of threat to survival - or loss of safety - occur throughout.

While Freud initially hypothesised that hysteria was as a result of trauma, he further developed his ideas towards more developmental models³⁰. Significantly, Freud recorded that it was possible to separate developmental trauma and that experienced as a result of a single traumatic event. As we know, Klein related such loss of feelings of safety to the early infant experience of the breast³¹. When the feeding breast was removed the sense of abandonment felt was overwhelming. Infant-caregiver observations have revealed the overpowering nature of sensations for the infant in these situations. The impact of this experience was at such an early stage of development, before the resources or language for processing or assimilating the experience. The experience of a traumatic event can thus be seen as one of being abandoned by all that holds one safe (good internal objects), leaving one at the mercy of that which appears to have caused the trauma (hating and hateful objects). Bion wrote of "nameless dread" to describe the state of the infant when mother could neither contain nor tolerate the baby's anxiety and in turn magnifies this feeling. The infant is left feeling helpless on the brink of disaster³².

³⁰ Freud, S. (1901) The Psychopathology of Everyday Life *Standard Edition* Vol. 4-5

³¹ Klein, M. (1940) Mourning and its Relation to Manic-Depressive States In: „Love, guilt and reparation and other papers, 1921-1946“ London, Hogarth (1947) pp 311-38

³² Bion, W. R. (1962) Learning from Experience London, Heinemann

Bowlby considered the earliest relationships from infancy into childhood had a central survival function, enabling the developing child to feel safe and protected³³. It would be impossible for the adults in these relationships to have created a constant state of security for the infant. Bowlby wrote in detail about the result of developmental changes in infant perception from feeling safe to feeling unsafe, particularly focusing on the sense of loss of safe attachment and its implications for later life.

Stern also considered how the two participants in the first relationship brought their individual life experiences to the interaction³⁴. Here, for instance, through her own developed patterns of response, mother passed on to her child her experience of *her* mother. However conscious the adult is of the experience, and however they aim to protect the infant from this, they still have the memory of their own losses at the unconscious level. While in altered form, this inherited experience passes through generations. Winnicott wrote aptly of this dilemma,

*"She [mother] was a baby once, and she has in her memories of having been a baby; she also has memories of having been cared for, and these memories either help or hinder her in her own experience as a mother."*³⁵

If we think back to Jerry's story we can deepen our understanding of his experiences of an underlying state of uncertainty, both within his community and in the family home. Jerry's parents did not discuss their fears with their two children in order to protect them from these terrors. This is totally understandable and not at all an uncommon response within families. This was further magnified by the collective protecting mechanism of community silence. However, it is not difficult to imagine what had to be contained silently whenever Jerry's Dad was late home from work. Keeping

³³ Bowlby, J. (1988) A Secure Base London, Tavistock

³⁴ Stern, D. (1977) The First Relationship USA, Harvard University Press

the family safe was a major priority and I well recall visiting them for the first time. Jerry's Dad, who was kind and gentle with his children, sat in a comfortable-looking armchair, resting his hands on the flowery material covering the arms as we talked. Under his right hand was his legally held firearm, yet neither he nor I made any reference to it. In Northern Ireland only the security forces carry firearms - this is not the case in the rest of the UK where the police are generally unarmed. We are not used to seeing people carry guns. By not commenting on this - by keeping silent was exactly how everyone dealt with the unpredictably violent situation.

During the first third of his therapy Jerry frequently tested how safe the therapy room could be in a number of ways. At first it was important to be able to provide the space for his continuous, chaotic playing. He needed to know how long and how often his sessions took place and that I would take care of this basic boundary for him. He also needed the sense of space *inside* the boundary, within which he was unobstructed in communicating how he felt. Jerry needed to know how "safe" I was and what I could tolerate. At one point I remember him bouncing sticks violently off the four walls. While at times the beaters flew around my head I never felt that the space had become unsafe - it was as if Jerry was pushing at the very fabric of the room to check how resilient and containing it could be. It was not always easy to stay in the room and at one point Jerry climbed onto the windowsill and put his head out of the window. I felt at the time how aptly he was communicating how difficult it was and noted how relieved he looked when I invited him to rejoin me in the room. The reliability of the space and what it could contain was central to this early work. Garland picked up this point when she wrote:

"we need to be able to listen without being so overwhelmed by the raw intensity of our patients' experiences that we retreat from the emotional impact of what they are saying....If we retreat in this way

³⁵ Winnicott, D. W. (1966) "The Ordinary Devoted Mother" In: Babies and Their Mothers Free Association Books

then we confirm the survivor's view that what happened to them, and is still happening inside them, is indeed unbearable."³⁶

I feel that Jerry needed to be invited to return to the room in much this way.

As Jerry's story developed further the sessions took on an intensity and pace that resulted in twice-weekly sessions of 50 to 60 minutes. This was a relatively short period (covering four weeks in total) within the 40 sessions of his therapy. These sessions were difficult and I was left with a sense of increasing tension moving towards some unnamed, dreadful conclusion. This culminated in one, long session of almost 90 minutes in total (the extra 30 minutes comprised a period of recovery and reassembling). During this session Jerry's story moved to a point where he developed a dialogue between two apparently warring characters. They taunted each other, with one character having to actively stand up to the other. Eventually the words ran out and Jerry screamed and screamed.

I think that at this point it was just enough to survive. It is difficult to listen to this session even now and in hindsight I wonder how I might have responded differently. However, at the time I made an honest response to material that was difficult for Jerry and for me too. I feel that this session marked a point at which the terrors I spoke of earlier not only surfaced but were expelled into music. We can hypothesise this process as linked to Bion's 'beta elements', the chaotic, the broken up and the unbearable, that if uncontained result in the state of "nameless dread".

In summary, it can be suggested that our early experiences are not only carried throughout life but also in some altered form passed on our children. When faced with physical threat to survival as a result of violence in the outside community, these early survival experiences influence the ways in

³⁶ Garland, C. (1998) as before, pp29

which adults and children respond. Along with these early experiences are also the fundamental, 'ancestral' survival mechanisms.

The neurologist Damasio considered the implications of the differences between these two kinds of processes³⁷. Using the concept of "primary" and "secondary" emotions to differentiate between ancestral responses and early experiences, Damasio suggested the former being "wired at birth"³⁸ and inextricably linked with the limbic system. In comparison, secondary emotions related to perception of an "emotional body state"³⁹ and could be said to be 'soft-wired' through life experience. We could say that the "primary emotions" processes impinges on the impact of living through potentially life-threatening situations, with "secondary emotions" processes offering opportunities of finding ways of adjusting to having experienced such situations. The processes are inevitably interconnected in the sense that Damasio says: "secondary emotions utilise the machinery of primary emotions"⁴⁰.

This brings us to the third area, drawing from the field of neurology and linking this with existing psychological theory.

Trauma and neurology

I have found Erdonmez helpful in thinking about why an integrated approach to music therapy should include brain function⁴¹. While we cannot forget that we are music therapists, we can inform our work further by considering brain processes. This is particularly relevant if there is a strong neurological component to the needs and difficulties experienced by our clients. It is useful therefore to consider the neuro-psychological implications of the

³⁷ Damasio, A. R. (1994) Descartes's Error. Emotion, Reason and the Human Brain UK, Picador

³⁸ Damasio, A. R. (1994) pp131

³⁹ Damasio, A. R. (1994) pp138

⁴⁰ Damasio, A. R. (1994) pp137

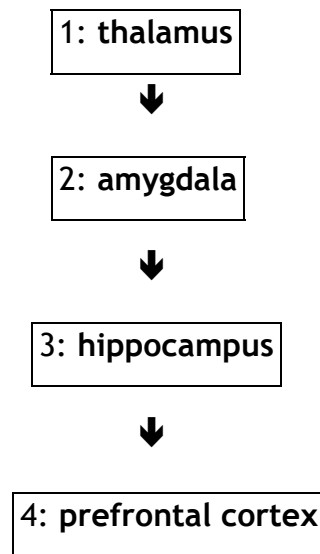
⁴¹ Erdonmez, D. (1993) "Music. A Mega Vitamin for the Brain" in: M. Heal, T. Wigram (eds) Music Therapy in Health and Education London, Jessica Kingsley, pp112-125

human response to extreme stress in order to understand further the impact of PTSD and psychological trauma in general.

In addition to the literature from psychologists, neurologists have considered the impact of psychological trauma with reference to chemical and electrical neurotransmitters. Research has shown a depletion in neurotransmitters such as norepinephrine, epinephrine and dopamine in animals exposed to situations where escape is impossible⁴². In this research the symptoms produced seemed to echo the shock responses of human „fear or flight“. Other researchers developed theories centred on the limbic system, in particular the „conditioned emotional response (CER) model⁴³. The model suggests that changes take place within the limbic system, because of overstimulation due to excessive exposure to extreme stress. Another possible model for brain processing of traumatic events includes the four-stage process of the limbic system. This theorises that chemical transmitters in the brain block further processing when faced with traumatic situations. The model can be simplified in the following diagram:

⁴² van der Kolk, B., Greenberg, M., Boyd, H., Krystal, J. (1985) „Inescapable shock, neurotransmitters, and addiction to trauma: Toward a psychology of posttraumatic stress“ *Biological Psychiatry*, 20, 314-325

⁴³ Kolb, L. C. (1988) „A critical survey of hypotheses regarding PTSD in light of recent research findings“ *Journal of Traumatic Stress*, 1, 291-304



In this model, the amygdala normally receives sensory information from the thalamus and „screens“ this for survival threat. If the stress is not too great, the information is assessed and passed to the hippocampus for emotional processing - that is, a sense of feeling about the stress is developed. After this emotional „evaluation“ the next step is the higher processing at the prefrontal cortex. If extreme stress is assessed at the amygdala stage, an alarm call results and any further processing is blocked. This removes the possibility of placing emotional value on the experience and is sensed in the body through feelings of numbness and shock. Here, the „flight or flight“ mechanism occurs. In the most extreme experiences, it is believed that permanent damage occurs in the amygdala. For those who live with PTSD the social support systems we rely on to survive stressful events are no longer available because of this damage. Without the ability to assign emotional value on our responses to situations involving others, the normal social interactions become useless.

Even if not developing psychiatric symptoms those traumatised by violent conflict experience the sense of loss of security and safety at a level that can feel like a threat to physical and/or psychological survival. The communities of Belfast and Mostar have had access to such experiences, in

response to two different kinds of conflict. The underlying feature is this loss of one's physical, emotional and psychological sense of security. While in essence linked with the ancestral defence against survival threat, this sense of loss also has roots in infant experiences of abandonment and separation. At moments in human development, while not necessarily a physical reality, one's very survival can feel to be under threat.

In Jerry's case this was compounded by the range of coping mechanisms prevalent in the whole community, to the extent that he had become silenced. In the earlier sessions he had tested how safe the therapy setting could be and developed a sense of how reliable this was. This enabled him to begin to voice some of what he had been unable to speak about. This he did first of all without words, in his music. There then unfolded the story of the "Trap". After the Trap he then voiced, wordlessly, some of what I felt was the "nameless dread" that Bion described. At that stage he was in twice-weekly 50-minute sessions, with the central "Scream" requiring a full 90 minutes from beginning to end. >From that point Jerry's therapy changed dramatically and much of the tension felt previously disappeared.

Trauma and music therapy

I anticipated that by following Jerry's story we have come to some awareness of how music therapy was of use to him. At the simplest level it gave him a space and a voice in a setting that was not available elsewhere for him. That he was able to make real, creative use of this should not be understated. On another level I feel that the music he made, along with the music I made and the music we made together served as a container for what had yet to be expressed.

In thinking about music therapy, my own training developed my awareness of a clinical setting where both client and therapist can be actively negotiating musical sound and silence. This kind of music making has potential to connect on different levels that also reflect different states of being. These states of being can be experienced in relation to an "other" and

as such can resonate with early life experiences of the type described in the overview of psychological theory. This allows a process where these areas can be explored, using a medium (music) that I think of as pre-conscious, existing somewhere before words and symbolic thought. It is *this* quality of music that is of particular use for those vulnerable to trauma.

The current literature describing the neurobiology of trauma suggests a real place for music as therapy, where normal brain process can become interrupted, impaired or even damaged as a result of overwhelming traumatic stimulus. It is the protecting mechanism itself that becomes overwhelmed. This very process renders thought unavailable. Emotional memory is disrupted to the extent that it remains unprocessed. The person experiences not the memory of the traumatic event, but the event *itself*, again and again. I believe that the kind of music that occurs within clinical music therapy sessions offers opportunities to process some of these traumatic experiences at a *felt* rather than *thought* level. This becomes a place that can then move from a raw state to one where experience has the potential to become thought about. Garland wrote about this process:

*"[the therapist can] help transform the unbearable into something that can eventually be thought about, held in the mind and considered, rather than responded to as an overwhelming experience that causes a further breakdown of the ability to think."*⁴⁴

I believe that music has this identifiable place within this process. It enables us to contain, experience and explore the unthinkable in ways that can become meaningful and have potential to be thought about.

In Jerry's case he began silenced. He moved between states where he had no words to those where words enabled him to voice part of his story. After this he reached a place *before* words, and then moved on to other kinds of verbal narrative. I have observed this varied use of music in work with other

children who have witnessed events "beyond the ordinary". My colleagues in Mostar are also reporting similar responses. What seems to be significant is the musical containing and expressing of the impact of the traumatic experience. This somehow offers potential for processing what cannot yet be thought about.

Jerry's story did not end here. In the later sessions he chose to recreate some music that by chance was in the therapy room - the James Bond film music. At the risk of stating the obvious this allowed him to assume the hero-like character and not only vanquish the "baddies" but also achieve this by the use of his gun (remember the father's gun earlier?). This task was undertaken with a real sense of freedom and playfulness, with Jerry dancing and leaping around the whole room. From this point it became clear that we were at the end of our work together. It was decided that he would return to mainstream education. He chose to mark the end of therapy with some improvised songs and I will end this paper with part of one of these. Fittingly, these are Jerry's words about his experience and, while he is clearly a boy who will always be very full of feelings and energy, it seems that he has achieved a perspective on where he is.

e.g. "Lonely 1, 2"

AUDIO - OHP

In this paper I have considered aspects of the impact of traumatic events from different perspectives and theoretical viewpoints. I believe that through thinking about trauma in many different ways we can take an informed, objective approach to work with clients who have been made so vulnerable after experiencing events beyond the ordinary. We can identify a rationale for working in creative therapy and in *music* therapy in particular. And we can expand this thinking further into our other work and to where we stand ourselves within it.

⁴⁴ Garland, C. (1988) as before, pp110

The projects:

In Belfast a current two-year project has explored the use of music and music therapy with children who have experienced psychological stress or trauma. The Music Project involved a team of five registered music therapists. The main focus of the project offered creative music making to groups of children in a range of community settings. In particular, work in conjunction with existing groups has been set up, for instance in community centres, or collaborating with voluntary organisations such as NSPCC.

The aim of this work has been to come to an understanding of the ways in which children living in areas where there is community violence use music spontaneously. A further aspect to the project has focused on the clinical setting, where a small number of children attended short-term⁴⁵ individual music therapy. This work will be discussed in detail in this paper.

In Bosnia the WarChild organisation has been supporting ongoing musical work that ranges from a broad-based therapeutic approach through to clinical music therapy. A small number of music therapists have been invited to observe and advise on this work, of which my visit during December 1996 was the first. The WarChild project in Bosnia has continued to develop and the Music Therapy Wing in the Pavarotti Music Centre in Mostar is now flourishing. To date five music therapists from the UK, Denmark and Ireland have been directly involved in this work.

Acknowledgements:

I thank Jerry and his family for trusting me to tell his story and for agreeing to the playing of the audio examples.

I am grateful for the support of WarChild London and Amsterdam and in particular Nigel Osborne and Ian Ritchie, who offered me the opportunity to

⁴⁵ After an initial meeting, weekly sessions are held. The children have attended 4-20 sessions, depending on a range of circumstances (for instance, one child whose family home had been burned down eventually left N. Ireland and was therefore unable to continue attending).

become involved with the work in Bosnia and who were generous in their encouragement.

I acknowledge the clinical work in Bosnia of Alison Acton, Louise Lang, Charlotte Dammeyer-Fonsbo and Una McInerney, as well as the support of my UK colleagues Rosie Monaghan and Elaine Streeter.

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Performance and Product: Clinical Implications for the Music Therapist Alan Turvy

Introduction

Can a music therapist be fully attending to the needs and issues of their clients when performing with a client or group of clients? What happens when the therapy consists of or includes working towards a product such as a recording of music from sessions? How can we discern what clients can benefit from these experiences and when it may be contra-indicated? As the music therapy profession has developed, the idea of therapists performing and creating products with clients has become a controversial subject. There are many issues to be aware of when integrating performance and creating products in our clinical work.

Background⁴⁶

When the field of music therapy was in its infancy, music therapists were often hired on lines that were previously relegated to recreation therapists or music teachers.⁴⁷ Music teachers in special education often did performances with their students, and music therapists struggled to establish their own professional identity. Some therapists who were trained to use music in a recreational fashion were unaware that there were other considerations aside from the product. The music therapy literature contained research which described how clients "performed." Music was

⁴⁶ Though I have done some research in discussing the historical development of performance and product in music therapy, I admit that some of the ideas I am presenting are conjecture, based on my analysis of the situation rather than first hand accounts.

⁴⁷ Ruppenthal, one of the founders of the NAMT and one of the first registered music therapists to work in psychiatry, described a battle (that he eventually won) over maintaining his autonomy rather than being part of a centralized department with occupational and recreational therapists. He describes some of the events in his program as rhythm bands, church choirs, and vocal and instrumental ensembles.

used instructionally, as a reinforcer, and quantitative research was done to measure "music performance behaviors."⁴⁸ Some supervisors of music therapists considered performances and products to be natural outcomes when the music therapist worked with their clients. Often therapists were given large amount of clients to work with simultaneously, which made it extremely difficult to do activities besides performance. Structured activities, including sing-alongs and rhythm band type of performances, were often chosen as the only way for the therapist to work. There were times when administrators dictated to therapists that they were expected to perform publicly with their clients in order to increase visibility and awareness of music therapy in their facilities. Therapists were forced to participate in these kinds of activities or risk losing their jobs. The therapist created vocal choirs, bell choirs, and other recreational types of musical performances. Some utilized performance willingly without conflict; others went along with the idea though they wanted to do something else.⁴⁹

Though this kind of work may have been beneficial in some respects, through the lens of a contemporary music psychotherapist it would seem to be potentially hazardous to the therapeutic relationship. By setting the goal of a good performance as a high priority, patient's issues may have been ignored by the therapist. The therapist was forced to consider his own agenda and might not have been as focused or aware of the client's process. The clients may have experienced a sense of being abandoned and exploited, not valued for who they were but for what they did for the

Despite the fact that he considered himself a Freudian, he spent much of his early years in psychiatry creating performance type activities with patients.

⁴⁸ For example, in the *Journal of Music Therapy*, Vol.XIV, Dorow "dealt with the reinforcement value of musical performance using free operant selection." Her study set out to "determine the effects of high approval instruction versus discovery method on performance achievement." Subjects were administered a "recorder performance posttest". In her summary she concludes by stating "it is clear that beginning instrumentalists, students in elementary school general music programs, or clients in music therapy instrumental programs need structured instructional programs with the music itself and music performance being paired with reinforcement in order for them to find reinforcement value in performing." It is debatable whether this study would be considered relevant to contemporary practicing clinicians.

⁴⁹ Even today, music therapists, particularly those trained at undergraduate facilities, are running these types of activity oriented recreation groups. Manufacturers of musical instruments continue to create instruments that make it possible for disabled people to perform.

therapist. The therapist may have internalized the message from his supervisor to focus on the musical product rather than on the client's process-that success was measured on how the performance was perceived rather than on its effect on the clients overall progress.

In the early days of the profession, when many therapists did perform and produce products with their clients willingly, they were unaware of these potential hazards, and unaware of their own personal motivations that might have impeded on the therapy process in a destructive way.⁵⁰ Under the guise of helping the client or promoting the field, therapists may have been acting on their own hidden agendas such as self-promotion, the need to feel self-important, and the need for recognition and acknowledgement. Some saw themselves as the only person trying to help the clients do something positive rather than reduce them to a diagnosis, and placed themselves unconsciously in the position of savior. They may have felt that music was the way to save the client, since music might have functioned for themselves in this way. They may have wanted their own music to be heard, and utilized the patients participation in order to achieve this. Perhaps the therapist was also a musical performer and assumed that since he enjoyed doing it, the patients would also. Perhaps the therapist chose to be a therapist in order to avoid the performance anxiety that comes with being a musician. Perhaps the performance was a way for the therapist to work on his own issues. Perhaps the therapist had always wanted to have his own band. These unconscious dynamics were potentially damaging for the client. The basic problem was this: if the therapist was acting on his own unmet desire to be a performer or professional musician, ***who was watching out for the clients?*** Unconscious motivations were impeding on the therapy process and preventing the therapist from working on a deeper level with his clients, ***whether the therapist acknowledged the importance of unconscious motivations or not.***

Of course, therapeutically beneficial performances and products did occur during the early stages of the profession. Successful events and products helped to create hope and raise the self-esteem for clients who participated. Clients gained a sense of mastery and confidence in presenting themselves publicly. When performing as a group, support and camaraderie developed among clients. A feeling of community helped to create a sense of belonging and self worth for clients. Pioneering music therapists such as Nordoff and Robbins were able to successfully integrate performance into their clinical practice. In their book, Therapy in Music for Handicapped Children, they describe the benefits of working in rehearsal for a performance of the piece "hist-whist." The piece was written specifically for the clients to perform. Eight sessions were required to "perfect" the piece, and the hard work in achieving this was "where the therapy lay." They also worked on performing musical plays with children, and the resulting performances changed the way the children were perceived by their housemothers, therapists and teachers. Nordoff and Robbins felt that "the performance was the summation of a therapeutic process that had its origin and development in the rehearsals." The children became "a team of performers, sharing new experiences that their own efforts made possible." Nordoff and Robbins carefully studied the effects of these events on the children, recording each session and reflecting on the benefits of this kind of activity. Dr. Herbert Geuter supervised them, and often made suggestions about the activities, which were based on anthroposophic teachings.

Therapists utilized performance in a variety of settings with a wide range of client populations. Schmidt-Peters (1987) surveyed the field for her book, Music Therapy: An Introduction. She described the work with a variety of populations including visually impaired clients. She stated that "group music activities, such as dances, singing groups, and instrumental ensembles, can provide places for visually impaired clients to learn skills to interact and socialize with each other and with sighted individuals." She

⁵⁰ I am deliberately avoiding the use of the term countertransference, as this term implies an awareness of the therapeutic relationship that simply wasn't present for most, if any, music therapists at this point

goes on to say that some may be able to support themselves by performing. She added that visually impaired clients need not become performers in order to reap the benefits from music. She also described how ensembles, such as community choirs, can be used therapeutically to cultivate self-confidence and leadership abilities, and facilitate adjustment to school and community for socially maladjusted adolescents.

Shulberg (1981) listed choral singing as an activity that can promote socialization, and stated that the group could prepare a presentation to sing to others. She has an entire chapter in her book on music therapy entitled, "Musical Productions." Shulberg believed that "when a production of any sort is created and then brought to life by it's creators, the performance transmits their capacities for care, perception, and cooperation to the audience, who also experience the commitment and sense of fulfillment of these participants." She was careful to state that the "production itself is the means, not the end."

In other types of adult facilities, performance also had successful outcomes. Michel (1976) describes how men who were members of a popular music combo in prison continued to play together as a commercial group when they were released from prison.

Advanced Training

As music therapy training programs became interested in more depth-oriented work, music therapists integrated process oriented philosophies into their clinical practice. As therapists trained in more advanced ways, the significance of performance and product became more fully understood. Rather than having extrinsic music activities imposed on clients, therapists came to value the music created intrinsically by clients. As the field developed, the importance of reflective supervision to examine the dynamics of the relationship between therapist and client helped bring

in the fields development.

awareness to the therapist the many dynamics that might come into play. The masters program in music therapy at New York University developed by Barbara Hesser helped to pioneer music psychotherapy, and product oriented activities were understood as part of a supportive approach to music therapy, rather than the deeper levels of reeducative or reconstructive music therapy. Therapists began to question the benefits of performance. The rationale behind performance was looked at closely, and often was seen as impeding the clients need for self expression which would not be judged aesthetically by an audience, but was important in and of itself for the clients self discovery and emotional contact to the therapist. It was seen as valuable for the client, rather than looking for external validation by performing, to discover meaning and worth based on looking within. Self-reflection, rather than public acknowledgement, was encouraged.

Personal Experience

In 1979, as I began my experiences at Bellevue hospital, performances were done with both psychiatric adolescents and adults. The process was often difficult, and there were times when the client was unable to follow through on the performance. The therapist, aware of the dynamics inherent in music psychotherapy as an approach, was careful to guide the process and see it as a step in the clients overall treatment. Clients could easily sabotage their own performance due to a lack of self esteem and the inability to face up to the challenge of performing. Performance was seen as a part of, not the end product, of the music therapy process. For some clients, the challenge of working towards a public performance was similar to Campbell's description of "The Hero's journey". By focusing and disciplining himself, the client was able to face his fears and play music publicly, and the experience left him feeling better about himself.

During the early 1980's, performance was also integrated into the work done by creative arts therapists at Metropolitan hospital with psychiatric adolescents. Music was performed at graduation ceremonies and during groups where parents participated in the music making. These events were considered meaningful and important in creating an atmosphere of trust and support among clients and staff. Performance was a way for these clients to make a statement, begin to establish their own identity, and express themselves in a way talking could not.

Underlying Dynamics of Performance

For some clients, however, receiving the external validation that comes from sharing publicly did not have a beneficial effect on the client as a whole. Even when others acknowledged the performance or product as successful, the client was not satisfied. For those clients, the desire to perform and receive public acknowledgement was an attempt to fill an emotional need for nourishment and connection that was never met interpersonally. No matter how much public sharing and acknowledgement, the client continued to feel unsatisfied, driven to perform again. They were unable to share the spotlight with their peers. Their relationship to others in every day interactions continued to be difficult.

Psychoanalytic theory has described the person who consistently seeks external notice by performing, who achieves public acclaim yet continually feels an underlying sense of emptiness and shame, to be suffering from narcissistic personality disorder. When early in their lives their basic needs are unmet by a distant parent who needs their child to be special in order to feel self-worth themselves, the child experiences a feeling of abandonment and rejection. The child grows to be an adult desperately seeking recognition and "specialness" as a way to defend against feelings of inadequacy and powerlessness. Though he may have an exaggerated view of his talents and accomplishments (grandiosity), this is a fragile state and considered a defense. What is driving this exaggerated self

importance is that deep down he feels hopelessly unlovable and defective, so he seeks to create an ideal self through the pursuit of celebrity and external success. He constantly depends on others for approval and recognition. It is very difficult to establish trusting, intimate relationships for a person struggling with these issues.

Lasch, a psychoanalyst and social critic, wrote in his seminal book, "The Culture of Narcissism", that this kind of personality structure is indicative of our contemporary society. It is not an isolated phenomenon to be found only in pathological states, but is created by the values and systems of our culture and is therefore present in all of us to a greater or lesser degree. Contemporary American culture places a high value on image (over substance), celebrity (over real accomplishment), self (over community), immediate gratification (over consideration of links to the past and the meaning for the future) and commercial success (over intrinsically meaningful work). He feels that these are symptoms of a lack of true emotional connection and belonging among people. In his view, we are all susceptible to these feelings of emptiness or inadequacy, and to combat them by yearning for fame or external recognition. It may be helpful for the music therapist to look at these phenomena in a broad sense, that there is a continuum where potentially every client who seeks to perform may have these issues lurking somewhere. It is also important for the therapist to see if his own motivations to perform with clients is stemming from this very same issue-his own desire to be recognized publicly as a defense against feelings of inadequacy or emptiness. It may be a countertransference reaction- that he is experiencing something lacking emotionally in the relationship with his client and is dealing with it by deciding to perform- or is acting on the clients unspoken desire to perform.

Despite the fact that the external validation that comes from public acknowledgement does not vanquish these feelings of emptiness and inadequacy, performing may be an effective component of music therapy treatment with this kind of client. Kohut, the renowned psychoanalyst who

identified this dynamic in his patients, felt that "useful, creative work, which confronts the individual with unsolved intellectual and aesthetic problems" was the way to try to help these patients. He felt it was important to try to mobilize the "narcissistic impulse" on behalf of activities outside the self. The creative act of music making can be seen as a step in this direction. The music therapist could utilize performance as a way to engage the client who felt the need to perform. For clients struggling with this core issue, processing their feelings after the performance or completion of the product could help them to feel valued as a person, worthy not solely for their external achievements but for who they were in totality. In other words, in psychoanalytic terms, there is a healthy narcissistic impulse in all of us that can be addressed constructively, rather than pathologized.

Strategies

A key element in successfully integrating performance and product into the music therapy relationship can be the processing of the therapy partnership. The relationship between therapist and client changes when they perform or create a product together. Roles can become confusing, boundaries unclear. Some clients, in order to avoid working on difficult issues or feelings, may try to defend themselves by abdicating their role as client and try to ignore the therapist's role. This can happen when both therapist and client are performing together and experience each other in a new context. It can be important for the therapist to emphasize that he is still observing and guiding the therapeutic process even as he collaborates as a performer with the client. The therapist needs to guard against dual roles that may compromise his focus on the client's development.

Clinical Vignettes

Brian Wilson, composer and creative force behind the beach boys, described his therapy relationship with the psychologist Dr. Eugene Landy in his book "Wouldn't it be Nice." Wilson was struggling with schizophrenia and chronic drug use when Landy began working with him. During the course of therapy, Landy began to write songs with Wilson. Wilson writes, "with Dr Landy, I worked on "Child, Adult, Parent," a suite that mirrored, in music, the transitions my own life had undergone. The collaboration was among the most fascinating I'd ever been engaged in, involving nearly constant analysis and discussion." Wilson credits Landy with getting his life back together and helping him rediscover his abilities as a composer. Landy had many roles with Wilson. He was his executive producer, business manager, and co-songwriter. Wilson describes Landy as saving his life-"he returned my career to me." Landy took charge of Wilson's career and co-produced an album with him. This created controversy. Landy's detractors claimed that Wilson was brainwashed. Despite Wilson's obvious improvements, the Board of Medical Quality Assurance of California charged Landy with ethical and licensing code violations. They stated that during treatment a therapist should not enter into any nonprofessional relationship with a patient. The charges implied that Landy took advantage of Wilson. Wilson ponders the situation this way:

My situation had presented extraordinary circumstances, and Dr Landy by reputation was an extraordinary therapist-the reason he'd been contracted originally. At a certain juncture, he was faced with a dilemma created by the state's canon: Is it ethical to take a patient to a certain point and then leave him there because the ethics say not to go any further? Should he depart from his traditional therapeutic process and enter into another role in which he could help me or should he not help because of an ethical process? Should he stop at a certain point because ethics imposed restrictions, or should he throw ethics to the wind and continue to improve my life? Dr Landy and I ended our formal doctor-patient relationship. Dr.

Landy became my friend, partner, and manager. If he and I were going to collaborate, we had to have equality.

It is obvious that Wilson valued the partnership between he and Landy. Wilson seems to be saying it was not possible to feel like an equal with Landy within the therapeutic relationship. It could be that the therapy relationship became too confusing for Wilson to continue as it was. Landy felt he had to get involved with all aspects of Wilson's life in order to help him. It is unclear whether Landy was discussing the implications of his many roles with Wilson. In the book Wilson describes Landy as an ally, though at times Landy seems more concerned with the product he was producing with Wilson than the effect on Wilson as a whole. It might have been intoxicating for Landy to be working with an artist of Wilson's stature. It is unlikely that this kind of creative music-making situation had ever arose before for Landy, a psychotherapist. He was not a professional musician, and may have had undifferentiated feelings associated with creating music with Brian Wilson. He was not prepared to enter into the creative process and be an observer of the process, as music therapists are. As music therapists, we try to be prepared for these issues to arise. Music is created to be heard by others, and clients may naturally want to share their music with others. For music therapists, performance and product can fall within the purview of the music therapy relationship. We attempt to be able to play while observing the process-to attend to others even as we create with them in front of an audience. At times, we need to take actions that may not feel natural to us, but benefit the client in the long run.

I have been in therapeutic relationships where I established a clear boundary by encouraging the client to perform with another musician, rather than with myself as his therapist. This was not easy to do, and I certainly felt an attachment to the songs and the client. I made the decision based on what I felt the client needed. This actually helped the client to take initiative, gain a sense of independence, and attain a strong sense of

accomplishment which helped him continue pursuing music as a career, without relying on me to participate with him. I did attend the concert, and we processed what it was like in the subsequent therapy session.

Austin (personal communication 1999) has performed with clients and also chosen not to perform. She feels that there are certain clients who are too fragile and unable to tolerate experiencing their therapist as not attending solely to their needs. Austin described one client who thanked her for saying no after the client asked to perform together. This was a significant moment in the therapy relationship, as Austin felt the client could trust her and experienced a sense of safety as they continued to work together.

There have been times when I have chosen to perform with a client. In order to maintain the therapeutic alliance it may be vital to share thoughts and feelings about the performance or product after it is shared. During these kinds of public events, the therapist may reveal parts of themselves that the client had never been exposed to before. This can have a powerful effect on the relationship. When the client sees their therapist not functioning solely as the container and caretaker of the therapy process, but also as a performer focusing on their own performance or producer working on a product, strong feelings may arise. Feelings of being abandoned, and anger toward the therapist may manifest. What if the therapist makes an obvious mistake as a performer-how will the client experience this? What if the client makes a mistake? Will the client feel that they let down the therapist as well as feeling disappointed in their own performance? What if the therapist gains more applause? Are there feelings of competition between therapist and client that get played out? Will the therapist develop personal feelings over the product they created with a client? Will there be issues over who controls the product created in a therapy session? These potential issues are "grist for the mill" if the therapist is ready to work with them.

How Therapeutic Process effects Performance

Many of the issues that arise when performing or creating a product may feel familiar to the client, and in fact could be a reliving of experiences he had with his parents. The client may have had parents who demanded improvement whenever the client performed, or only paid attention and acknowledged the client when they performed. Having a successful performance while being attended to by the therapist, the client may experience a powerful sense of satisfaction. By experiencing performance in a new way with the therapist, the client may be able to become aware of issues and deal with feelings that were previously too difficult. The therapist provides a corrective emotional experience by being emotionally present, able to be present with the client's feelings, whether they be joy or rage, happiness or sadness. Even if the event was considered a success, the therapist needs to be ready for any reaction the client may have. This may be more difficult than a normal therapy situation for the therapist as he has also performed and may have more personal investment in the client sharing in a positive experience with him.

The client may transfer strong feelings that have been unresolved since childhood onto the therapist. By engaging in an exploration of these issues, the therapist helps the client become more aware of and deal more realistically with his emotional reactions. These issues may manifest themselves in the music improvised by the therapist and client in subsequent sessions.

The therapist will need to be on the lookout for dynamics that arise when performing with a client or producing a product with them. It may be difficult for the client to discuss them; but exploring these issues has the potential to enhance the relationship and the therapy process for the client. The client may feel a great sense of relief that he does not have to hide the feelings that are brought up during the performance process. By sharing private feelings that came up in a public forum, the client through time may

be able to integrate the vulnerable and omnipotent parts of himself and not maintain either a grandiose or inferior position. The client may reflect on the process and make new discoveries, gain new insights. They may establish a more intimate, satisfying relationship with the therapist, able to trust their feelings and build a meaningful connection. They may begin to see themselves as worthy of care for who they are, rather than for what they do. Instead of feeling insecure and inferior, they may be able to experience themselves as an equal member of the therapy team. They may begin to feel less driven to perform due to a need to maintain their esteem, and make the choice to perform when they have something they want to share with others. They begin to see the performance as a way of learning about themselves rather than a way to feel superior. They look forward to performing as a way to feel invested in the future, rather than a way to stem feelings of emptiness. They may accept their mistakes more easily rather than expect perfection each time they perform. Each performance can help to indicate what is going on in the client's inner life. The focus is on the client's inner development and process through time.

Contemporary Work

Presently, music therapists working with a variety of populations are choosing to perform publicly with their clients, and focus on products to be heard outside of sessions. Peter Jampel and Sten Roer, among others, have formed rock bands with their psychiatric patients. The process of traveling and working together has helped their clients to feel more confident, and more integrated into the community. Jampel has made a point to call this kind of work rehabilitation rather than therapy, yet has created a therapeutic environment based on the idea of approaching performance as a vehicle of potential development for his clients.⁵¹ Emma O'Brien has

⁵¹ Jampel sites Newman as an influence in building a safe space for performance. Newman is the founder of social therapy, a "cultural-performatory method for curing emotional pain and psychopathology." Newman believes that performance is the natural way to change and grow, and, in fact, children do this in their play. Performing, in his view, promotes development, and being social has a performance aspect to it. Performing gives the person an opportunity to try on new behaviors and attitudes.

recorded songs of clients with terminal illnesses. These clients have described the recording project as giving their life purpose, and feeling less isolated.⁵² David Ramsey has made multi track recording the focus of his work with neurologically impaired clients, and has arranged for performances of the music within the hospital setting. This has helped to change how these clients view themselves-from identifying themselves as a damaged patient to someone who can accomplish and experience a sense of completion and wholeness. Rather than feeling helpless they are motivated to work and rehabilitate. They have been able to find ways to express themselves, as Ramsey has found the technical means to allow them to create music despite their disabilities.⁵³

Sharing the results and accomplishments publicly of the music created privately in a music therapy session can be a way of cultivating a sense of achievement within the client. Public sharing can be a way of validating changes the client has made internally. Maria Logis, a client who has worked with me in music therapy and has shared her process publicly, has stated that sharing the music she has created in music therapy sessions has helped her to "reclaim" her voice. She began public sharing by playing audiotapes of her music therapy sessions with close friends and family. The improvised music contained thoughts and feelings not just about her illness⁵⁴ but about life long issues. In this way she felt she successfully communicated her feelings in a way she could not verbally. She decided to learn the music created in sessions and sing the music publicly for friends and family. The act of sharing publicly gave her the experience of overcoming her feelings of isolation, and she describes that she now has more options besides hiding in a private world of self-criticism. Explaining

⁵² O'Brien, like Landy, was under pressure from those within the profession who felt it was unethical for a therapist to be economically supporting her program with the profits of recordings made by patients and herself. She has stated that the idea of giving the proceeds to the music therapy program she runs came from the patients themselves.

⁵³ Ramsey, who has experience working within the psychoanalytic framework, feels no conflict to be working on performance and products with his clients. He explains that the clients he is currently working with are "not suffering from bad mothering," and thus he concentrates on the task of creating music, ready and available to deal with underlying emotional issues if they arise.

her process in music therapy to music therapists, Logis feels, has given her life a sense of purpose. She continues to seek out public projects that allow her to share her music therapy journey.

Conclusion

Performing with clients is a legitimate activity that can bring many potential benefits to the client. Recording music created in therapy sessions can allow clients to share personal feelings and expressions to others in a meaningful way. These activities can create a sense of accomplishment and self worth within the client. It is important for the therapist to determine what the important dynamics and issues are for the client in order to discern what performing or recording will mean for the client. The therapist can help the client concentrate on the product while being aware of the overall process of the therapy. It is important for the therapist to realize that the client may have many reactions to a successful performance-that successful performance or product does not equal successful therapy.

The performing process can bring up new issues and areas of development, which feed back into the therapy process. Experiencing a sense of being valued and being attended to after the performance by the therapist, clients can feel an internal sense of validation and nurturing that can be more powerful than the public response. With supervision, which examines underlying motivations and dynamics, reflecting on the process and examining how the performance and product effect the client, therapists can successfully integrate these activities into their music therapy practice.

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⁵⁴ Logis has non-Hodgkin's Lymphoma that is currently in regression, which means the tumors have shrunk but are still present.

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WORLD FEDERATION OF MUSIC THERAPY

**COMMISSION ON EDUCATION,
TRAINING AND ACCREDITATION**

**EDUCATION SYMPOSIUM
NOVEMBER 1999
WASHINGTON, DC, USA
*Symposium convened by Denise Erdonmez Grocke***

Proceedings

Compiled and edited by

Barbara L. Wheeler

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Introductory Comments - Setting the Scene

Erdonmez Grocke, Denise

PhD, MT-BC, FAMI University of Melbourne, Australia

The planning for this Education symposium has spanned many years, and it is particularly pleasing that sixteen key educators from across the globe have made the commitment to attend two days in advance of the World Congress program. I thank you all for coming.

In order to Set the Scene, I propose to give a short history of the work of the Education Commission of the World Federation of Music Therapy.

The Education and Training Commission was formed at the 6th World Congress at Rio de Janeiro, Brazil. Denise Erdonmez was elected Chair of the Commission. The objective for the Education Commission's work 1990-1993, was to survey music therapy training courses throughout the world to determine the content of the courses and other aspects of training music therapists.

The European Music Therapy Committee was also embarking on the same type of survey, and Denise Erdonmez collaborated with Tony Wigram and Hanne Mette Kortegaard in formulating an extensive survey form. The survey was sent to a sample of music therapy training courses, and 40 responses were obtained.

The results of the WEK (Wigram-Erdonmez-Kortegaard) survey were compiled by Erdonmez and presented at the 7th World Congress in Vitoria, Spain. The results of the survey were also published in the WFMT Newsletter, vol VII, 1994. It was also published as a Monograph (May 1994.)

In 1996 Denise Erdonmez compiled a Directory of training courses throughout the world for the 8th World Congress in Hamburg, Germany. She approached the country co-ordinators and asked them to circulate the one-page summary sheet giving details of the music therapy courses in each country. There were a number of difficulties in reaching all courses, for example, the details of courses in Germany arrived too late for inclusion. Likewise the information about courses in Japan came in after the Congress date, and the courses could not be listed.

At the World Congress in Hamburg (1996), there were two Round Table discussions on music therapy training. One was entitled Basic training, and the other (that Helen Odell Miller and Denise Erdonmez Grocke chaired) was on Advanced level training. A recommendation of the Advanced Training Round Table was that fundamental concepts needed to be clarified, in particular, the difference between Basic and Advanced levels of training, and the difference between Generic and Specialist training.

The Education Commission was broadened to include members from the various geographical regions of the world. The Commission members 1996-1999 were:




Connie Isenberg-Grzeda (Canada)
Mayra Hugo (Uruguay)
Fumio Kuribayashi (Japan)
Mechtild Langenberg (Germany)
Marilyn Sandness (USA)
Helen Tyler (UK).

In preparing for this symposium, the following objectives emerged:-

- 1) to establish Model Guidelines for Training courses world-wide, at entry level to the profession.
- 2) to address 'advanced' levels of training (i.e., beyond entry level)
- 3) to create a forum for discussion and debate of education and training issues.

In order to address these issues a Model was developed to assist in the discussions and in compiling the Guidelines.

A Model of Music Therapy Education and Training

<u>Entry to the profession</u>			<u>Advanced level educn & training</u> (beyond accreditation/registration)	
Undergraduate	Graduate Diplomas	Masters by coursework and research	Clinical advancement	Research
- 3 years or 4 years	1 or 2 yrs (beyond an undergraduate degree in music or other field)	1 or 2 yrs		
<ul style="list-style-type: none">  specialist courses (specialising in one particular client group - eg children)  specialist in that one theoretical approach is taught in depth - eg Nordoff-Robbins; psycho-analytic; behavioural  eclectic - a range of client applications is taught and a range of theoretical approaches 			Guided Imagery and Music (GIM)	Masters by research and thesis
			Nordoff-Robbins (where not studied at entry level)	PhD by research and thesis
			Other	

Denise Erdonmez Grocke (1999)

The outcome of the symposium therefore is to write Guidelines for Education and Training in Music Therapy. This is in accordance with other Guidelines developed by the WFMT on Ethics and Research. I welcome each person's contribution.

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MODELS OF MUSIC THERAPY EDUCATION AND TRAINING

The first main section of the symposium dealt with models of music therapy education and training, including organization by the countries and parts of the world in which they are practiced as well as one (Nordoff-Robbins) practiced in various countries.

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ENTRY LEVEL STANDARDS FOR MUSIC THERAPY EDUCATION AND CLINICAL TRAINING OF THE AMERICAN MUSIC THERAPY ASSOCIATION (USA)

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University of Dayton (Retired Professor Emerita), USA

Introduction

In 1998 the former American Association for Music Therapy and the National Association for Music Therapy unified to become the American Music Therapy Association. As part of the unification agreement, a Commission on Education and Clinical Training was charged in 1996 to formulate recommendations on how to best embrace both of the educational and clinical training models that were approved by AAMT and NAMT. The Commission's *Final Report and Recommendations* were presented to AMTA at its 1999 conference with a vote for approval to take place in 2000. A principle of the unification agreement was that the AMTA yield credentialing responsibilities to the Certification Board for Music Therapists (CBMT), thus allowing the music therapy profession to move toward using one entry level credential, the MT-BC. In order not to leave music therapists credential-less, AMTA established the National Music Therapy Registry for exceptions for individuals previously holding the CMT/ACMT (granted by the former AAMT) and the RMT (granted by the former NAMT) for a limited period of time.

Certification Board for Music Therapists

The mission of the CBMT is to evaluate individuals who wish to enter, continue and/or advance in the discipline of Music Therapy through a certification process, and to issue the credential of MT-BC (Music Therapist-Board Certified) to individuals who demonstrate the required level of competence. This credential is granted to music therapists who have met specific educational and clinical training eligibility requirements, and have passed the certification exam demonstrating the knowledge, skills and abilities necessary to practice at the current entry level of the profession. The MT-BC must recertify every five years by accruing 100 Continuing Music Therapy Education (CMTE) credits or by taking the Certification Exam during the fourth year of the five-year cycle. It is anticipated that in the future an advanced credential will be created to correspond to advanced level training.

Accreditation of Music Therapy Programs

In the United States nearly all music therapy academic programs are located in music units of colleges and universities, and with very few exceptions are in institutions accredited by the National Association of Schools of Music (NASM). NASM is not a governmental agency but has been designated by the U.S. Department of Education as the agency responsible for the accreditation of all music curricula in higher education. One of its primary purposes is to establish and maintain minimum standards for the education of musicians. Since the basis of music therapy education is strong music skill development, accreditation by NASM is a standard for AMTA-approved academic programs. NASM provides general standards for curricula leading to baccalaureate, as well as graduate degree programs in music. Standards for musicianship and competencies common to all professional baccalaureate degrees in music include performance, aural skills and analysis, composition and improvisation, repertory and history, technology, and synthesis. Competencies, standards, and guidelines are also provided for specific baccalaureate degrees in music. Guidelines for the curricular structure in music therapy and percentages of the total curriculum allocated to each content area are as follows: studies in music (45-50%); music therapy and related behavioral/health sciences (20-30%); general studies (20-25%); and electives (5%).

Approval of Music Therapy Programs

The American Music Therapy Association currently approves music therapy baccalaureate and master's degree programs according to the standards of the former AAMT and NAMT and will continue until such time as the Association adopts new standards, tentatively in 2000.

AMERICAN MUSIC THERAPY ASSOCIATION: STANDARDS FOR EDUCATION AND CLINICAL TRAINING

Marilyn Sandness

An Overview of the NAMT Model

Accreditation

NAMT-approved academic programs must be accredited by the National Association of Schools of Music (NASM), which is a "professional" accreditation agency responsible for the accreditation of all music curricula in higher education in the U.S.

Faculty

"Faculty authorization" is required for directing/teaching in undergraduate programs. Eligibility includes the MT-BC (or RMT previously); Master's degree in music therapy or related field with a minimum of 12 sem. hrs. of graduate music therapy course work; and a minimum of 5040 hrs. of paid, documented clinical experience. For directing/teaching in graduate programs, all of the above are required plus a doctorate or five years experience as an authorized teacher of music therapy undergraduates. (Exceptions are made for teaching the introductory course and clinical practica, which require the MT-BC or RMT; and an exception for psychology of music).

The music therapy program director must be employed full-time as defined by the degree-granting institution; two full-time authorized faculty are required if both degree programs are offered.

Curricula

Baccalaureate Degree - Music Therapy Principles/Psychology of Music/Practicum/Internship comprise a minimum 16% (20 Sem. Hrs. or 30 Qt. Hrs.); Music courses comprise a minimum 45% (54 Sem. Hrs. or 81 Qt. Hrs.); Behavioral/Health/Natural Sciences comprise a minimum 16% (20 Sem. Hrs. or 30 Qt. Hrs.) and must include courses in abnormal psychology, exceptional children, and human anatomy/physiology. Study of research and statistical methods are required (may be included in the Psychology of Music). The above courses should be evaluated in relation to the list of *NAMT Professional Competencies* to determine how/where the competencies are being addressed in the course curriculum. Master's Degree - Candidates must have completed an undergraduate music therapy degree or "equivalency" program and a six-month approved clinical internship. The normal requirement is 30 Sem. Hrs. (45 Qt. Hrs.); one-half

of the hours should be music therapy courses and one-half should be supportive courses. (Note: There are no standards for a doctorate degree).

Clinical Internship

It must consist of a minimum of 6 continuous months and 1040 hours of clinical training. Any accredited or licensed facility or group of facilities is eligible if it provides music therapy services and has an RMT or MT-BC a minimum of 20 hrs. per week. A program proposal must be submitted for approval to the AMTA Clinical Training Committee. AMTA has responsibility for the clinical internship programs. The Clinical Training Director must be a professional member of AMTA; hold the MT-BC credential (effective 1/1/88); be retained by one or more settings for a minimum 20 hrs. per week; have a minimum of 3 years full-time, post-internship experience (or equivalent); one year full-time experience in facility; and completion of one 5-hour CMTE workshop on Music Therapy Intern supervision or other documented training.

An Overview of the AAMT Model

Accreditation

Academic institutions offering music therapy programs shall be accredited by a professional or regional agency. Schools may apply for both NASM accreditation and AAMT Model approval or only AAMT Model approval. The National Association of Schools of Music (NASM) and originators of the AAMT Model established a consultative relationship which serves to unify procedures and schedules for review for schools seeking both accreditation and AAMT approval and to provide consistency between accreditation and approval standards.

Faculty

The academic institution shall employ a sufficient number of music therapy faculty who are qualified by education and experience to administer the music therapy program, teach core courses, advise music therapy students, and organize and supervise field and internship training programs. The academic institution determines the qualifications of faculty.

Approval Standards

Approval standards are established for both the Baccalaureate and Master's degrees. The ultimate measure of the quality of an educational program in music therapy is the extent to which graduates of the program have acquired the competencies needed to practice music therapy. A list of required competencies has been formulated to serve as the focal point for all approval standards. That is, all variables and factors affecting the quality of a program (as outlined in the AAMT Model standards) are viewed in terms of what effects they have on enabling the student to acquire the competencies of a music therapist. In short, the AAMT Model standards

have been formulated according to a competency-based approach. The standards seek to insure the end result of education and training (e.g., student competencies) rather than to dictate or mandate specific educational or training procedures (i.e., curricular requirements, internship specifications, field agency limitations, specific qualifications of academic and field personnel, etc.).

AAMT Model Essential Competencies

The list of required competencies includes the following content areas: Musical Foundations (Music Theory and History; Composition and Arrangement; Major Performance Medium; Keyboard; Guitar; Voice; Nonsymphonic Instruments; Improvisation; Conducting; and Movement); Clinical Foundations (Exceptionality; Dynamics of Therapy; The Therapeutic Relationship); Music Therapy (Foundations and Principles; Client Assessment; Treatment Planning; Therapy Implementation; Therapy Evaluation; Discharge from Therapy; Communication About Therapy; Interdisciplinary Collaboration; Supervision and Administration; and Ethics). (Bruscia, K.E., Hesser, B. & Boxill, E. H., 1981).

Pre-Internship Field Training and Internship

The academic institution has primary responsibility for the education and training of its students; including both the pre-internship field training and internship, which requires a minimum of 900 clinical hours over an extended period of time. Internships are designed to meet the individual needs of the student.

For other standards related to education and clinical training (NAMT and AAMT Models) refer to: *NAMT Standards and Procedures for Academic Program Approval; NAMT Clinical Training Guidelines; NAMT Standards of Practice for Music Therapy Educators; NAMT Professional Competencies; Manual for AMTA Approval of Educational Programs in Music Therapy under the AAMT Model; and the AAMT Model Essential Competencies.* Other resources include the *AMTA Standards of Clinical Practice* and the *AMTA Code of Ethics*.

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Bruscia, K.E., Hesser, B. & Boxill, E. H. (1981). Essential competencies for the practice of music therapy. *Music Therapy*, 43-49.

Discussion

Discussion centered around the new model and the meaning and implications of it being competency-based. Barbara Hesser, who was a representative on the American Music Therapy Association Commission on

Education and Training, the group that formulated the new standards proposed by AMTA, was in a key position to answer many of the questions.

Universities will translate the competencies into courses. Questions and concerns were raised about who would teach the courses and whether a university could employ whomever they like to teach a course. It was felt that they would probably not gain approval of AMTA unless they employed a person who met the proposed new AMTA standards for academic faculty and clinical supervisors. Under the former NAMT model, faculty authorization by the Association was required for program approval. However, in the proposed new model, the university would determine who was qualified based on Association standards.

This system is very different than that used in other countries, where a person must be recognized by a government law as being able to teach. The change from a mandated curriculum to one that is based on competencies generated discussion and concerns.

A major concern was how music therapists from the United States would be evaluated if they had not met certain course requirements. The point was made that this ability to evaluate music therapists from one system to another is exactly the point of this two-day Symposium. Questions about how competency-based education related to practices in other professions were raised but not answered at this time.

Barbara Hesser reported that the AMTA Commission on Education and Training had moved to the use of competencies because of the wide variety of what was being taught in courses, even when the courses had similar names.

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**Schools Approved by the
American Association for Music Therapy**

	Northridge, CA	Dept. of Music,
	91330-8314	Theatre, and Dance
Alabama	(818) 677-3174	Fort Collins, CO
	Ronald Borczon, MM,	80523
U. of Alabama	MT-BC	(970) 491-5888
School of Music		William Davis, PhD,
P.O. Box 870366	Chapman University	RMT
Tuscaloosa, AL	School of Music	
35487-0366	333 North Glassell	*Naropa Institute
(205) 348-1432	Street	2130 Arapahoe
Carol A. Prickett,	Orange, CA 92866	Avenue
PhD, MT-BC	(714) 532-6032	Boulder, CO 80301
	Kay Roskam, PhD,	(303) 546-3590
Arizona	MT-BC	Laurie Rugenstein,
		MT-BC
Arizona State	*University of the	
University	Pacific	District of Columbia
School of Music	Conservatory of	
Box 870405	Music	Howard University
Tempe, AZ 85287-	Department of Music	College of Fine
0405	Therapy	Arts/Music Dept.
(602) 965-7413	Stockton, CA 95211	Childers Hall
Barbara Crowe, MM,	(209) 946-3194	Washington, DC
MT-BC	David Wolfe, PhD,	20059
	RMT	(202) 806-7136
California		Donna Washington,
		MCAT, MT-BC
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NEW DEVELOPMENTS IN MUSIC THERAPY

Barbara Hesser, MA, CMT

New York University

I have been training music therapists now for 25 years. We have seen a lot of changes in the profession and discipline in this time. It is encouraging that the uses of music in/as therapy have grown to such an extent.

1. There seem to be four large areas emerging: Music in Medicine; Music in Psychotherapy; Sound and Music Healing; and Music in Special Education. And the development of each of these areas is encouraging.

2. We have explored the use of music therapy with more clinical populations. We are practicing in a wider variety of settings - which influences the kind of therapy we do.

3. There are more MT clinical approaches available for the student to choose from. These approaches have been developed in more depth over recent years. i.e. Now we have 3 levels of Nordoff -Robbins training.....when 25 years ago we did not even have an official training program in Nordoff - Robbins.

4. There are more music therapy materials available in many new books and journals. The area of theory and research is expanding. We now have qualitative research as well as quantitative. There are more theoretical materials both indigenous and non - indigenous.

The Entry Level

The American Association for Music Therapy model of training uses competencies (Bruscia, Hesser & Boxill, 1981) to guide entry level training. Entry level training programs (bachelors degrees and equivalencies) are designed to offer beginning students a broad understanding of the field of music therapy. Students are encouraged to develop a basic understanding of established music therapy approaches and their application to many different client populations. They are taught to assess clients, plan and carry out music therapy treatment, and evaluate this process. The student is encouraged to develop flexible musical skills that can be applied with a wide range of clinical populations. This training is intended to prepare the music therapist to enter the job market with a basic understanding of the profession.

Currently, certification in music therapy in the U.S. is at the entry level. Training takes place at the bachelor's degree level or in an equivalency program as part of an MA.

Beyond Entry Level Training

Because of these many areas of development in our field it is obvious that it is now necessary to offer training to the music therapist beyond the entry level. It is no longer even possible to offer a full generalist training at the entry level as we in the US initially proposed. There is now just too much material at even an entry level to cover in the time allowed.

Over the years, comparatively few music therapists in the U.S. have taken an advanced clinical training in music therapy, but the numbers are growing. Those who sought advanced training often opted for degrees in other professions to expand their skills. (Psychology, special education, recreation therapy, etc) At the present time there are relatively few colleges, universities, or post graduate institutes that are offering advanced clinical training programs in music therapy. We will want to develop more advanced training in music therapy - masters, doctoral, and post graduate training programs- to provide the advanced training that will be needed by music therapists in the next years. We need to encourage entry level therapists to continue their education in order to better prepare them for our growing profession.

The music therapy organizations need to create advanced competencies that address the various skills and knowledge needed by advanced clinicians to guide this development. Perhaps an advanced credential for music therapy will also need to be developed. It would be impossible for any one university or college to offer the expert music therapy staff and curriculum required for training students in every area and level of advanced practice. Each college or university could offer a specialization which emphasizes the strengths and talents of its music therapy faculty and affiliated clinical programs and supervisors. Each graduate program can specify which advanced competencies of many they will focus on in their training. Different advanced competencies can be addressed in masters degrees, doctoral degrees and post graduate training programs. Each advanced specialization might necessitate a different type and length of training.

Development at New York University

It is not possible in a short time to discuss this important topic fully - but I would certainly like to continue this dialogue with you over the next days.

I have devoted the last 25 years life to the exploration and development of advanced music therapy training. Many years ago I closed the undergraduate entry level music therapy program at my university to focus exclusively on advanced clinical training. The U.S. had many entry level programs at that time and few advanced training programs. I wanted to concentrate my energies on the development of advanced training. To that end I have developed an advanced MA, a DA and many continuing

education and post graduate training opportunities for clinicians who do not wish to pursue a doctorate.

Areas and Levels of Practice

The areas of Music therapy that I describe are: Music Medicine, Music in Special Education, Music Psychotherapy, and Music Healing. Because of my clinical interests and the expertise of my current clinical faculty, I focus my advanced training programs on the area of MUSIC PSYCHOTHERAPY.

I also talk about three LEVELS OF MUSIC PSYCHOTHERAPY- supportive, reeducative. and reconstructive (Wolberg, 1967). The LEVELS of Practice that I am aiming for at NYU are - Reeducative and Reconstructive Music Psychotherapy . The MA and the N-R Certification Program at NYU focuses on helping students achieve a reeducative level of music psychotherapy practice; the GIM Certification program and the doctoral program moves students toward a reconstructive level of practice. Students are carefully auditioned and interviewed and we select those students who demonstrate the ability and readiness to practice in this particular specialization.

Masters Degree

The masters level goals for this program are:

1. To further the breadth and depth of the entry level competency areas - musical foundations, clinical foundations, and music therapy. No matter how good the entry level training program is at this time the student still arrives with areas of music therapy that were not covered, entry level literature that has not been read, approaches to music therapy that were not studied, musical skills for the practice of music therapy that need work
Courses: Advanced Seminar, Independent Study
2. To deepen the understanding of Music Psychotherapy and levels of practice
Courses: Key Concepts in Music Therapy
3. To select a patient population and study in depth the needs and problems that affect these specific clients (i.e. mental, emotional, physical, spiritual, sociological, ethical, etc.).
Courses: Psychology electives, Clinical Supervision
4. To develop a music therapy treatment approach that is best suited to the needs of this clients population and the skills and abilities of the therapist. This can involve studying an already established approach to music therapy such as N-R or developing a new MT approach. A treatment approach requires that a student:
Courses: Specialization coursework, i.e. N-R courses, advanced supervision seminar and onsite supervision

A treatment approach involves:

- Developing an in depth understanding of the dynamics and processes of individual and group music therapy for this population.
Courses: Advanced Supervision Seminar, Independent Studies,
- Developing a theoretical framework and context for the treatment
Courses: Theory Development in Music Therapy
- Expand the ability to use music in the treatment approach.
Courses: Advanced clinical improvisation, Music supervision of clinical

work

5. To expand a student's personal awareness and help them recognize the impact of their personality on the music therapy process.
Courses: Music therapy group, advanced supervision

The final project in the MA is a masters thesis which describes in depth the clinical specialization of the student

Doctoral Degree Program in Music Therapy

The DOCTORAL DEGREE is designed for practicing music therapy clinicians with many years of clinical experience as well as a music therapy masters degree. We chose professionals who have a well developed clinical music therapy approach. The doctoral curriculum offers advanced competencies in the areas of qualitative clinical research, advanced music therapy supervision, teaching and group leading skills. I believe qualitative research is an area that needs exploration and application in the field of music therapy and allows the advanced clinician to deeply study the process of their clinical work.

Continuing Education and Post Graduate Training

Designed for clinicians who do not wish to pursue a doctoral degree. This is an ongoing concern. Things tried over the years:

- Post graduate Training Institutes: N-R ; GIM; developing other clinical specializations - i.e. Analytic Music Therapy, mind-body approaches. I am exploring the possibility of an integrative music psychotherapy institute that offers one core curriculum and a number of possible specializations which are practiced by different faculty.
- summer advanced training institutes,
- music therapy renewal retreats - week long experiences for practicing music therapists,
- gatherings of advanced music therapists for day long seminars - i.e. Transpersonal Music Therapy
- conferences on specific topics i.e. Rusk, Beth Israel,
- ongoing music therapy experiential group for professionals (6

years)

- ongoing advanced supervision groups

Thoughts for the Group

Benefits I have seen from advanced training over the years

- opens new doors for practice with new client populations
- encourages greater salaries
- allows music therapists to have a more respected place on clinical treatment teams
- allows music therapists to provide more primary treatment to clients
- gives entry level music therapists within the field an opportunity to further their education in their own field

Other Issues

1. Advanced training must be developed after the concept of entry level training has been concretized.
2. Competency based approach makes this very much easier.
3. Amount of training and at what level should be determined by the Area of practice and the level of practice to be attained
4. Amount of training should also be patterned after comparable professions in the country.

In US -

Psychiatry - 4 years university, 4 years medical school, 2-4 years internship and residency in psychiatry, sometimes psychotherapy institute training

Clinical Psychology - 4 years university training in psychology, 5 years doctoral study in clinical psychology, sometimes institute training

Social work - 4 years university, 2 years MA, post graduate certification for private practice, sometimes institute training

5. Some of the new areas of music therapy practice require more training - music psychotherapy, private practice, work with clients formerly seen in therapy with psychiatrist and clinical psychologists in verbal psychotherapy

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Discussion

It was pointed out that an important issue in the UK is how to combine clinical work with research. Fairly recently there is also interest in each university finding its specialty. Helen Odell Miller's university, Anglia, has

received pressure from the government to move toward undergraduate training. This seems to be motivated by universities and the possibility of less expensive health.

Barbara suggested that most people create their own approach, such as a theoretical context or deeper look at music. She said that her students can dip into several areas, but not do their certification in one and also dip into another.

It was suggested that we can compare specializations with the medical world where all physicians have specializations.

It was asked whether the specializations of the NYU graduates have labels. The response was that no, the only labels are if graduates have a certification, such as Nordoff-Robbins or GIM.

A question was raised regarding music in psychotherapy vs. music as psychotherapy. Barbara answered that music is used on a continuum: Music can be used in and as therapy in her model; and an entire session can be done with music, or can be done with verbal processing.

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NORDOFF-ROBBINS TRAINING WORLD-WIDE

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Introduction to the Nordoff-Robbins Approach to Music Therapy

Paul Nordoff (1909-1977) and Clive Robbins (b.1925) began their collaboration in 1959 when they met by chance in a Rudolf Steiner school in Britain, where Robbins was a teacher of children with special needs. Nordoff was an American composer and pianist with involvement in the anthroposophical movement while Robbins had a commitment to bringing creative experiences through the arts to children in his care. Their meeting and subsequent pioneering work at Sunfield School is well-documented in their first book, *Therapy in Music for Handicapped Children*. (Nordoff and Robbins, 1971)⁵⁵ and even at this early stage, key elements of the approach are already apparent. Four aspects in particular are evident:

- The belief that within everyone is an innate responsiveness to music.
- Use of improvised music as the primary medium of the therapy.
- Tape recording, analysis and evaluation of the sessions so that goals, both musical and personal, could be identified.
- Belief reinforced by evidence, that changes brought about in the musical relationship would be reflected in the client's emotional, physical, cognitive and psychological well-being.

As the work of Nordoff and Robbins became widely known through lectures, workshops and demonstrations, it attracted research funding from various sources including the National Institute of Mental Health, U.S.A. They subsequently spent five years (1962-67) working on a music therapy project as part of a team at the 'Day-care Unit for Psychotic children under 7' in the University of Pennsylvania in Philadelphia. From this work came much of the contents of '*Creative Music Therapy*', (Nordoff and Robbins, 1977)⁵⁶ which is a key text in Nordoff-Robbins training. Each of the five sections of the book contains a core aspect of the training:

1. Meeting the Music Child
2. Three Case Studies
3. Clinical Techniques and Procedures
4. Evaluation
5. Developing Musical Resources

⁵⁵ Nordoff P. and Robbins C.1971, *Therapy in Music for Handicapped Children*, London: Gollanz

The first training course run by Nordoff and Robbins began in 1974 based on these five areas, and despite changes in the intervening years, they continue to be at the heart of all developments.

NORDOFF-ROBBINS TRAINING COURSES FROM 1974 -2000

LONDON

Course established: 1974

Situated at the Nordoff-Robbins Music Therapy Centre, London, U.K. Maximum number of students: 12

Status: 2years full-time Masters Degree (MMT)

Admission: Entry level -following music degree or equivalent

HERDECKE

Course established: 1982

Situated at the University of Witten/Herdecke, Germany

Maximum number of students: 16

Status: 2 years full-time Diplom/Masters

Admission: Entry level - following undergraduate music degree or equivalent

NEW YORK

Course established: 1990. Situated at New York University, USA

⁵⁶ Nordoff P. and Robbins C.1977,*Creative Music Therapy*, USA: John Day

Maximum number of students: 12

Status: 3 levels - 1-2 years

Level 1: Basic N-R education; Level 2 - Advanced N-R clinician; Level 3 - Educator

Admission: Advanced level following undergraduate music therapy degree or equivalent

PRETORIA

Course established: 1998. Situated at University of Pretoria, South Africa.

Maximum number of students: 8

Status: 2 years full-time Masters Degree.

Admission: Entry level following undergraduate music degree or equivalent.

SYDNEY (proposed course)

Course planned to commence: 2001.

Situated at University of Western Sydney, Australia.

Status: 2 years part-time Graduate Diploma.

Admission: Entry level following undergraduate music degree or equivalent.

Each of the training courses has its own character and specific curriculum in line with the academic demands and the cultural environment of the country. Each course will be validated and accredited by the national music therapy association. However, in order to use the name of Nordoff-Robbins, certain key criteria are mandatory. These are laid down by the

International Trust for Nordoff-Robbins Music Therapy.

INTERNATIONAL TRUST FOR NORDOFF-ROBBINS MUSIC THERAPY

The International Trust was set up in 1996 with the following aims:

1. To protect the use of the name 'Nordoff-Robbins' in all matters relating to fund-raising, clinical work and training.
2. To safeguard the intellectual property of Nordoff-Robbins Music Therapy including archive material.
3. To uphold standards of Nordoff-Robbins clinical practice and training.

The criteria laid down by the International Trust are as follows:

1. The Head of Training must have trained on a recognised Nordoff-Robbins course.
2. All training must be informed by the approach to music therapy developed by Paul Nordoff and Clive Robbins.
3. The curriculum of each course should be based on criteria drawn from the first Nordoff-Robbins training course (London, 1974), but is open to amendment according to the academic and cultural environment of the country.

ASPECTS OF TRAINING

The following aspects of training are common to all Nordoff-Robbins courses, either as components or as pre-requisites to entry on the course. The detail and delivery of these aspects varies from course to course.

MUSIC STUDIES

 Musical Resources / Clinical Improvisation

 Clinical techniques and Procedures

CLINICAL STUDIES and PRACTICE

- Observation of Clinical Work
- Nordoff-Robbins archive and contemporary case studies
- Clinical placements with child and adult clients, individual and group
- Tape analysis, indexing and supervision
- Relevant supporting theory: therapeutic, psychological, musicological

PERSONAL DEVELOPMENT

This varies from course to course but may include:

- Personal Music Therapy
- Group music therapy
- Clinical Support Group and pastoral care

Voice and / or movement

THEORETICAL / ACADEMIC STUDIES

- Critical and comparative study of music therapy literature
- Written course work: case studies and theoretical essays
- Research methodology and Dissertation

PROFESSIONAL STUDIES

- Evaluation and assessment -Nordoff-Robbins rating scales
- Medical and supportive studies
- Multi-disciplinary team-work -presentation skills

Discussion

Only the New York University N-R training is at an advanced level (advanced level certification) since people must be at the master's level in order to do it. The other programs are all entry-level.

The question was raised as to whether there are differences in entry-level and advanced training, and whether this has been addressed. In the UK, entry into the N-R training is the same as into other programs: conservatory music study, a university music degree or other relevant course of study. In the U.S., the NYU program does not give the music therapy credential since their students are already music therapists when they take this training. In the other N-R course the music therapy credential is part of the training.

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German Models of Training

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The politics of the German music therapy societies was to establish Music Therapy Trainings in Public/Governmental Universities. I, as a representative of these developments, focus in this presentation on the eight German public models. There are also many different private courses and institutes which follow their own guidelines.

The AMA Group, a working group of directors of music therapy trainings at governmental universities, meets every year in November. One delegate of the private courses SAMT Group is included in this meeting, as well as a delegate of the Kasseler Konferenz, another working group of all German music therapy societies. The aim is to discuss professional quality standards and develop guidelines as orientation for the programs.

The years 1978 - 1980 were important for German music therapy when the postgraduate development of a program started in the Mentorenkurs Herdecke, led by Konrad Schily and Johannes Th. Eschen, was recognized by the government. The curricula that were developed by these pioneers; the students, who all had a university degree in music, musicology, psychology, or pedagogics; and their professors, are basic to the postgraduate programs today on a Diploma (Masters) level. After this start, Hamburg was the first University of the Arts that took over these curricula of the pioneer group.

The starter in Herdecke was a two year, full-time course, bilingual (German and English), with an international staff of professors. The two main strands of methods were the Analytical Music Therapy, initiated and primarily trained by Mary Priestley, and the Nordoff/Robbins approach, primarily trained by Clive and Carol Robbins.

In addition to the development of postgraduate training as entry to the profession, there started in Heidelberg a program on the graduate level, Fachhochschule, today called University of Applied Sciences, led by Volker Bolay, Walter Selle and Rainer Boller.

As you can see in the chart we have today 8 university programs, all entry to the profession:

Graduate levels, Fachhochschule: Heidelberg and Magdeburg (just began in 1999)

Postgraduate levels, Universities with Diplom (Masters): Hamburg, Witten/Herdecke, Münster, Berlin

Postgraduate levels, Universities with Advanced Studies, Certificate: Frankfurt/Main, Siegen

German music therapy methods focus on psychotherapy.

Since January 1999 Germany has had a law as to who can be a psychotherapist. This protected title does not include music therapy, which means a confrontation with new psychotherapy guidelines and the approbation title for music therapists, if they intend to do psychotherapy.

Some programs like Berlin and Hamburg have reformed their curricula to discuss the recognition as music psychotherapy. The politics for music therapy, comparable with standards of psychotherapy as a protected title, is discussed in the societies.

There is a difficult discussion to decide on who would be covered with a protected title.

The AMA Group developed guidelines for Lehrmusiktherapie, music therapy self-experience, as one important subject in training the own therapy process of the students. This is the important focus in psychotherapy oriented programs like Hamburg, Berlin, and Münster.

Three study areas in Berlin are:

1. Clinical - Music Therapy Studies (Lehrmusiktherapie, individual experiential training, and Clinical Practice with supervision, paid separately)
2. Music Studies
3. Medical, Psychological, Scientific Studies

The various courses work on quality standards professional comparison of the contents and examination procedures.

German Models of Music Therapy -- Public/Government Universities

Name of University	City	Professors	Level
Hochschule der Künste Fakultat Musik, Seminar Musiktherapie Weiterbildungs – und Ergänzungsstudiengang	Berlin	Prof. Dr. Mechtild Jahn-Langenberg Prof. Dr. Karin Schumacher	Masters Diplom 3 years postgraduate part time course
Hochschule für Musik und Theater Institute für Musiktherapie Aufbaustudium Musiktherapie	Hamburg	Prof. Dr. Hans Helmut Decker- Voigt Prof. Eckard Weymann	Masters Diplom 3 years postgraduate part time course
Westfälische Wilhelms- Universität Institut für Musikpädagogik Zusatzstudiengang Musiktherapie	Münster	Dr. Rosemarie Tüpker	Masters Diplom 2 years postgraduate full time course
Universität Witten-Herdecke (privat) Medizinische Fakultät Institut für Musiktherapie	Witten- Herdecke	Prof. Dr. Dagmar Gustorff Prof. Dr. Lutz Neugebauer	Diplom 2 years postgraduate full time course
Fachhochschule Heidelberg University of Applied Sciences Fachbereich Musiktherapie Studiengang Musiktherapie	Heidelberg	Prof. Dr. Volker Bolay Prof. Dr. Ernst- Walter Selle Prof. Dr. Rainer Boller	Graduate Diplom 4 years full time course
Fachhochschule Magdeburg University of Applied Sciences Fachbereich Sozial- und Gesundheitswesen Diplomstudiengang Musiktherapie	Magdeburg	Dr. Manuela Schwartz Thomas Wosch MA Dr. Christoph Louven	Graduate Diplom 4 years full time course
Fachhochschule Frankfurt/ M. University of Applied Sciences Weiterbildendes Studium Sozialpädagogische Musiktherapie	Frankfurt/ Main	Prof. Dr. Almut Seidel	Advanced studies certificate 3 years part time course
Universität - Gesamthochschule Siegen Musikalisch-therapeutische Zusatzausbildung für Helfende Berufe	Siegen	Prof. Hartmut Kapteina	Advanced studies certificate 3 years part time course

Discussion

Since this presentation focused on the public training courses in Germany, there was a

question about how many private courses there were. There are many, including:

Private Courses (SAMT Ausbildungsinstitute)

Europäische Akademie für psychosoziale Gesundheit und
Kreativitätsförderung Abt. Integrative Musiktherapie
Dr. Isabelle Frohne-Hagemann

Akademie für angewandte Musiktherapie Crossen Fachklinik Klosterwald
Dr. Christoph Schwabe

Institut für Musiktherapie Freies Musikzentrum München
Dr. Monika Nöcker-Ribaupierre, Dr. Tonius Timmermann

Orff-Musiktherapie am Kinderzentrum München
Dr. Melanie Voigt

Institut für Musiktherapie Berlin
Petra Jürgens

Musiktherapeutische Arbeitsstätte e.V Berlin
Georg Mayer

Mechtild spoke of trying to get "music psychotherapy" as a protected title. The discussion focused on the fact that it would be difficult to determine who would be covered with a a protected title, and that having a protected title is very unusual.

The courses have different contents, including examination procedures and status (qualifications). The courses in Berlin, Hamburg, and Münster are all psychotherapy oriented. Berlin includes three study areas: clinical, art and music, and scientific/ theoretical. Students in that course now need experiential training. This is done individually and is paid for privately.

Prof.Dr.Mechtild Jahn-Langenberg, Dipl.-Musiktherapeutin

Hochschule der Künste FK 3

Seminar Musiktherapie

Mierendorffstr.30

10589 Berlin

Tel.030/3185-2552

Fax 030/3185-2680

e-mail: langenmu@hdk-berlin.de

SOUTH AMERICAN MODELS OF TRAINING

Mayra Hugo, MT

Pereira Rossell Pediatric Hospital, Uruguay

My work for this symposium involves nine Latin-American countries, where, somehow, and in many different ways, there is activity around Education and Training in Music Therapy. I'm going to go through Music Therapy's history in South America, to better understand the present situation.

Music Therapy in Latin America started formally in Argentina in 1966, with Dr. Rolando Benenzon, psychiatrist, as the principal starter. He and a group of doctors, psychologists, phonoaudiologists and Music teachers who gathered around ASAM(Argentinean Association of Music Therapy), achieved the opening of the first University Training Course in Latin America, at the "School of Paramedic Disciplines", which is part of the School of Medicine of the private University of El Salvador, in the Capital City of Buenos Aires. This will be the only Music Therapy training course in the area which will be part of a Medical School.

Almost at the same time, in 1968 the Music Therapy Association of Rio de Janeiro, Brazil, was created, and the next year, The Uruguayan Association of Music Therapy also started. Soon, activity in Peru, Venezuela and Colombia, was being developed.

It was not until 1981, that a third country in South America started with training. It was in Uruguay, where a non-official (with no recognition from the government) course that formed part of a small School of Arts, was opened.

Brazil and Argentina are the two countries where there has been a constant growing of the discipline, thanks to the fact that, Music Therapy received official recognition, almost from the beginning. In the rest of the continent, we also find activity around Music Therapy, but not in the official ground. This particular situation, causes the development and growing of the discipline in the different countries, to be sharply uneven and diverse.

The Latin American Music Therapy Committee

In 1993, during the 7th World Congress held in Vitoria, Spain, the Latin-American Music Therapists who participated created a ground of exchange and communication between Latin-American countries, since some of them had similar professional realities, and also similar historic, political and cultural circumstances. A council was created, integrated by Music Therapists that represented those countries.

At the present time, The Music Therapy Latin American Committee, has its own statute and functioning rules, and has been supporting the development of the discipline by helping in the organization of congresses and different kinds of events, such as 2 Latin-American Encounters, held in Rio de Janeiro in 1996 and 1998.

The principal goal of this Committee is to create a communication and exchange net between Latin-American countries, taking care of the needs of each country, in aspects that have to do with the diffusion of music therapy, the development of research projects, as well as, and very especially, the education and training of the music therapists.

Activity Around Music Therapy

Today, we find that in Latin America we have 3 countries with official activity, and 6 more where a lot of non-official activity is being held. There are:

Ten Official Undergraduate Training Courses, which are distributed as follows:

Four in Argentina

- * University of Salvador (1966) (private) Faculty of Medicine School of Paramedic Disciplines
- * University of Buenos Aires (U.B.A) (1993) (free)
- * Interamerican Open University (U.A.I.) (private) branch Rosario, 1991; branch Buenos Aires, 1996

Six in Brazil

- * Art Faculty of Parana (1970) ,
- * Brazilian Conservatory of Music (1972)

- * Catholic University of Salvador (1991)
- * University of Riberao Preto (Sao Paulo) (1994)
- * Paulist Faculty of Arts (Sao Paulo) (1998)
- * Federal University of Goias (1999)

Five Official Postgraduate Training Courses, distributed as follows:

Four in Brazil

- * Brazilian Conservatory of Music (1993) (Rio de Janeiro)
- * Federal University of Goias (1997) (Goias),
- * Paulist Faculty of Arts (1999) (Sao Paulo),
- * Carlos Gomez Faculty (1999) (Sao Paulo),

One in Chile

- * University of Chile (1999)

Besides all this "official" activity, we find that there are:

- * Around 10 non-official courses of different sorts and lengths, that take place in different countries, such as: Mexico, Peru, Argentina, Brazil, Colombia, Cuba and Venezuela. The training course that started in Uruguay in 1981, gave place to the creation of P.E.M.U. (First School of Music Therapy of Uruguay) in 1992, that could not continue after 1994 due to financial problems.
- * 21 Music Therapy Associations, which are distributed as follows: 3 in Peru, 3 in Argentina, 11 in Brazil, 1 in Colombia, 1 in Mexico, 1 in Uruguay and 1 in Venezuela.

These Associations are constantly organizing Forums, Symposiums, Encounters, working for the development of the discipline, and for it to become officially recognized, in the countries where it is not yet recognized. For example, the Uruguayan Association of Music Therapy presented a project to the National University, which suggests that the Music Therapy Training Course be a part of the University School of Music. A program with two options of degrees is being studied by the University authorities: Music Therapist (3 years) and Licentiate in Music Therapy (5 years).

The professionals who are already starting training courses in those countries where we don't find official activity, or who are gathered around associations formed by just a few people, have studied in Argentina, Spain, Brazil, or even Germany. They hold a very important task: To outspread Music Therapy to make it grow and settle in sites where it is usually very little known in real terms and above all, to give this discipline a frame of seriousness and scientific acceptance since in many countries, ordinary people and even other professionals in the field

of health and education, go on believing that Music Therapy is merely “playing music to calm the beasts”.

Music Therapy Training Courses

Each course establishes its own *standards for the entry level*, but in very general terms, we find that there are requirements that are common to all courses.

MUSIC - PRACTICAL SKILLS In most of the graduate courses, there is not an extremely demanding level of requirements. These are around: handling of a melodic instrument; handling of an harmonic instrument; reading and writing in traditional musical notation; being able to sing, accompanying oneself with an instrument; having aptitudes for improvisation.

Besides the musical requirements, the aspirant must go through a **PERSONAL INTERVIEW** in which the aptitudes and desires that move the person to incline himself towards this election, are evaluated.

Basically, the post-graduated courses maintain the same musical requirements, with some exceptions, (those courses which are in the orbit of a Music School) which demands from those interested, to have a superior training in Music. The post-graduated courses are directed to professionals in adjacent careers, such as: medicine, psychology, music, social service, physiotherapy, occupational therapy or psychopedagogy

About the CONTENTS of the courses, in general terms, they all go through the following areas: Music, Psychology, Medical areas and Music Therapy.

In **MUSIC**, the knowledge granted moves around :Musical history, Acoustics, musical perception, vocal and instrumental techniques, ethnomusicology, improvisation, folkloric music and music theory.

In **PSYCHOLOGY**, the following tendencies are undertaken, with different levels of deepness, in the different courses: General psychology, Psychology of development, psychopathology, psychotherapeutic techniques (being psychoanalysis, Gestalt, Social Psychology and the humanistic trends, as the theories mostly mentioned.)

In the **MEDICAL AREAS**, there is an approximation to the study of Anatomy and Physiology, Neurology, Neuropsychology and Psychiatric pathology.

In relation to **MUSIC THERAPY** specifically, we talk about: Origins, Theory and techniques and Research.

All the students go through **SUPERVISED CLINICAL PRACTICE**, with different amounts of demands and timetables.

In some courses, not in all of them, subjects such as Communicational Theories, Anthropology, Sociology, Philosophy, Theology, Ethics and Interdisciplinarity are undertaken.

In general terms, the **MODELS** mentioned in the 9th. Congress have not been part of the contents of regular courses, excepting Benenzon's, which is obviously the best known in the region. In the last years, though, there has been an opening towards other models, and recognized professionals such as Kenneth Bruscia, Joseph Moreno, Edith Lecourt, Kenneth Aigen, Noah Shapiro, Barbara Hesser, Cheryl Dileo, Gianluigi Di Franco, and John Carpenente have been invited to attend different events, especially in Argentina and Brazil, and have taught and shared their work with Latin-American professionals.

Methods such as the Nordoff-Robbins or the GIM are not developed in depth, since we count with no professionals adequately trained in these areas, and in the official level, there isn't any major post-graduate education for Music Therapists. Lía Rejane Mendes, from Brazil is completing her training in GIM here in the U.S.

During this last period of time, the production of theory has been increased. Quite a few books on Music Therapeutic clinical practice and theory have been published in Brazil as well as in Argentina. Well known Music Therapists such as Lía Rejane Mendes and Antonio Milleco,

from Brazil, or Rolando Benenzon, Gabriela Wagner, Mónica Papalía, Patricia Pellizzari, Rubén Gallardo, Gustavo Gauna or Diego Schapira, from Argentina, have already published their work or will be publishing it pretty soon.

Conclusion

I have been talking about history and development of Music Therapy in Latin America for over 30 years, in spite of which this development has been very uneven. We can observe a concentration of the activity in the coast line that goes from East to West in the continent, and a strong increase in the opening of training courses over these last few years.

The Latin-American Music Therapeutic community, is working hard in order to grow and develop, to consolidate even more the courses already in existence, and also, to allow more and more people to find their professional option through this discipline.

It is my desire as a Latin-American, to be able to consolidate these links that bound us together, as well as to widen this exchange to other continents.

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12400 Montevideo, Uruguay
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Discussion

There was a question as to whether there is a distinction between people with psychologist or physician credentials who can practice independently, and those without those credentials who could not practice independently (as is the situation in Italy and France). There is no such distinction in Latin America.

Another question was what is meant by official recognition. Mayra clarified that many things are done on a smaller, unofficial level, but it is difficult to get official recognition because of budgetary issues and the fact that music therapy is not well known.

MUSIC THERAPY TRAINING IN CANADA

Connie Isenberg-Grzeda, MM, MTA, MT-BC
Université du Québec à Montréal, Canada

Structural Aspects of Music Therapy Training

There are four music therapy training programs in Canada, all of which, to date, provide entry-level training at the undergraduate or Bachelor's level. Capilano College in Vancouver, British Columbia, has been offering music therapy training since 1976. This training, which had previously been offered at a diploma level, has been offered within the context of a Bachelor's degree through the Open University since 1990. Université du Québec à Montréal (UQAM) in Montreal, Quebec, has been offering a Bachelor's level program in music therapy since 1985. This is the only French-language music therapy training program available in Canada. Wilfrid Laurier University in Waterloo, Ontario, has been offering a Bachelor's level program since 1986 and University of Windsor in Windsor, Ontario has been offering one since 1990. All but the program at UQAM are four-year university programs. In Quebec, the higher education system consists of two years of mandatory junior college followed by a three-year university undergraduate program. The number of years devoted to music therapy training, per se, however, do not differ among these universities. Whereas music therapy courses are taught throughout the entire length of the university program at UQAM, that is, throughout the three years, they are taught only in the last two or three years of the four-year university programs in Ontario and British Columbia.

Student Population

The student population is varied. A large proportion of students is young and inexperienced as is typical of undergraduate students in North America. Less typically, however, a fairly large proportion of the students is older, already possesses undergraduate degrees and in some cases, graduate degrees, has experience in related fields and is seeking a career change. This reality results in a confounding of levels of training. Whereas the actual training remains entry-level, the student population is one that lends itself to more advanced training sometimes resulting in more in-depth work and some blurring of the boundaries of academic levels of education.

Approval Process

In 1996, the Canadian Association for Music Therapy (CAMT) instituted its approval process for university training programs, subsequent to the development of a document entitled *CAMT Standards and Procedures for the Approval of Undergraduate Music Therapy Programs* (1995). The faculty

of each program responded to a lengthy questionnaire that described all aspects of the program in detail. There was also an on-site visit by a committee during which students and faculty members were consulted. On the basis of the approval process, all programs were granted provisional approval, pending modifications or explanations specific to each program. It is believed that all programs could meet the requirements over time.

The five major areas evaluated during the approval process are:

1. program objectives, philosophy, curriculum and methods of internal review. The curriculum is evaluated for its capacity to help students develop required competencies.
2. capacity of the music therapy faculty to perform all required functions on the basis of number of faculty, credentials and experience
3. student selection and retention policies, including admission criteria and criteria for retention. It is important to note that to respond to the needs of institutional fiscal responsibility, programs are sometimes obliged to fill a certain number of student places, but then students who are deemed unsuitable for this type of training are counseled out of the program.
4. clinical training and practica. All music therapy students in Canada are required to complete a minimum of six hours per week of supervised clinical training for a period of two years during undergraduate training.
5. internship. Each program is required to organize 1000-hour internship experiences for all of its students.

Competency- Versus Curriculum-Based Training

In Canada, training is competency-based. The original competencies, elaborated and approved in 1979, were derived from the American Association for Music Therapy model. The current version of the competencies (second revision, 1993) are described in the document entitled *CAMT Music Therapy Competencies* and this document is complemented by the *CAMT Curriculum Guide* which provides general guidelines for the development of a music therapy curriculum rather than precise and detailed specifications for course content. Course titles within the curriculum guide intentionally remain vague. The link between competencies and courses is concretized through the program-approval process, which requires the programs to demonstrate the teaching of competencies by specifying the courses that provide for the development or acquisition of each of the competencies. This immediately reveals, to the university faculty members and the CAMT, which competencies cannot be developed within the program as it exists, since they are not addressed in any course offered.

The required competencies, as outlined by the CAMT (*CAMT Music Therapy Competencies*) are divided into four major categories:

1. Music Therapy Foundations - this category is comprised of

theoretical knowledge that serves as the underpinnings for the practice of music therapy. It includes music therapy-related knowledge such as, the history of the development of music therapy and music therapy theories, theories relating to the influence of music, theoretical knowledge of music therapy approaches and techniques and knowledge of music therapy literature. In addition, it includes theoretical knowledge derived from the fields of human development, psychopathology, psychotherapy and Creative Arts Therapies.

2. Music Therapy Competencies - this category is comprised of music therapy clinical skills which allow for the unfolding of the therapeutic process. It includes skills required for assessment, treatment planning, interactions with clients within the context of both individual and group therapy, and evaluation. This category also includes skills that promote access to awareness, professional and personal, that serves to enhance the therapeutic experience. Musical expression and interaction, musical improvisation and music therapy self experience are examples.

3. Music Competencies - this category is comprised of a variety of music skills, both theoretical and performance-related that are necessary for clinical work. Knowledge of music theory, history and literature is complemented by instrumental, vocal, movement and conducting skills. The Canadian emphasis on musicianship as the basis for the work of a music therapist is apparent in this category and the previous one.

4. Professional Competencies - this category is comprised of professional knowledge and skills in the areas of communication, team membership, administration and ethics.

The *CAMT Curriculum Guide* facilitates the translation and organization of these competencies into specific course content within the context of a university curriculum. It not only provides guidelines for the organization of program content across the years of training, but also recommends the percentage of time that students should spend on each of the areas of study throughout the program. The Canadian Association for Music Therapy *Curriculum Guide* recommends that 35% of program time be spent on Music Therapy Foundations. This is broken down into 20% for music therapy per se, and 15% for related knowledge. A total of 30% is recommended for Music Therapy Competencies, evenly divided among the areas of clinical training; music therapy theory in practice; and improvisation techniques and self-experience. It is recommended that a total of 25% of program time be devoted to the development of Music Skills, with 20% devoted to practical skills and 5% to theory. The remaining 10% are to be devoted to the area of Professional Competencies.

Graduate Training

The present focus has been on undergraduate music therapy training in Canada. Although this portrait represents the present Canadian reality, it does not currently, nor has it ever, represented the collective will of the Canadian music therapy community. Historically, the desire in Canada had been to establish music therapy training at the graduate level. The first two Canadian programs, that at Capilano College in Vancouver and that at Université du Québec à Montréal (UQAM) in Montreal had been conceived of

as graduate programs. Unfortunately, the institutional and financial support required for the establishment of a Master's program was not available in either city. Faced with the choice of music therapy training at a college, in the case of Capilano, and at the undergraduate level, in the case of UQAM, or no music therapy training program at all, the decision was self-evident. In contrast, the programs at Wilfrid Laurier and University of Windsor were conceived of and developed as undergraduate programs.

The belief in the importance of graduate training for music therapists is as strong as ever in Canada, but whereas the earlier view had been that entry-level training should occur at the graduate level, conflicting views now co-exist. It has become more widely accepted to view graduate training as advanced training, that is, training that follows entry-level undergraduate training. There are some, however, who still believe that entry-level training should occur at the graduate level. Whatever the view, the emphasis on the need for graduate training has prevailed. This has led to several attempts, in different parts of the country, to establish a Master's program. The Open University in Vancouver, the degree-granting institution for the undergraduate program at Capilano College, did succeed in setting up a Master's program with a creative structure which, unfortunately, could only be sustained for one cohort of students. There are currently two other Master's projects being proposed, one at Wilfrid Laurier in Ontario and the other at UQAM in Montreal. The latter is a proposal for a joint music therapy option within the context of a Master's in Creative Arts Therapies program (Université du Québec à Montréal and Concordia University).

The Canadian Association for Music Therapy (CAMT) has been supporting these efforts by developing the *Standards and Procedures for the Approval of Graduate Music Therapy Programs* document (May, 1999). The stated objectives for graduate training specify that this level of training represents advanced music therapy training, that students will be able to make original contributions to the field of music therapy both through their clinical work and through research, and that they will be prepared to take on roles as supervisors and educators within the field of music therapy. In this way, graduate training is designed to both deepen and expand the music therapist's skills.

CAMT has recommended competencies to be attained during graduate training. These consist of advanced competencies in the areas of music therapy theory, methods and clinical skills, including a focus on multicultural issues. In the area of related knowledge, counseling theory and skills and group process theory and skills are emphasized, as are research methods and design. In the area of professional skills, the document emphasizes advanced understanding of ethical issues and the capacity for ethical decision-making, supervisory skills, sophisticated intra- and inter-professional communication, and the capacity to manage conflict through conflict resolution skills.

The Canadian Association for Music Therapy, the professional association representing music therapists nationally, has developed

standards for approval of training programs and for the accreditation of individual graduates of these programs. These standards are, hence, uniform throughout the country. Recognition of graduates by governmental bodies, however, remains a regional issue, with each provincial group of music therapists trying to negotiate with its own province. Levels of recognition, reserved titles and acts, and third party payments are not uniform throughout the country.

Training Programs in Canada

Capilano College/Open University

2055 Purcell Way
North Vancouver, British Columbia V7J 3H5
CANADA
(604) 986-1911 (phone)
Established: 1976
Director: Stephen Williams
Email: <swilliam@capcollege.bc.ca>

Université du Québec à Montréal

Pavillon de la Musique (Musicothérapie)
C.P. 8888, succursale 'Centre Ville'
Montréal, Québec H3C 3P8
CANADA
(514) 987-3000 ext. 8533 (phone)
Established: 1985
Director: Connie Isenberg-Grzeda
Email: <isenberg-grzeda.connie@uqam.ca>

Wilfrid Laurier University

Faculty of Music
Waterloo, Ontario N2L 3C5
CANADA
(519) 884-1970 ext. 2658
Established: 1986
Director: Dr. Colin Lee
Email: <clee@wlu.ca>

University of Windsor

Music Therapy Program
School of Music
Windsor, Ontario N9B 3P4
CANADA
phone: (519) 253-4232 ext. 2793
Established: 1990
Director: Valerie Ivy
E-mail: <vaivy@aol.com>

Discussion

The possibility was raised that the difference between “competencies” vs. “curricula” is whether the program states “the ability to” vs. “the study of” and that many music therapy program may establish the development of competencies through evaluations of curricula. Connie stated that this type of list provides us with a mental structure that states that these courses give students these competencies; therefore this program can be evaluated by them. As to the degree to which it does that, the exact competencies needed may not be specified. Tony Wigram said that he bases an external examination of a course on what the course says is being taught; he then evaluates whether that is what is taught.

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Music Therapy Training in the United Kingdom

Helen Odell-Miller, SRATh (Music Therapy), BAHons, LGSM (MT), M.Phil.

*Addenbrookes NHS Trust Mental Health Services and
Anglia Polytechnic University, UK*

This presentation was based around slides and therefore has been edited to fit with the style of the publication, but reflects the summarised nature of the presentation.

Music therapy training is at postgraduate level in the UK, and music therapy has recently become a State Registered profession under the Council for Professions Supplementary to Medicine (CPSM) together with Art Therapists and Dramatherapists. There are six validated training courses,⁵⁷ which will have to be regularly reviewed by the Arts Therapies Board of the CPSM to ensure standards of training are maintained for public protection.

Why Is Regulation Important?

Generally, state registration exists to protect the public when they are involved in or seeking treatment. In training terms, if a training course does not meet required standards it will have to do so, or cease to train music therapists.

Regulation by Law

As this is now a requirement, there is a need to define basic training. The music therapy profession in the UK already had a basic training document, and a competencies document compiled through the Association of Professional Music Therapists (APMT). The task was therefore to define common elements with the two other arts therapy professions, ensuring that the specific professional requirements for music therapy and discrete elements of each discipline were maintained. Members of the Arts Therapies Professional Associations, and the Arts Therapies Board of the CPSM (which has a high level of professional arts therapists as elected members), met

⁵⁷ Arts Therapies Board JVC Handbook. Obtainable from The Arts Therapies Board CPSM; Park House, 184 Kennington Park Road; London SE11 4BU. Recognised courses run at the following institutions at the time of publication:

Guildhall School of Music and Drama, London
Nordoff-Robbins Music Therapy Centre, London
University of Surrey Roehampton, London
Anglia Polytechnic University (Cambridge)
University of Bristol, Avon
Welsh College of Music and Drama, Cardiff
For more information, APMT publications leaflet 'A Career in Music Therapy' gives details.

together following the State Registration bill being passed in the House of Lords in 1998. They agreed standards and criteria generally and also specifically to each profession. This was a rigorous and useful exercise, and resulted in the publication of the JVC (Joint Validation Committee) Handbook,⁵⁸ upon which this presentation is based.

JVC Handbook

This was prepared for Higher Education institutions, employers, funding bodies, and relevant healthcare organisations. It is used for joint validation of courses at government level, which is now a legal requirement, in addition to internal validation by universities. As mentioned above, it incorporates previous music therapy competencies and basic training documents. These are now summarised below.

Guidelines on Course Structure and Content

Level: All courses must be Post Graduate Diploma level or above
Duration: Courses must be for at least one academic year full-time (or equivalent part-time). This is following at least 3 years music degree or equivalent.

An academic year is 1000 hrs. or 30 taught weeks

General Course Delivery Requirements

There must be written, oral and group-work, as well as research and clinical elements.

- A high proportion of course work must be experiential in nature
- Practical/clinical elements must be integrated with academic/theoretical parts.
- Time must be allowed for independent study

Entry Requirements

- Relevant arts degree or equivalent
Demonstration of arts accomplishment and understanding of academic basis of the relevant art form (music, art or drama depending upon which arts therapy training is undertaken)
Demonstration of personal maturity, commitment, suitability (normally applicants will be at least 23 years old)
Relevant field experience and employability

⁵⁸ Arts Therapies Board JVC Handbook. Obtainable from The Arts Therapies Board CPSM; Park House, 184 Kennington Park Road; London SE11 4BU.

Interview

The JVC Handbook states that:

Applicants should normally be accepted onto a course only after interview by a State Registered Arts Therapist (i.e., Music Therapist for music therapy trainings) and assessment of artistic (musical) accomplishment. They would also have to demonstrate that they meet the criteria stated in the Entry Requirements section above

General Content for All Three Modalities

Practice:

Courses must include:

- Personal therapy
- Clinical work practice
- Personal supervision
- Groupwork as participant and facilitator
- Skills training in the modality
- Further practical experience and training in the relevant art form
- Practical experience of art forms akin to the main modality
- Writing of case studies, management reports, records

Theory:

Courses must include:

-Study of relevant art form, psychology, psychiatry, sociology, psychotherapy, group and individual work, the therapeutic relationship and management of the therapeutic process, the supervision process, cultural and ethical issues, procedures for assessment and evaluation of therapy. Professional matters such as record keeping, code of ethics etc (e.g., mental health act, child protection act) should also be included.

Clinical Skills and Knowledge

Courses must include

- Congenital and acquired disability - its aetiology, diagnosis and implications for

- management and environmental modification
- Disorders of social functioning
- Principal psychotherapeutic interventions and their theoretical bases
- The nature and applications of other major interventions (e.g., speech, occupational therapies)

Clinical Work Practice and Supervision

All trainees must:

- Undertake a substantial period of clinical practice (12-20 weeks) in a wide variety of settings
- Undergo clinical supervision when working clinically
Organization and location of placements must be adequately resourced and planned

Professional Skills Required

- Ability to take responsibility and accept direction and guidance
- Ability to establish a good working relationship with all colleagues
- Awareness of professional and institutional code of ethics
- Insight and self awareness resulting from having personal therapy whilst training
- Experience of working in a multi-disciplinary team, sharing and accessing appropriate information, observing confidentiality and health and safety requirements
- Skills of written verbal case presentation and verbal record keeping
- Direct experience of working with at least two contrasted client groups of which at least 1 should be in adult or child mental health or emotional/behavioural disorder, at least 1 should and at least 1 in adult or child learning disability
- Experience of carrying out referral and assessment procedures and taking clinical responsibility under supervision
- Knowledge of the range of institutional and community settings in which music therapy is provided, the general needs of those clients, and the contribution of music therapy towards meeting them
- An understanding of institutional dynamics and their effect on client functioning

Personal Therapy (General)

All trainees must be in personal therapy throughout the course preferably off-site and with a therapist not involved with the course, but recommended by the course

Specific APMT requirements exist for music therapists as follows:

Personal Therapy for Music Therapists

Students must be in weekly individual therapy to run concurrently with the course.

This must be with either:

A music or arts therapist qualified for a minimum of 5 years or-
An accredited member of the UKCP, BCP or BAC (any other arrangement must be in consultation with course head.)

Clinical Skills and Knowledge

A basic grounding is required in:

Normal human development; normal and abnormal psychology;
normal and
abnormal human communication and language development; mental
illness,
psychiatric assessment and treatment.

Practical Music Therapy Skills Required to be taught (summary)

- Clinical improvisation
- Observation and recording of musical and other behaviour, assessment, and diagnosis.
- Musical and psychological analysis with a view to subsequent treatment
- A wide variety of music therapy techniques
- Planning, implementing, effectively completing and terminating individual and group treatment

Music Skills and Knowledge Required:

- Knowledge of a range of musical cultures, practical skill and knowledge.
- A high level of performance on at least one instrument; and ability to use voice flexibly
- Keyboard skills if not specialising in a harmonic instrument
Ability to improvise fluently and flexibly in a variety of emotional areas, and tonal and atonal idioms
- Highly developed aural awareness
- The ability to make arrangements for unconventional combinations of instruments requiring variable or minimal levels of playing proficiency

Knowledge of Music Therapy Theory (summary of requirements)

- A basic knowledge of the human psychological, physiological and emotional responses to music
- An awareness of the main fields of MT research
- Basic knowledge of historical development of music therapy
- A detailed study of at least one music therapy approach
- A basic knowledge of a wide range of MT approaches and their theoretical bases
- Ability to compare contrast and critically evaluate clinical applications of different MT approaches

Assessment Components Required (General to all three arts therapies)

- Balance between formal assessment (clinical practice assessment) and informal
- Assessment work must be related to practical work
- Shared assessment processes

Minimum requirements for written work: long essay/thesis, case studies, satisfactory performance in experiential work, supervision and presentation in seminars

Additional JVC Guidelines

Instructions must be laid down for external examiners in-put
Timing and procedures for validation events must be specified
Annual monitoring procedures must be available (through external examiners reports)

Other Requirements

Minimum requirements are stipulated in the JVC Handbook for accommodation facilities, library, equipment, sound proofing, audio visual, and other elements.
Health and safety, staff development, and research policies must be available.

Discussion

It was asked whether there are any advantages to being under the CPSM regulations. Helen felt that music therapy is a small profession, but when combined with the other arts therapies groups, there is greater strength in larger numbers.

There was discussion on what external examiners do. The response was that they examine the students on practical skills, and they assess written work. (They give a second opinion, as the lecturer in charge of the course also assesses and marks the written work.) External examiners give validity to the course.

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SCANDINAVIAN MUSIC THERAPY EDUCATION

Dr. Tony Wigram, RMT, SRATsT

Aalborg University, Denmark

There are a variety of different programmes in the Scandinavian countries, and the following material is a summary of the information supplied for these courses. The main purpose of describing this as part of the WFMT Education Symposium was to document current status and to offer some points for guidelines that could be adopted by WFMT.

Norway:

1. Oslo University/Conservertoire of Music

Two Years full-time course following three year undergraduate studies in music.

2. Sogn og Fjordane College. Sandane

Two years full-time following three years education at College/University. Entry possible for musicians, teachers, social workers or health workers.

Norwegian Courses include studies in

- musical arranging, chamber music, ensemble work, composing, instrumental and vocal education
- Music therapy theory, psychology, psychiatry, special education
- music pedagogy
- practical experience

3. Oslo University:

Two years Masters Conversion Course for qualified therapists

Even Ruud established a two-year conversion course for qualified therapists to achieve master's qualifications. Emphasis on additional studies in music therapy theory, research and case study work. Completion of a Master's thesis.

Norwegian Music Therapy courses emerged from the groundwork of Paul Nordoff and Clive Robbins. Now their approach concentrates on three main areas of music therapy practice:

Educational Didactic Music Therapy

Psychotherapeutic Music Therapy
Music Therapy as Community based music therapy

Denmark:

Aalborg University - Five year Integrated Bachelors/Masters Education

The Danish Model is a five-year (full time) integrated music therapy training. Entry criteria from 21 years of age (though frequently student's ages range from 23-35 on entry) include high proficiency in musical skills.

The educational philosophy and foundation is primarily Analytical Music Therapy, and music therapy practised within a psychotherapeutic framework.

The four elements within the course are:

Musical Studies: instrumental and vocal, group ensemble, intuitive music, auditory and keyboard training, guitar, percussion, clinical keyboard skills and Graphic Notation.

Theoretical Studies: Psychology, psychiatry, psychology of music, theory of science, theory of therapy, theory of music therapy, qualitative and quantitative research methods, music therapy research.

Experiential Training in Music Therapy: Psychodynamic movement, Group therapy, individual music therapy, clinical group music therapy, psychodynamic group leading, intertherapy.

Practicum training: three observational placements, two short practicums (1 day a week for 15 weeks) in psychiatry, learning disability or social services, one long practicum (6 months).

Qualification from the course is a Master's Degree in Music Therapy (Cand.Mag).

Sweden

1. Part Time Music Therapy training at Musikhogskolan I Stockholm over three years (soon extended to four years).

Psychotherapeutic orientation involving studies in the following areas:

Music Therapy Theory
Individual therapy
Music psychology

Developmental psychology
Psychotherapeutic theory and methods
Psychopathology (mental and physical handicaps)
Treatment methods
Theory of science and research methods

Practicums in individual and group therapy

Students also have 20 hours individual therapy (GIM) and 50 hours individual therapy as self-experience.

Masters Qualification.

Finland

1. Tampere Institute of Social Work: Degree programme in rehabilitation option: Music Therapy.

A 3.5-year study in music therapy. Entry requirement is a bachelor's degree in music, health care or social services.

The main orientation of the programme is rehabilitation, and psychotherapeutic studies are also emphasised

Studies include:

Courses in Rehabilitation

Music Studies: Instrumental instruction, computer music, music theory and notation, sound recording, basics of music.

Music Therapy studies: Basics of music therapy, therapeutic approach, professional practice, research in therapy, music therapy methods

Group Therapy and Group Process: a taught course rather than an experiential course.

Creative therapies.

Masters Thesis written at the end of the study leads to Master's qualification.

2. North Karelia Polytechnic. Outokumpu: Degree programme in Social Welfare Work: Specialisation line of Creative Arts/Music Therapy.

Eclectic training of 3.5 years. The approaches taught are psychoanalytical, psychodynamic, humanistic-existential, learning-theoretical, and constructive.

The qualification level is Bachelors. The course content includes:

Sociology

Introduction to research methods

Social and health care systems, social change, social philosophy, ethics, and professional growth

Music studies: theory of music, ear training, piano, band/ensemble, vocal training, composition, history of music

Music Therapy studies: group process, theory and method of music therapy, client-based methods, other creative arts therapies, analysis of music therapy process,

quantitative and qualitative research methods.

The qualification is accepted by the Union of Finnish Music Therapy (SUMUKE).

3. University of Jyvaskyla. Bachelor's Degree in Music Therapy

Course Content:

Basic studies: psychology of music, psychotherapy and music therapy, methods of music therapy, music therapy and medicine, analysis and assessment methods in music therapy, group music therapy

Subject Studies: Finnish tradition in music therapy, psychological and psychotherapeutic theories of music therapy, music therapy and medicine, clinical music therapy, clinical improvisation in music therapy, introduction to research in music therapy

Musical Studies: piano, guitar, ensemble, improvisation, arranging, musical analysis, and music history

Clinical Studies and self-experience; three years group music therapy process, clinical training, supervision process.

Qualification in music therapy at Bachelors level, accepted by the Union of Finnish Music Therapy (SUMUKE).

4. University of Jyvaskyla - Master's Education in Music Therapy

Open to qualified music therapists, this course matches the style and content of Even Ruud's Masters programme in music therapy at Oslo University, including selected topics in music therapy, project studies, thesis seminar and master's thesis It is an advanced course for qualified therapists.

5. Functionally Orientated Music Therapy (FMT)

Developed by Lasse Hjelm and taught in Finland and Sweden. Main focus on

rehabilitation of neurological disorders - CP, Mental retardation, autism, Rett Syndrome. Developmental therapy, and not psychotherapeutic. Taught to and used by related professionals. Qualification unclear.

WFMT GUIDELINES NEEDED FOR MUSIC THERAPY EDUCATION FROM THE SCANDINAVIAN POINT OF VIEW:

Entry Criteria:

- Skills and qualifications in music
- Awareness through literature study of music therapy
- Informal experience in clinical situations
- Suitability from the point of view of personality

Course criteria:

- Studies in music including piano, guitar, percussion, improvisation, notation, composition and arranging, and auditory skills
- Theoretical studies including psychology, theory of therapy, theory of music therapy, research methods
- Clinical pathology
- Studies in music therapy methods including group and individual therapy methods, methods of assessment, methods of analysis and evaluation, methods of case reporting
- Experiential Training in Music Therapy including some form of personal therapy and group therapy, and group dynamics
- Practica: undertaking clinical placements supervised by qualified music therapists
- Ethical and professional studies

Examination Criteria:

- Practical, theoretical and music examinations
- Examination by external censors/examiners. A percentage of the course should be externally and independently assessed.
- Examination of clinical competence

Discussion

The discussion focused on external examination. The external examiner examines alongside the internal examiner. The external examiner can fail a student, against the wishes of the internal examiner. However, it is the decision of the university whether the external examiner's assessment carries sufficient weight to fail a student. Clinical work is evaluated by the external examiner throughout the year. The external examiner is often in partnership with the internal examiner. For instance, the external

examiner can help in counseling out inappropriate students. The list of external examiners is revised every 3 years.

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Models of Music Therapy Courses in Australia and New Zealand

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The Australian Music Therapy Association (AMTA) developed Guidelines for Establishing Music Therapy Training Programs in 1977. These Guidelines identified five key areas that were to be included in approved programs: Music studies; Psychology studies; Medical conditions; Music Therapy theory and Clinical Practice. The Guidelines also required that lecturers in music therapy programs had at least two years experience as an accredited music therapist. From 1978-1990 the only course in music therapy in Australia was offered at the University of Melbourne. However in the past 10 years three new courses have been established.

In 1996, AMTA revised the Education Guidelines, and the content areas of the education programs are now expanded and expressed in competencies. AMTA is responsible for the approval of courses, and for re-accreditation through a process of Validation each 5 years. Graduates of courses approved by AMTA apply for Registration with the National Registration and Education Board.

There are two types of education structures within Australian Universities which lead to accreditation (entry to the profession). These are:

The undergraduate degree (4 years duration)

Graduate Diploma (or Post Graduate Diploma) courses (over 2 years), for those with a qualification at tertiary (University) level

Master's and PhD programs are research degrees in Australia. A brief summary of each of the four courses approved by AMTA follow.

University of Melbourne (1978)

4-year undergraduate degree, specialising in music therapy (B.Mus)

2 year Graduate Diploma in Music Therapy (Grad. Dip. MT)

Graduate Diploma in Guided Imagery and Music - advanced level training in GIM

Master's by research; PhD by research.

Content of music therapy courses, includes: Music core subjects (which are pre-requisites for the Grad Dip); Music Therapy theory and practice; Music Therapy Methods; Psychology; Human Development; Music Psychology; Music in Medicine;

Clinical training: 1040 hours

Accreditation: Australian Music Therapy Association.

University of Queensland (1990)

4-year undergraduate degree, specialising in music therapy (B. Mus. Thy)

2 year Post Graduate Diploma in Music Therapy (PGradDipMusThy)

Content of music therapy courses, includes: Music core subjects (which are pre-requisites for the Grad Dip); Music Therapy theory and practice; Music Therapy Methods; Individual and community development; Individual and community health; special education. The model is based on competencies gained over four semesters:

1: observer, describer, reporter; 2: co-leader, integrator, reflector; 3: leader, initiator, developer, evaluator. 4: 'emerging practitioner'.

Clinical training: 1040 hours

Accreditation: Australian Music Therapy Association.

University of Technology, Sydney (1993)

Graduate Diploma; 2 years part time

Qualification: PGrad Music Therapy

Content: Meets criteria of Australian Music Therapy Association

Clinical training: 1040 hours

Accreditation: Australian Music Therapy Association

Nordoff-Robbins Australia and University of Western Sydney, Nepean, (2000)

Graduate Diploma in Creative Music Therapy

2 years; part time

Qualification: Grad Dip Creative Music Therapy

Content: Meets criteria of Australian Music Therapy Association

Clinical training hours: 1040

Accreditation: Australian Music Therapy Association

Australian Music Therapy Association Criteria

MUSIC SKILLS

Includes: Proficiency on principle instrument; improvisation, repertoire, voice skills, aural competency

PSYCHOSOCIAL KNOWLEDGE

Includes: Psychological theories and their applications, group theory and dynamics, the whole spectrum of human development through the lifespan, counselling skills, research methods and statistics.

CLINICAL KNOWLEDGE

Includes: aetiology, symptomatology, treatment of disorders through the lifespan, impact of social policy on health/welfare provision.

MUSIC THERAPY KNOWLEDGE

Includes: History of the profession; an understanding of a wide range of music therapy approaches and techniques, the influence of music on behaviour, music therapy and other creative arts therapies. Music Therapy research

MUSIC THERAPY PRACTICE SKILLS

Includes: The role of music therapy in clinical settings; referrals, assessment, program design, evaluation, reporting and ethics.

At least three placements include the areas of disability, psychiatry, aged care and in a variety of institutional and community settings.

CLINICAL TRAINING

Includes: 1040 hours of supervised clinical training.

New Zealand

The course in New Zealand was established very recently and will take its first intake of students in 2000.

Massey University at Wellington Conservatory of Music (2000)

Master's degree: 2 years full time (can be taken part time)

Qualification: MMus

Accreditation: Committee for University Academic Programs, and the New Zealand Society for Music Therapy

Commencing: 2000

Morva Croxson has been instrumental in getting this course started:

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Contact for prospective course applicants:

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MUSIC THERAPY TRAINING PROGRAMS - EUROPE

Chava Sekeles, OTR, RMTI

The David Yellin College, Israel

1st report: 4th E.M.T. Congress (Leuven)

2nd report 9th Congress of the W.F. M.T. (Washington)

History

The subject "Developing European Training Standards for Basic Competencies," already has a history:

One. Tony Wigram first addressed the topic at the 1992 Cambridge Music Therapy Congress.

Two. Denise Erdonmez-Groce summarized and evaluated the WFMT questionnaire at the 1993 World Congress in Spain.

Three. Tony Wigram held a round table session on the topic at the Aalborg congress in 1995, in which he proposed a minimum number of hours based on a full-time three-year program.

Four. Chava Sekeles brought at the Lisbon EMTC seminar in 1997 another proposal which most members felt was too extensive.

Five. After the above-mentioned seminar, Sekeles distributed a questionnaire to the participants in order to gain further insight into the organizational and therapeutic philosophy of the different European Music Therapy Courses. The results of this questionnaire were brought to the E.M.T. Congress in 1998 in Leuven and now again at the W.F.M.T. Congress in 1999 - Washington.

This last questionnaire addressed the therapeutic philosophy, acceptance criteria, program framework (duration of program, certificate awarded, institutional setting), curricular content/ total hours (music, medicine, psychology, special education, music therapy integrative studies, supervised internship), and specific topics. The general idea was to establish a common standard that will enable and facilitate free movement of music therapists within EMT countries.

After reviewing and summarizing the programs sent to me, I would like to point out the following issues without mentioning the name of any specific program, which I feel would be irrelevant.

Criteria for Acceptance

Some programs only accept candidates with previous academic degrees. Specific background fields may vary, for example:

1. A Bachelor's degree in musicology and psychology/ a Bachelor's degree in music, and a course in developmental psychology.
2. University training either in music or in a health care profession + a reasonable level of proficiency in music.

3. A degree in music or its equivalent. Some programs provide gradual training. For example, the first two years may be devoted to a basic background in music and other subjects, while the next two years focus specifically on music therapy. One school, for example, devotes the first year to general creative studies, and only allows students to choose a specific creative modality afterwards.

4. Other acceptance criteria are: maturity and experience, appropriate personality, personal interview, official and dynamic testing in music, usually including an audition.

It seems to me that, notwithstanding differences in acceptance criteria, there are many similarities in the course requirements. In this particular case, developing a basic standard may be easier than I had imagined. In fact, this is one of the topics I propose for today's discussion.

Duration of Program

Depending on the beginning level of the program, I suggest that two full years of studies be set as the minimum requirement for candidates who have already earned a Bachelor degree in music and have a sufficient background in one of the health professions. Another possibility is a degree in one of the health professions and high level of music.

Main Therapeutic Approach

Most programs have based their approach on one of the well-established psychological models: Psychoanalytic, Psychodynamic, Humanistic, Developmental-Integrative, Gestalt, Eclectic. Generally speaking, there is no possibility of dictating any standard orientation or philosophy, as programs are initiated and established by individuals who stand behind a specific approach. Since this is a very interesting issue in itself, I would suggest organizing a seminar in which program directors deal with the impact of the original philosophy on their music therapy program.

Academic Studies and Workshops

In sum, the following conclusions can be drawn:

1. Many programs lack medical courses. Since music therapy by nature influences locomotion, senses/sensations, vocality - as well as emotions, cognition and socialization - a training program in the field must provide tools for proper treatment of psychological/neurological/physical/medical disabilities. For this purpose, a basic paramedical background is obligatory. From my point of view, we are talking about subjects such as: anatomy, neuroanatomy, pathology, sensory-motor integration, kinesiology, development of speech and language and, of course, psychiatry.⁵⁹
2. Special Education is not always considered important. Taking into consideration the damage that learning disabilities and other childhood problems might cause to the life of the adolescent and adult, courses in special education (at least some main topics) are highly recommended.

3. Some programs offer courses in ethno-cultural topics, but most do not. Music is not an international language - it is a cultural modality. Thus, in order for therapists to be able to practice in any European country, a basic knowledge of the cultural differences is necessary. Moreover, we all know the important role that authentic childhood music might play in the therapeutic process.
4. The U.K. Association of Professional Music Therapists has collected information from all of its schools and integrated it into one basic module of training. This procedure provides a reasonable picture of the distinct and shared aspects of each program. It would be worthwhile for every country with more than one program to follow the same procedure.
5. Research is the Achilles Heel of many programs. In most cases, research projects are part of the requirements for a Master's and/or Ph.D. degree. As research in music therapy is essential and has become increasingly developed, it is recommended to include research methods in each program, even at the stage of basic studies.
6. The student (future music therapist) should be encouraged by his teachers to take psychotherapy for self-development.
7. Generally speaking, there must be a way to design a basic program which includes the following relevant branches of study:

<u>SUBJECT</u>	<u>HOURS</u>
	<u>H=45 Min</u>
Complementary studies in <u>music</u> (after having a previous degree in music)	150-210
<u>Medicine</u>	150-210
<u>Psychology</u>	400-450
<u>Special Education</u>	60-90
<u>Ethno-cultural Aspects of Music</u>	45-60
<u>Research methods</u>	30-60
<u>Integrative Studies in Music Therapy</u> (including theory, workshops, internship and supervision).	1000-1300
<u>Specific subjects</u> (such as movement, visual arts, advanced technology in MT etc.)	90-120
<u>European Examinations</u>	

It would be desirable to consider establishing a European Committee for General Examinations in Music Therapy in order to ensure a basic level of knowledge and maturity, at least for professionals who wish to work in another country. At the moment this is impossible even within one country.

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CONCEPTS AND ISSUES IN EDUCATION AND TRAINING

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Self Experience for Music Therapy Students - Experiential Training in Music Therapy as a methodology - a compulsory part of the Music Therapy Programme at Aalborg University

Ass. Professor Inge Nygaard Pedersen, RMT
Aalborg University, Denmark

Introduction

As a pre-experience for clinical work, students at the Music Therapy Program at Aalborg University, Denmark are placed in the role of "student-clients", over four years, as a preparation for work in music therapy from a psychotherapeutic basis with **many different client populations**.

Overall this part of the **training** program is called "Experiential Training in Music Therapy" (ETMT), and the music therapy **teachers** working in this area are called "Experiential Training Music Therapy Teachers." (ETMT teachers)

The basic method of ETMT at this program is improvisational, active, music therapy as developed primarily by Mary Priestley in her model of Analytical Music Therapy (AMT). This model has been further developed and adapted for the programme at Aalborg University as this Program offers a five-year, full-time Masters level (MA) Degree in Music Therapy.

Important elements in the 5-year training program are:

MUSICAL SKILLS - Musical and clinical approach to vocal, instrumental and keyboard improvisation. Musical repertoire.

SELF EXPERIENCE, - individual and group training in the therapy process

DIDACTICS AND METHODOLOGY - Theory and practice including practice placements with different client populations.

THEORETICAL KNOWLEDGE - Psychology of Music; general and clinical

psychology; Psychiatry; Theory of science and therapy. Theory of music therapy

A comprehensive entrance test includes instrumental and vocal skills, improvisational skills and talents, and a personal interview. 12-15 of over 40 applicants are admitted every year with an average age of 23-45.

Status and Aim of Experiential Training

Overall the ETMT training has an equally important role as a part of the basis training as have basic training in musical skills and theoretical knowledge. The overall aims of this training are as follows:

- to increase the sensitivity and flexibility of the students ability for establishing contact and communication through therapeutic musical experiences
- to explore traumatic blocks, and to develop more personal insight and resources through therapeutic musical experiences
- to develop musical techniques to work with transference and countertransference issues.
- to develop musical techniques to listen to, and to be in a fluent relationship with body, feelings and consciousness
- to generally develop musical techniques to establish and develop contact with clients at different levels.

Therefore ETMT is designed to emphasise the artistic and 'sensitivity' training of the students to be aware of themselves as the resonating tool for music therapy work, and from there to build bridges to their consciousness about methodological possibilities with different client populations. Knowledge is acquired about the connection between their way of understanding people, music, health, and therapy and their theoretical foundation and choice of method.

Why Experiential Training?

Whatever method you use in music therapy, a basic tool is your own presence and mental preparedness as a therapist in just being present, and in musical and verbal communication, with clients. ETMT offers training in learning not only to listen in order to analyse the client or clients music, but also to listen to oneself listening to the client.

The training is very complex, as it has to be done with a clear understanding of the double character of mental resources and preparedness, and how these are experienced and expressed through music. These are, on the one hand, a consequence of a person's life story and actual social circumstances, and on the other hand they are genetically cognitive and emotional fundamentals, with which a person selects, perceives and influences his/her circumstances.

It can be a vulnerable area to work with because of the vital nature of these processes. Exploring your life's experiences and the way you

function some of which you might not find practical or limiting, can be experienced as threatening and anxiety provoking.

So clear ethical rules and a respectful understanding of the processes around the training are necessary.

The Potential Space

In the music therapy training, among other definitions, we use Winnicott`s concept of "the potential space" (or "transitional area"). In the ETMT it is understood as the range of individual and inter-relational possibilities of action, which "student clients" are able to use, and are in contact with, in playing situations during a developmental process. Developing processes means grounding and extending the potential space of a human being.

For groups of "student-clients" the playground of their potential space is:

The group therapy sessions and the every day milieu with the group of students to which they belong

The processes going on with the ETMT teachers (the group music therapist and the individual music therapist) in exploring, grounding and expanding their "potential space."

The ETMT teacher, in a paradoxical way, becomes both:

a kind of partner to the student`s disposition; a person the student may relate to in a very close way

a part of a teachers group in a program where the student has to be evaluated and examined in many other disciplines - even if the ETMT teachers do not have other functions in the program.

Once a year we have a 'check up meeting' in the whole teachers group where serious problems identified with students are addressed and discussed with the involved teachers and the student. We never discuss any personal information but the ETMT teachers can communicate within a confidential frame to a permanent teacher (a professor in the program) issues such as: weak boundaries, extreme anxiety problems, low motivation or a lack of ability for self-reflection etc. At the meeting it is then briefly discussed if those particular issues are evident in the individual student in both Experiential Training disciplines as well as in other disciplines, and it is discussed whether the problem is being dealt with in a responsible way.

The students know that we have these meetings, and that we never bring issues up which have not been discussed with the student beforehand. If there is general anxiety about a student, the student will be immediately informed and advised what to do.

3. The playground for "the potential space" of the students also includes their ability to go into therapeutic processes at the same time as training in many other musical and theoretical disciplines.

The Basic Tools

In the self-experience disciplines the students, as student clients, are trained in the following areas:

Learning to be familiar with their personal improvisational language - especially in music making

Experiencing the power of music as a tool for reflection of mental abilities, limitations and preparedness.

Learning to be part of ongoing dynamic processes over time

Learning to deal with projections, introjections and self-containment in practice.

Learning to develop and keep a high level of sensitivity and flexibility in music therapy practice

Learning how to be vitally involved, and at the same time to survive as a music therapist

Concerning the last area, two issues are important. The students must learn to protect themselves and build up their own energy in, and between, music therapy sessions. The students also have to learn to have their own needs properly fulfilled so the clients won't be placed in a situation where *they* must fulfil the needs of the *therapist*.

The Musical Framework Around ETMT

At the music therapy program music is taught and experienced in many different ways - as formalised knowledge, as skills, as a symbolic product and in different improvisation models. The improvisational models, which are closest to the musical learning processes in ETMT, can be divided into four areas:

Improvisation within identified musical styles

Improvisation based on musical, clinical guidelines not necessarily representing a recognisable musical style

Improvisation based on associations (images, memories etc) symbolically expressed through music

Improvisation expressing inter-relational experiences and identity in music - "here and now relationships" or "as if relationships"

Area 1 belongs to the disciplines of training musical skills whereas areas 2- 4 mostly belong to the disciplines of training therapeutic skills. Area 3 overlaps between disciplines.

Ethical Rules Around the Experiential Training Disciplines

As mentioned above clear ethical rules and a respectful understanding of the processes around the training are necessary.

The most important ethical rules are:

Work takes place behind a closed door and no disturbances are

allowed. There is a "Don't disturb" note on the door, which is highly respected by everyone.

All ETMT teachers are subject to professional confidentiality according to the ethical code for professional music therapists. That means no personal information must be made public. At the same time ETMT teachers, in their role as employees of the university, are obliged to report specific difficulties which may be identified as problematical for further development as a professional therapist.

All sessions are recorded or videotaped for several reasons. The students have a responsibility to reflect on their own process as an added learning process to the therapeutic process they experience. In case of disagreements regarding "serious problems" between the student client and the ETMT teacher, a neutral third party (supervisor) can listen to the tapes to try to double check the evaluation of the ETMT teacher.

Supervision is compulsory for the ETMT teachers.

Taking part in ETMT differs from a purely personal, individual music therapy process. Some special circumstances have to be taken into account:

The student client cannot just choose her/his therapist - (s)he can express wishes about the sex of the therapist and this wish will be accepted if in any way possible. There are, at the most, three therapists available, two females and one male therapist.

There are a prescribed number of sessions available - no matter where you have come to by the end of ETMT. (If the student wants, or needs, to go deeper into her/his personal process (s)he must consider obtaining personal, individual therapy outside the training program).

The development of the therapeutic process will be subject to current evaluation concerning future professional work.

Learning Processes and Ways of Understanding Steps of Progression in ETMT

In the first two years of training where the student is in the client role there is no formal evaluation except for the responsibility of the therapist to be aware of the potential for serious problems for future professional work.

For the ETMT teachers to be able to orient themselves in the direction of this therapeutic process, we have developed the following working schema of learning processes which has evolved through the years to be representational for a wide range of personal 'stories' that emerge in the ETMT:

learning to see/experience intimate relations/parents in the way they are and the way you want them to be (distinguishing ideal from reality)

learning to contain and accept pain, disappointment, aggression, joy

and other feelings related to intimate relationships
In these two steps of the learning process conscious awareness of projections and transferences are addressed musically and verbally.

learning to recognise oneself in "ones own eyes" instead of in the eyes of other

people

learning to act the way you feel is right for you, independent of parent censorship

and of your own defence mechanisms, in a responsible way for yourself and others

In these two steps of the learning process conscious awareness of introjections are addressed musically and verbally.

learning how to develop important tools for clinical music therapy work when you contain feelings at the same time as you allow feelings to appear and to be used as information in the relationship and interaction.

In this last step of the learning process self-containment as a music therapy tool is addressed.

This way of understanding therapeutic learning process is only one way of understanding, and it is related to a psychoanalytical/psychodynamic way of understanding human beings.

Paradoxes

In order to avoid "trust problems" the ETMT teachers have to be conscious of, and to deal with paradoxes such as:

Remember / Forget

The ETMT teacher is the one who is supposed to remember the important information the student brings into the process work. On the other hand the ETMT teacher has to enter each individual therapy session with students knowing exactly nothing - thus letting the student be present and have a chance to "be born" in each new moment.

A Disciplined Way of being present (disciplined subjectivity) / Being rather authentic

The ETMT teacher has to be able to deal consciously with transference and counter-transference. In these situations the work of the ETMT teacher can be compared with that of an actress on the stage - the role must be so convincingly played that it moves the audience.

But at the same time the ETMT teacher must be as authentic as possible in her/his way of being present in the different situations in order to keep the basic trust of the student-client alive.

Knowledge / No knowledge

In a program where ETMT is a compulsory and integrated part of the program you cannot avoid mixing roles as an ETMT teacher, but (s)he is not allowed to be in a role involving day-to-day teaching, or any formal evaluation of examination procedures simultaneously with undertaking ETMT work.

Whenever an ETMT teacher becomes an ordinary teacher after the therapy process has ended (s)he has the responsibility of “forgetting” all confidential information from the therapy sessions and to meet the student in this new role-constellation.

Love / Not make love

Last but not least: It will be emphasised in the employment of an ETMT teacher the importance of being able to love the students as human beings (primary love). It can only be formally tested by ensuring (s)he as a music therapist has undertaken a relevant experiential training and also through information and interview when employed. At the same time (s)he is informed of the fact that (s)he is not allowed to or supposed to have personal sexual relationships with any of the student clients.

As an ETMT teacher you cannot help being the target of many, and often strong, positive or (in some periods) negative transferences, and the student may 'fall in love' with you. This can be a very important part of the developmental process if you as an ETMT teacher can contain and handle this in a respectful way. As mentioned above we have one male and two female ETMT teachers so that those specific wishes from the students about the gender of the therapist can be met when possible.

Discussion

There was considerable discussion of this presentation. The average age of the students in the Aalborg program is 23-45. It was felt that having students who are somewhat older is important for their ability to take advantage of this work.

In response to a question about what kind of practice the students would be able to do following training, Inge stated that they chose to have the training be psychodynamic and psychotherapeutic, to delineate it from special education music therapists who were practicing. But students use this training to work with many levels; they can use increased self-understanding even when working with certain populations at lower functioning levels. This is what distinguishes the music therapist from the music pedagogue who might be doing similar work. So it is not the area of work that is defining, but rather the basic training that can be used in various areas.

Questions were raised about the distinction between what is completely private work and work like this which has its own boundaries but is not completely private. Does it ever come up that students are felt to need

completely private therapy in addition to (or rather than) that connected to the course?

Another area discussed concerned boundaries. Where does idea that exploring traumatic blocks is part of training come from? How does that become an educational goal? How do they bridge personal boundaries and education? Inge responded that the goal is "to explore," not "to cure." It was suggested that other disciplines do not include personal growth. Inge responded that that gives experiential ETMT teachers the possibility of showing and transferring to students how self-experiences can be a part of a therapeutic identity. It was then asked why boundary problems and diffuse anxiety problems would not be shown in other aspects of the education? Why should someone who is essentially a personal therapist need to bring those back to class; they would normally show up in other aspects of class. Inge's answer was that students with these problems can be referred from other aspects of class. If they are referred from the ETMT teacher, they will only go to one professor and it can then be determined how to deal with the problems.

A question was raised about the tape recording, with the point that it is unusual to use a tape with third person to "arbitrate." Inge responded that they have never had to use this, so it is really done as a security for the student. Students often use the tapes to listen back to as a learning project. The therapist keeps, then destroys when the therapy is finished. But the student can have copies for personal use.

It was questioned why supervisors of ETMT are psychologists and not music therapists? Inge responded that no music therapists have been trained so far to be supervisors. Tony also pointed out that the supervisor who is used has been involved with the program for many years.

Mechtild said that she has been working in Berlin to have Lehrmusiktherapie included as requirement in the program, but that the Lehrmusiktherapie is done outside of the training. Students must go through a self-process in order to work. Mechtild is concerned that students cannot work if they know too much about each other - the boundaries are not safe. Boundaries are important; the work for the professors is to integrate the outside and the inside. She thinks the boundaries are extremely important. She also believes that paying for it is important. Mechtild thought that her program in Berlin must be very different from the program at Aalborg because of this, and that it must be more analytically based. Inge responded that they have 20 hours, focused on the student being a therapist. Mechtild has 100 hours and a very different focus.

The point was made that in Guided Imagery and Music (GIM) it is essential that the therapist experiences the method in a very full way in order for the educational method to be effective. But while experiencing it, certain issues come up. So when you see personal growth as the primary focus, versus having to deal with personal issues as they come up in training, it is

a subtle but very important shift. It was suggested that in North American academia, faculty are not given the freedom to do what is needed.

It was also suggested that there needs to be a balance between personal issues and what is private. The program at New York University has personal groups for 2 years.

It was questioned whether there is tension between the idea that trainers have responsibility for students' welfare, and knowing that the student has another place to go for help as a therapist, and how students cope with not having private place for their training. In the UK, they can say that everyone needs to be in individual therapy in order to train as a music therapist. How does it feel for the student if their training institution is so involved in their personal life? Inge responded that students feel as though it is a private place because they have three people doing only that training. It was then asked if students can choose their own therapist?

It was pointed out that it needed to be clear what kind of therapy was being talked about. There is a need to be clear when saying that 100 hours of therapy are required. This area needs more clarification.

It was reemphasized that confidential information is not shared in the Aalborg system. It is very unusual that a student gets into such difficulties in their work that the study leader is confronted with personal information. It was also questioned how people in the UK can require students to do something that is not paid for. Is it written into the requirements? Helen Odell Miller responded that it is very clear to people entering the training. This is done in all of the UK now, and is written into the JVC document that was presented previously. It was, however, pointed out that this is a new system whereby therapy is compulsory. It is delivered in different ways in the various systems within the UK. Nordoff-Robbins trainees know that they will have music therapy throughout 2 years with same person, and that they do not have to pay for this therapy.

This cannot be required in the U.S.

The question was raised as to how students experience the ETMT therapy. A student at Temple University did a thesis on what students experienced in various types of experiential training (this has been done at Temple for 15 years). She called people from different phases of the program. The thing that concerned them most was the GRADE, although all had been told that they were not going to get marked. This was thought to have been a fear of an academic evaluation, retribution for what happened academically.

Reference was made to articles on training analysis for psychoanalysis, which is not really considered an analysis because it is part of the training. This is done with Guided Imagery and Music. There is a level at which people know that it is part of the training. So if people go back to what the objectives are, and they really want personal growth and to look at themselves without deeper levels of concerns, maybe the music therapy

should be separated out from the training. But if objectives are different than strictly personal growth, maybe is best to put into training.

It was thought that this comes back to the age of the students. Maybe when students are 23 or 24, it is appropriate, while with younger students it is not appropriate. It was mentioned that AMTA (American) has many debates about whether to call people therapists at the baccalaureate level, or whether they should be referred to as technicians. It was also suggested that it is not just age; some of the older students are less flexible than the younger ones.

A question was raised as to what we are really caring about in the students? Inge thinks that the caring is whether we are prepared to do something if things go wrong.

Distinctions between psychotherapist vs. music therapist were discussed. They do not use the word music-psychotherapist in Denmark because a music therapist is synonymous with music-psychotherapist. All music therapists run through a psycho-therapeutic training during their basic training. A person has to have extra training concerning knowledge of client population wherever they go because theirs is a basic training. Music therapists in Denmark are on the level of psychologists and psychiatrists in psychiatry and are at a higher level than occupational therapists and physical therapists.

It was pointed out that when we talk about experiential training, we are usually talking about immersing students in some experience. But we also do therapeutic teaching in which, in our roles as teachers, we handle things in a therapeutic way. This comes up when supervising someone who is supervising someone else. Every dissertation ends up being countertransference teaching/supervision. This is different from experiential training, but blurs the boundary of professor and therapist. What is the nature of caring and is there a difference in caring as a teacher and as a therapist? Another person found a similar situation when students come in for a supervision class; after skills and knowledge, personal growth issues are there all the time. In supervision, we have to look at personal growth all the time.

Inge said that she has experienced students being invaded in teaching more than in therapy, because one has to think of being invaded as a therapist but does not have to think so much of this as a teacher. Inge was asked if she has developed good skills at maintaining the balance over so many years of teaching, and how it is for her as an educator. Inge said that she has learned to be very honest, to be sure that she is telling the student what she is saying and doing so the student is not taken by surprise. She thinks that honesty and respect for the students and their processes are very important. It is important to be very careful not to tell a student that you don't refer, and then make a referral. And to let processes come and go, really forgetting. Remembering and forgetting. To love and not to make love.

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TEACHING RESEARCH AT THREE LEVELS OF EDUCATION

Kenneth E. Bruscia, PhD, MT-BC

Temple University, USA

In the USA, we have three levels of education in music therapy, corresponding to the bachelor's, master's and doctoral degrees. Each level has its own educational objectives and curriculum, and each level includes studies in clinical practice, theory and research.

The basic assumption of this presentation is that because students at each level have different educational needs, what they are taught at each level about clinical practice, theory, and research must vary accordingly. In short, competency objectives in the areas of practice, theory and research are different for each level of education.

This presentation is specifically concerned with competency objectives in the areas of music therapy research. There are several variables to consider in formulating these objectives:

A. What a student is able to learn about research will vary in direct relation to the level of clinical practice that the student is learning at the time.

Specifically, a bachelor's degree student learning to practice music therapy at the adjunctive level should study research designs and methods appropriate to that level of practice; while students at the master's and doctoral level who are learning to practice at more intensive or primary levels of practice should be taught research designs and methods appropriate to those levels.

Put another way, the competencies needed to research activity music therapy are different than those needed to research music psychotherapy.

B. Simple research designs and methodologies must be taught before complex ones.

C. A decision must be made as to whether the student should study quantitative and/or qualitative paradigms, depending upon not only the orientation of the clinical work being researched, but also the philosophy of the teacher and student.

D. There are levels of competency within the domain of research itself. At the beginning level, students learn how to read and understand, and evaluate research, while also gaining a working knowledge of the research literature.

At more advanced levels, the student learns how to actually design

research, analyze and interpret data, and report the findings.

E. Competency objectives in the area of research should be consistent with the student's career goals, and more specifically, whether the student is working to become a clinician, researcher, or educator.

With these variables in mind, I am proposing three levels of competency objectives in teaching music therapy research.

ENTRY-LEVEL RESEARCH COMPETENCIES
(Bachelor's: Adjunctive level of practice)

- Basic understanding of differences between quantitative and qualitative research
- Ability to read and comprehend simple research (both quantitative and qualitative)
- Limited or specialized knowledge of the research literature
- Ability to design research-based clinical work at the adjunctive level (i.e., quantitative evaluations of client responses to therapy)

INTERMEDIATE LEVEL
(Master's: Intensive level of practice)

- Ability to read and comprehend complex research (both quantitative and qualitative)
- Breadth of knowledge of the research literature (both quantitative and qualitative)
- Ability to design simple quantitative OR qualitative research studies at the intensive level of practice
- Understanding of quantitative methods of data analysis and interpretation (i.e., basic statistics)
- Understanding of qualitative methods of data analysis and interpretation

ADVANCED LEVEL
(Doctoral: Primary level of practice)

- Ability to critically evaluate both quantitative and qualitative research
- Comprehensive knowledge of the research literature (both quantitative and qualitative)
- Ability to design complex quantitative AND qualitative research studies at the primary level of practice
- Ability to independently analyze and interpret data in both quantitative and qualitative paradigms
- Ability to write comprehensive reports of research in appropriate style and format

Discussion

It was suggested that at the master's level, students need to understand more complex statistics if they are interested in this area. They should not just rely on a statistician. Ken responded that they should be able to use statistics to analyze at a later (doctoral) level, but to read them at the master's level.

It was suggested that trying to design both quantitative and qualitative studies is too much. Another person responded that, in the doctoral level clinical psychology program in which she is a student, they are integrating both. Another person said that the problem is whether, when you are undertaking doctoral studies, you are learning to be a researcher. PhD students in the Aalborg program are learning both, although they may only want to do qualitative research. It was pointed out that students must know how to use a statistician, even if they learn about statistics. Others agreed, one saying that psychologists that she works with also use a statistician and another that the NHS Trust will not pass a research study without it also going through a statistician.

"Figures don't lie, but liars figure."

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Students who become unsuited to Music Therapy training

Denise Erdonmez Grocke, PhD, MT-BC, FAMI

University of Melbourne, Australia

One of the questions on the WEK questionnaire (1993) asked how courses dealt with students who became unsuited to music therapy training during the course (having successfully gone through the selection procedures). Most of the course respondents indicated that they counselled these students out of music therapy training.

The issue of counselling out students who are unsuited becomes problematical in Universities that subscribe to anti-discriminatory practices where students who are seen to have problems are given additional help, rather than being counselled out of courses.

At the University of Melbourne I was unable to include a question on the music therapy application form (up until 1999) that asked whether students had an existing illness which would effect their ability to complete the course. This question was considered discriminatory.

Universities however, also have a responsibility to the community - a Duty of Care - which requires that students of the University, while pursuing courses that require interaction with the wider community, must be capable enough to provide appropriate standards of care.

The University of Melbourne took this issue to its legal consultants and after many months of negotiation developed a question that addresses Duty of Care. The question approved for the University of Melbourne music therapy application form is:

“This course requires that students be accepted for clinical training placement by institutions external to the University. In this situation, the health and safety of patients must be put first, and students are required to declare any medical condition they have which may effect their acceptance for clinical work. Have you ever suffered from or received treatment for a physical or mental illness, which may impact on a clinical training placement?”

Other Faculties within the University, including the Faculty of Medicine now adopt this question.

To date, there have been no objections to the question, indeed a number of students have identified conditions which could impact on clinical training - e.g., epilepsy, diabetes (where the student may need sugar intake).

Having identified a possible factor influencing clinical training, we

are able to consult with the student and suggest they disclose the information to clinical training supervisors. Thus the supervisor is aware of the student's needs - e.g., to leave a session suddenly.

Should a student suffer from a psychiatric condition, the issue is more complicated. If the condition is known and disclosed, a careful selection procedure needs to be in place to ensure Duty of Care. If the student has been successfully selected on to the course, and subsequently develops a psychotic illness during the training, there needs to be provision for exclusion, or deferral, until the student's condition is not a danger to the Duty of Care provision.

Discussion

The question was asked about a person who had emotional problems, but did not know that they had them prior to entering the program? Denise responded that the University could not deal with getting the student out of the program in this case.

In the Aalborg program, they say, "Have you received any intervention within the healthcare/psychiatric system that may influence your training?" The UK has this, but it is not written down. At NYU, this generally comes up within the interview process, often from the potential student. She discovered recently through a lawsuit in which a student who had spoken of a disability in the interview and was not accepted to the program (not due to the disability) that the issue is whether the student had been ASKED about the disability in the interview. Students applying to Nordoff-Robbins courses in the UK all have to have a physician's certificate. "This is a stringent and professional training. Do you know of any reason that this person may not be able to complete this training?" The same question is asked in being employed in the UK; the same thing occurs in Israel. In Canada, they cannot ask about any illnesses or medication.

On the issue of how people are counseled out of the course, in the UK, they rewrote information about this. They now have an external examiner halfway through the program. An analytical psychotherapist meets 1:1 for an interview; also a music therapist is an external examiner. In Berlin, they found out that experiential training brought problems out. In two (both) cases, students brought problems up in the first interview but the faculty thought they could handle it. (These were before required experiential training.) One student was advised by the experiential therapist to go to psychiatric treatment. Another student was able to pass everything and, in spite of counseling, continued in the music therapy program.

One person suggested having a very objective evaluation for clinical practice, then a student can be given a low grade on clinical practice, allowing the instructor to be objective in documenting over a period of time. Another person said that she and her staff nurture people throughout, but have started failing students (against natural instincts). She now feels that it is best to get students who are not suitable for this

work out of the program as quickly as possible. Another person said that they have to do continuous assessment all along, covering many aspects. If they have been marking as Less than Adequate from the beginning, they have documented reason for failing them. Another said that they have a regulation that whatever they write, they summarize at several stages: at beginning with candidate, after the first year, near the end of the second year. They summarize and give to students, so they have a copy from the very beginning. Even those who are not accepted get exact reasons. Another person said that he doesn't trust his judgment, he has been wrong in his assessment of who can succeed and who can fail so many times. He wonders if we know enough to do this. Also, how do you counsel someone out without spoiling their career?

Another person spoke of a situation where she had had a problem with a student who was not well. One thing she did was to go the board of her university so they would not be surprised if they student needed to leave the program. Another person agreed that faculty need to be more "cold," but has also found that she is wrong at times.

Someone asked what do with someone who has problems that they didn't reveal? A response was that sometimes they are able to work with and help students through the self-experience, but sometimes this does not help, they get worse. Also, the faculty start to realize that they are concerned about a situation when they have problems sending them for clinical practice.

One person said that the things that scare her the most are the things that concern her as a therapist - confidentiality - suicide, homicide - and how she would deal with them. Sometimes she helps people to arrive at their own understanding that they are not right for this field. But she has more trouble dealing with people who have no insight and are not meant to be a therapist.

Another person said that there are some levels of practice that students with problems can manage. This may be a part of defining what is needed. The field of music therapy has not determined at what levels people can be effective.

QUALIFICATIONS OF MUSIC THERAPY EDUCATORS

Dr. Tony Wigram, PhD, RMT, SRAtsT

Aalborg University, Denmark

Following experiences in the UK where courses in music therapy were conceived, and attempts made to set-up and run them by people without any experience in leading a therapy course, the following criteria was established by the Association of Professional Music Therapists (APMT) for lecturers and head's of programmes:

Head of Training:

Qualifications required to be a Head of Training (Program Director) on a music therapy course:

- Post-Graduate qualification in Music Therapy
- Minimum 5 years clinical experience
- Specialisation in two clinical areas
- Experience of teaching/lecturing on a music therapy course
- Experience in supervising music therapy students in training
- Administrative experience relevant to running an academic course
- Counselling experience to meet the needs of music therapy students

Permanent Lecturer:

Qualifications required to be a permanent lecturer on a music therapy course(not including guest teachers or adjunct professors):

- Post Graduate qualification in Music Therapy
- Minimum three years clinical experience
- Experience in supervising student music therapists
- Experience in teaching or lecturing in music therapy
- Specialised music therapy knowledge in one clinical area

Qualifications of Music Therapy Educators of the American Music Therapy association

Marilyn Sandness, MM, MT-BC

University of Dayton (Professor Emerita, Retired), USA

Note: The following outline is based on standards for educators and clinical supervisors of the former AAMT, NAMT, and recommended new standards proposed by the AMTA Commission on Education and Clinical Training. Qualifications vary depending on the area of responsibility in directing and/or teaching in music therapy undergraduate and graduate programs or for supervising pre-internship and internship programs. Experience as a teacher/educator is not specified. There should be a full-time faculty position for each degree program offered.

Qualifications

A professional credential in music therapy (e.g., MT-BC, CMT, ACMT, or RMT) is required for all educators and clinical supervisors. A Master's degree in music therapy or a related field with a minimum of 12 graduate credits in music therapy is required for directing and/or teaching full time in undergraduate or graduate music therapy programs. For teaching in graduate programs, a doctorate is preferred. A Baccalaureate degree in music therapy or its equivalent is required for adjunct or part-time faculty teaching specific courses or for clinical supervisors (pre-internship and internship). All educators and clinical supervisors must pursue continuing education relevant to his/her teaching and/or clinical and supervisory responsibilities. All full-time faculty must demonstrate mastery of all entry-level and selected advanced competencies in music therapy; effectiveness as a music therapy clinician in at least one area of practice; the ability to teach and clinically supervise undergraduate and graduate students (if applicable); and the ability to organize and administer an undergraduate or graduate music therapy program (if applicable). In addition, graduate faculty must demonstrate the ability to guide graduate research. Adjunct or part-time faculty must demonstrate specific competencies appropriate to the teaching assignment. Clinical supervisors (pre-internship and internship) must demonstrate all entry-level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of pre-internship and/or internship students; and skills in supervision.

Length of Experience as A Clinician

For directing and teaching in undergraduate programs, a minimum of 3 years full-time or its equivalent in part-time (estimate 5040 hours) clinical experience in music therapy beyond the internship is required. For

directing and teaching in graduate programs, a minimum of 5 years full-time or its equivalent in part-time clinical experience in music therapy is required. For teaching specific courses part-time or for internship supervisors a minimum of 2 years full-time or its equivalent in part-time clinical experience in music therapy is required. (Former NAMT standards require 3 years clinical experience for internship supervisors). For a pre-internship supervisor, a minimum of 1 year full-time or its equivalent in part-time clinical experience in music therapy is required.

Qualifications of Music Therapy Educators of the Canadian Association for Music Therapy

Connie Isenberg-Grzeda, MM, MTA, MT-BC
Université du Québec à Montréal, Canada

CAMT Standards and Procedures for the Approval of Undergraduate Music Therapy Programs (1995) stipulates that music therapy faculty members must hold a postgraduate degree and have completed training in music therapy at a recognized institution. Each music therapy faculty member must also be an accredited music therapist (MTA) with the equivalent of at least five years of full-time professional experience in music therapy. In addition, the *Standards and Procedures for the Approval of Graduate Music Therapy Programs* document (May, 1999) stipulates that at least one faculty member must hold a PhD in music therapy or in an allied profession. All faculty members in a graduate program must have made a significant academic or professional contribution to the field of music therapy and have contributed to the educational development of music therapists through teaching or supervision. In addition, all faculty members must have research experience at the graduate level.

Although not included in either document, it is my personal belief that faculty members must be currently involved in clinical work. They must have a sense of their own professional identity, that is, they must be able to describe themselves as a music therapist or a music psychotherapist, understanding the distinctions between these roles and the links between these and that of a psychotherapist. They must be able to understand the impact of the conceptualization of their professional identity on the content of their teachings.

Faculty members must also understand the importance of and have the capacity to create a safe container for the students, parallel to that they create for patients. The educational process may generate anxiety and increase vulnerability, as students become more self-aware. Students deserve a safe, contained space in which to explore.

Qualifications of Clinical Training Supervisors for Entry-Level Students

This section was developed as a discussion by all attendees and thus is summarized as a discussion.

Some of these issues were addressed from the U.S. viewpoint by Marilyn Sandness' presentation on Qualifications of Music Therapy Educators.

In the UK, they have an approved procedure for approving supervisors for professionals. This does not apply to supervising clinical training supervisors who are in training.

In Helen Odell Miller's course, they say that supervisors in the field should have at least 5 years of clinical experience (not necessarily 5 years full-time); the only qualification is being a qualified music therapist.

In the course run by Connie Isenberg-Grzeda in Canada, people must have a minimum of 3 years' experience to be a supervisor.

It was suggested that the amount of experience needed and other qualifications of a supervisor depends upon what supervision is needed; the depth of supervision is dependent upon the depth of placement (e.g., internship vs. pre-internship). It was stated that they had found in the UK that when they sent students to people who had only recently qualified, the supervisors were identifying more with the students than functioning as supervisor. This led to choosing 2 years experience as necessary to become a supervisor. Another person commented that some of the worst supervisors have 20 years of experience. She said that she is not opposed to recommendations for bettering the quality of supervisions or internships, but also wants to encourage people to go on for more training. She emphasized that we cannot get ahead of ourselves with qualifications -- we need to look at quality vs. quantity.

The question was raised whether the/an association or individual program should determine where students should go. Barbara Hesser said that she determines, but also wants to keep it clear that we are talking about whether an association or national group tells us what will make a person a good supervisor. It was stated that in Israel, qualifications were given by the association (an umbrella association for all arts therapies); the example was taken from the clinical psychology association. A supervisor needs a minimum of 5000 supervised clinical hours, and supervision in the last year must be supervision on supervision. The supervisor must be recognized as a qualified supervisor, as a registered music therapist through a set of examinations. In the first year after Chava's course, students have a music therapy supervisor and also another supervisor, such as a psychologist

or another supervisor who is specialist in field.

Helen Odell Miller said that the JVC document that has been worked on for many years includes both quantitative and qualitative aspects of approving supervisors.

Ken Bruscia asked: What are we doing to each other? What are we doing to ourselves? What is our need to do this? To screen people? It is almost as though we're drawing our discipline in non- or superhuman terms. Are we passing on a legacy of self-torture? Self-scrutiny? Ken suggests that there is a psychological process going on here that is not always healthy. Barbara asked if we are making jobs for ourselves.

Denise said that we are just trying to establish some guidelines that can be useful. putting in place guidelines for education and training that can be useful in helping countries that are developing education and training. This is something that is going to be global and it must be very broad.

Connie suggested that this is just to put us on a par with other professionals.

Tony asked for feedback from people in less developed areas. He knows that some countries, for instance in Europe, will really welcome this guidance.

Mayra said that she was wondering how countries with no training courses will start and is concerned that they will never qualify. She is afraid the guidelines will make it impossible for people to start music therapy courses. Countries that already have music therapy courses can meet the standards, but what happens in countries just trying to start. Tony answered that perhaps middle level standards give them something that they can use. We are trying to deal with countries where people start courses with no qualification whatsoever. This is dangerous as people can go away from some of those programs with no understanding of music therapy, but saying that they know.

Denise emphasized that the WFMT is only wanting to provide guidelines. It is not a monitoring group. Ken suggested that we are perhaps not looking at guidelines as requirements, but rather guidelines for how to do. Rather than making requirements, we could offer suggestions as to how one could go about establishing a cadre of supervisors.

Denise felt that it would be helpful for WFMT to say that music therapists. are musicians, since 95% of the world includes this as a requirement. Perhaps some areas are requirements, others are recommendations, and others dependent upon what a country's association finds useful.

Tony said that you would never find people in another profession

saying, "We don't have people who do this, so we'll use someone who doesn't." Countries can bring people in who do know, or send people to where they do have it in order to learn. He feels that we cannot afford to have any more situations where it is the blind leading the blind.

Helen Tyler mentioned that the Nordoff-Robbins Charity is often approached by someone who wants to start a course. The answer is always that they should send someone to a country that has the training, then rely on that person and the supervision and back-up that is available then.

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The guidelines that follow were the end-product of the two-day Symposium. They were later presented and discussed at a presentation at the World Congress of Music Therapy, after which minor revisions were made.

WFMT Guidelines for Music Therapy Education and Training

The following guidelines should be applied within the context of the culture of the country.

The practice of music therapy requires an intensive program of study and supervised clinical training through an institution of higher education over an extended period of time.

Intensive studies shall consist of:
Musical skills and knowledge
Biological, psychological, and social studies
Music therapy knowledge and skills

Clinical training shall consist of:
Supervised field experiences in various areas of music therapy

A program of study may be general or specialized.

A general program of study shall cover:

Active and receptive methods of music therapy;

Applications of music therapy with a wide variety of populations and

in

various settings;

Different philosophical and theoretical orientations;

Ethical principles and research; and

Existing models of music therapy practice.

A specialized program may focus on one or more specific models or orientations.

The program should promote the student's personal growth and professional development. It may be basic or advanced depending upon the depth and breadth of training, the system of education, the standards of practice, and the credential or qualification granted to the graduate. The most appropriate level may be determined partially by the educational system of the country.

The program of study is one which:

