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# Music Therapy and Medical Ethnomusicology: Distinctive and Connected

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## Abstract

A music therapist and an ethnomusicologist who is also qualified as a music therapist explore some of the ways in which music therapy and medical ethnomusicology might engage a dialogue that is helpful to expanding thinking and practice in both fields. We begin by describing music therapy and outlining some core concepts of therapeutic work. We then discuss ethnomusicology and reflect on the ways in which music therapy and ethnomusicology may complement one another in the field of medical ethnomusicology. We consider how an exploration of concepts informing cultural safety might be enacted in healthcare through the use of music and whether this might serve as a useful joint future enterprise between music therapists and medical ethnomusicologists. Finally we explain why we encourage medical ethnomusicologists to cease attempts to become applied therapeutic practitioners without further therapy skills training.

**Keywords**: music therapy, trauma informed practice, evidence based medicine

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## Where Can We Start Our Discussion of Music Therapy and Medical Ethnomusicology?

The opportunity to extend knowledge and communication between music therapy and ethnomusicology is welcome. Our fields contemplating each other begin like two fleets of ships that have been sailing the seas for many years. Each flotilla has taken different navigation routes, engaged particular methods and techniques of travel, and are involved in similar processes of piloting our crafts through both calm and tricky waters to explore new horizons. The oceans are vast and our paths cross rarely. We do not need to know about each other's navigations or plans to be able to develop, grow, and explore new vistas. To decide to travel side by side takes careful skill and attention to the others' space and orientation, and careful explanations of our purposes and directions.

Without hesitation we welcome this opportunity for dialogue and want to engage and explore its possibilities. We agree with the music therapist Sangeeta Swamy who wrote,

> The fields of anthropology and ethnomusicology can teach us a great deal about the influence of ethnography in our own work...to gain information and knowledge about a specific culture by asking permission, patiently observing, interacting, documenting, studying, analysing, and learning. Although formal ethnography requires training and oversight, music therapists can still learn about the historical, political, social, psychological, geographic, and anthropological context of specific groups of people (Swamy, 2014, p. 42)

Music therapists[1] have extended their practice beyond the clinic room and recently medical ethnomusicologists have wanted to find their way in; sometimes as practitioners[2]. Through applied music making both the therapist and the ethnomusicologist use music to help individuals and groups to strengthen their connections to community, directly or indirectly reducing symptomatology, and creating opportunities for interpersonal connections and resonances that create psychological safety. We propose that there are some capacities that ethnomusicology training provides that could benefit music therapy, and additionally recommend that therapeutic training is essential for practitioners in applied medical ethnomusicology in order to ensure safe and ethical services. Dually qualified medical anthropologists who are medical doctors have offered new perspectives to treatments and practices (for example Zaman, 2008) but we have not found references to applied medical anthropology beyond the dually qualified professional. It is curious that medical ethnomusicology has taken this turn towards applied healthcare practice, and we consider that if therapeutic intent is present then certain minimum standards in relation to cultural and relational safety need to be agreed upon and demonstrated.

# What Do We Mean by Music Therapy?

A description of music therapy's parameters and practices is useful in order to position ourselves in relation to the profession. We consider music therapy as a relational therapy in which music primarily, and verbal reflection when appropriate, is used as the means to communicate, reflect, and explore the inner world of the client and their relationships with others. Music therapy seeks to elucidate and positively influence the client's working models of attachment, or what is also referred to in contemporary therapeutic language as self-regulation (Siegel, 2012). Music therapy seeks to alleviate suffering, bring opportunities for growth and hope for individuals and communities, whether family constellations or other groups, by supporting the client(s) in a process of self-discovery towards positive change. Music therapists enter a collaborative and dynamic interpersonal space in which music making, or sometimes music listening, occurs.

Music therapy training is usually provided through a combination of classes, workshops, and fieldwork placements in education or health contexts. The student 1) extends existing skills in music making, 2) learns about therapeutic relating, and 3) engages self-development through a variety of means which can include

attending personal therapy and experiential group work, and reflection on placement experiences.

Historically music therapy developed as a post-war practice along with many other therapies in the allied health field such as Occupational Therapy, and Speech and Language Therapy. The improvement in medical and nursing skills available to treat battle inflicted wounds and bring soldiers home additionally raised the need for therapies that could help rehabilitate and bring back to civilian life those who had experienced the physical and psychological trauma of war (Edwards, 2008). In most countries where music therapy has developed it operates within the regional or national provision of health and social care with some therapists working in private practice.

Increasingly music therapy professional associations internationally are engaged in the process of professional recognition and regulation (see Nöcker-Ribaupierre, 2015). In some countries this has resulted in the term music therapist or arts therapist (meaning either art, music, drama or dance/movement therapists) becoming a protected title; people describing themselves or their work in this way who are not qualified can be prosecuted. Although some have challenged the recognition/regulation handshake desired by so many in the profession (for example Edwards, 2015) there is nonetheless an abiding concern that if people who are not qualified provide therapy-like work for people who are vulnerable without any sense of the borders that might be dangerous to cross then harm might ensue. We note for example the high numbers of adults who were abused as children who may not present with a trauma history in the first instance (Stoltenborgh, et al, 2011). Training supports a professional to be able to continue to think about what is going on when the material the client is presenting is overwhelming; this could be in the form of anger directed towards the therapist which the client feels towards another person or about something that happened to them but they are not yet able to acknowledge, or strong feelings such as sadness that might be transmitted non-verbally to the therapist and then experienced via some means such as bodily sensations or even unexplained aches and pains which might regularly be experienced following interaction with a particular client (Forester, 2007). These experiences are grist for the mill of therapeutic practice, processed through self-care (see Trondalen, 2015) and through regular supervision[3]. By making sense of the experience of being with the client useful feedback and understandings can emerge which are intended to help elaborate self-awareness and make what is unsafe for the client safer, or even in the best scenario ultimately engage in a process that results in psychological calm and safety beyond continual stress and worry.

# Buddy and His Family

In considering how we could present music therapy in this paper we envisioned describing a practice scenario similar to work we have done as music therapists. We present this composite case as a way to reflect on how music therapy is practiced; what music therapists do and how they think. In exploring the music therapist's stance in relation to the material presented we hope to show how additional training in this way of thinking is needed.

> Buddy and his Dad, Pete, are sitting opposite the music therapist on the floor of the playroom. Buddy is sitting in his Dad's lap reaching out for the

strings of the guitar as Erin, the music therapist, plays a tune to start the session. She is improvising vocally in the Dorian mode while moving between an open D and A on the guitar in triple metre. She is encouraging Buddy and his Dad to sway from side to side together – she even sings the words “and we sway back and forth” but Pete is staring into space and Buddy is determined to grab a string on the guitar even though it is tantalisingly far away. Pete suddenly opens his eyes wide in surprise, reaches into his pocket to bring out his phone and whispers “sorry” as he takes a few moments to look at the message he just received, turn it off, and put it back. Buddy becomes very still when he sees the phone, and stops looking at the therapist or reaching for the guitar. Erin hums more and more quietly and then stops.

Buddy is 27 months old. He receives regular visits from staff at the community health centre as some of his developmental milestones are significantly delayed. He rarely vocalises except to show distress and he only speaks a few words. As a resul he becomes frustrated because he cannot ask for what he wants. He is small in size for his age, he often wants to be picked up rather than walk, and his walking is sometimes unco-ordinated. He has no specific diagnosis although a description of generalised developmental delay is being used by the team in order for him to be eligible for services.

Buddy’s Mum Nancy was unable to care for him immediately after he was born because of the sudden onset of postpartum depression in the few days following his birth. This became so severe she was hospitalised with psychotic symptoms which she described as “living in a horror film.” Pete’s Mum, Mary, moved in to live with them to help Pete with Buddy’s everyday care. Every weekend Mary, Buddy, and Pete went to the hospital to see Nancy. Nancy would often sit in complete silence unable to acknowledge her baby son or respond to conversation. Pete has described since how he often felt very angry with her during and after these visits. Eventually after 4 months Nancy returned home feeling much more like herself although she was unable to return to work, continued to be extremely tired, and was frequently irritable with everyone in the household.

Nancy and Mary can feel tense when they are together. Nancy feels criticised by Mary and has told members of the team that Pete does not support her when Mary makes critical comments about how the house is kept, or her care of their son. Mary had let her rental place go as they were uncertain how long she would be needed, and was intending to move out when Nancy started to improve. She cannot afford to live alone with the high rental costs in the region. Nancy inherited their 2 bedroom cottage after her Mother’s death 10 years ago. Mary is increasingly unwilling to move away from her grandson into a more affordable area a long commute away.

Buddy and his family were referred to music therapy by the community health nurse who would like to provide any opportunity for the family to learn to interact more positively. For example, during a home visit she observed Pete leaning down to his son and shouting “shut up you little shit” when Buddy started crying after falling over and Nancy called out to Pete “you shut up arsehole” after which they began screaming abuse at each other until the nurse asked them to stop. While they were arguing Buddy remained face down on the floor crying until Mary came in from outside where she was hanging out the washing, lifted him up and calmed him, all the while glaring at Nancy. The team are hoping that if the family interactions are

improved it will allow Buddy to be more confident in his relating with others and this will build up his language skills along with stimulating his exploration and curiosity.

The music therapist could choose to work with anyone in the family system and anticipate positive shifts in the family away from their stuck and conflicted position with poor habits of relating, towards more satisfying interactions. She is aware of research that shows that when a Mother is depressed at pre or postnatal stage her child and the other parent are at risk of mental health difficulties (for example, Giallo et al., 2012). She suggests that Pete and Buddy might like to come to sessions together. Pete agrees and so it is that a week later they are all sitting on the floor of the playroom at the community health centre. But even though they have had a friendly chat about the purpose and structure of music therapy during which Erin asked him about musical interests of his son she notices that as the music starts Pete is palpably tense. Maybe it is embarrassing watching a woman sing so close to him? Maybe he doesn't often spend time with his son on his lap and it feels strange? Maybe he needs more time to get used to this?

> Erin stops singing and says do you play music Pete?
>
> Me, no, oh geez no. Can't sing either.
>
> And do you like listening to music?
>
> Pete explains he listens to music on his phone through headphones at his part-time job in the postal service. He likes death metal, heavy rock, but also sometimes listens to country music. He frowns as he mentions that he can only work part-time at the moment because of "the situation with the wife" and he smiles as he mentions the bands and singers he likes. As he talks he starts to look a bit more relaxed. Buddy has flopped back against his Dad staring straight ahead and although Pete is now leaning back on his hands with his legs crossed he does not seem to notice or mind his son resting into him. Erin starts to feel more positive and talks about having attended an amazing solo concert of one of the singers in the band that Pete mentioned. Awesome, he exclaims. When he says awesome in this excited way Buddy looks up at him and laughs. Pete is still smiling and briefly looks at his son. "Yes" Erin thinks to herself. "This is going to go well."

Let's stop the case here so that the authors can demonstrate how music therapists think and practice by reflecting on this family and a very short snippet of early work with them. It could be that the music therapist is replaced by a community arts worker, an infant mental health nurse who can play the guitar, or with anyone else with compassion, patience, and musical inclinations. Or perhaps the therapeutic opportunities could be pursued with an infant mental health worker without music? At the risk of promoting a self-interested professional view we do think that the music therapist has a distinctive theoretical and practice perspective to offer. Three core concepts that inform music therapy practice are used below to reflect further on the case presented; attachment theory, communicative musicality (Malloch & Trevarthen 2008a), and therapeutic presence (Geller & Porges, 2014)

# Core Concept: Secure Attachment is Essential to the Infant's Development

Throughout the second half of the 20th century research conducted by many influential figures gave credence to the necessity for a secure parent-infant base to support the development of lifelong capacities for psychological stability and the capacity to form intimate relationships successfully with others (Beebe & Lachmann, 1998; Ainsworth, Blehar, Waters, & Wall, 1978; Trevarthen, 2001; Winnicott, 1965). Although it might be considered infantalising to refer to infancy when working with ar adult, more than 6 decades of attachment research have shown that around 50% of people were not able to have their needs met in infancy and they live with the lifelong consequences (Siegel, 2015). Attachment behaviours have specific purposes and develop through sensitivity and responsiveness on the part of the caregiver(s). Through forming attachments with their caregivers, infants form interna working models about the structure of human relationships. Ideally the relationship will develop and be enhanced through the sensitive, playful, and caring interactions between caregivers and the infant.

In a healthy relationship the caregiver "...affords emotional access to the child and responds appropriately and promptly to his or her positive and negative states" (Schore, 2001 p. 205). This supports the adaptation of the infant towards internal regulation functions which relate to "the regulation of arousal, the maintenance of alertness, the capacity to dampen arousal in the face of overstimulation, the capacity to inhibit behavioral expression, and the capacity to develop predictable behavioral cycles." (Beebe & Lachmann, 1998 p. 485). This development of the ability to relate and communicate in playful and predictable ways has been described as a series of building blocks or developmental phases of intrapsychic and interpersonal capacity (Stern, 2000). At each stage of development the infant needs a communicating partner who is sensitive to their relating needs and can encourage and playfully enjoy the interaction. Papoušek has described how the communicating parental partner requires "(a) the presence or absence as well as the liveliness and expression of infant-directed qualities (e.g., the qualities of infant-directed speech) and (b) the sensitive attunement of this behavior to the infant's signals" (Papoušek, 2011, p. 35).

When the ability to seek or maintain this communication is absent or impaired in the relationship urgent support and help is needed. Through the music therapy process, gentle non-intrusive engagement with parents and their infants helps them to discover, strengthen, and enjoy their capacity for relating through the musical play that supports, and is derived from, the usual repertory of parent infant interactions.

In the case above the music therapist experiences a brief flicker of delight when the child notices the parent's emotional change from preoccupation to a highly charged moment of excitement. This augers well for the possibility of promoting and developing this tuning in between the Dad and his son as the sessions progress. Music can play a facilitating role in encouraging playful interactions between the adult and the infant. Music can provide structure and support for the development of the skills of relating between the pair.

# Core Concept: The Discovery of Communicative Musicality Informs the Work of Music Therapists With Infants and Families

When the capacity to function and to relate to others has broken down there is urgent need for the opportunity to build up these skills whether one is 12 months old 12 years old, or fully adult. Through the relationship that forms in music therapy the skills of relating are strengthened. These include sensitivity to the other person's way of being in the world. The music plays a crucial role in the functioning of this relationship. As the following research review indicates, in infancy communicative utterances with others are highly expressive, playful, and improvised. Increasingly infancy researchers have recognised the musicality and artful creativity of these interactions (Malloch & Trevarthen, 2008a).

Infancy researchers who are also musicians have discovered and elaborated the musicality of infants. While watching and listening to recordings of interactions between mothers and their infants Stephen Malloch, a jazz musician and psychobiology postdoctoral researcher working with Colwyn Trevarthen at the University of Edinburgh, found himself tapping his foot in time with the rhythmic aspects of the vocal interplay to which he was listening. This led to his proposal that "...a mother and her infant can jointly create a musical piece – both are musical partners within their communication space" (Malloch, 1999 p. 47). Papoušek (1996) had earlier described how when she was notating the pitches of infant directed speech created by adults that it was tempting to also record the other musical aspects of these interactions "such as crescendo/diminuendo, rallentando/accelerando, legato/staccato, dolce, or agitato" (Papoušek, 1996 p. 94). Malloch and Trevarthen (2008b) concluded that "these 'musical' narratives allow adult and infant, and adult and adult to share a sense of sympathy and situated meaning in a shared sense of passing time" (Malloch & Trevarthen, 2008b p. 4). Since all musical performance requires attention to timing, pitch and synchrony, musical elements can easily be heard in the playful interactions between caregivers and infants.

The musicality of communicative encounters between parents and infants was also noted by the ethnologist Dissanayake (2008). She proposed that the playful vocal interaction between caregivers and infants is proto-musical; a foundation source for the universals of human musical behavior. In her view, the proto-musical features of "formalization, repetition, exaggeration, dynamic variation, and manipulation of expectation" (Dissanayake, 2008, p. 176) facilitate emotional bonding because they impact on the "visual, vocal, and kinesic signals that enable their emotional bond with their mother" (Dissanayake, 2008, p. 176).

The use of these easily recognisable musical elements to co-create mutually satisfying encounters between parents and their offspring is increasingly understood to contribute to healthy and optimal growth through the early years. These positive interactions in turn create a strong foundation for future capacities for intimacy and positive relating, with these positive early relations influencing later mental health (Maselko, Kubzansky, Lipsitt, & Buka, 2010).

Music therapists use these ideas to understand the capacity of co-operative music making to build and enhance relational skills for individuals but especially in working

with parents and infants where a disruption has occurred or where a bond was not able to form in the earliest stage of life. In the case of Buddy and his family the music therapist hopes that regular sessions will allow exploration of new ways of being together that are playful, mutually enjoyable, and in which the balance between the needs of the Dad and his son can be achieved. Ultimately if the Dad tunes in more sensitively to his son he may enjoy a more co-operative parenting relationship with his partner. Increasing joyful interactions predicated on respect and trust will militate the interpersonal conflict between the adults in the household.

## Core Concept: The Use of Therapeutic Presence Promotes Trust and Safety

Since the mid-1990s allied health professions have been under increasing pressure to prove their work with patients is effective. The evidence based medicine movement (EBM) started in medical care but quickly moved into all areas of health care. On the one hand this has created difficulties for some practitioners such as music therapists working in areas in which clients with complex needs[4] are routinely encountered (Edwards, 2002; 2005). On the other it has allowed for further description and nuancing of aspects of care that have not traditionally needed to be explained outside of training. One such concept is therapeutic presence (Geller & Porges, 2014). Descriptions of the stance of the therapist, how they reason, think, and how they are when they are with the client are increasingly encountered in the literature (for example Payne, 2015). These descriptions indicate that is it not the showing up with a guitar that make the process therapeutic[5] but rather a combination of many factors including the presence of a therapist who is boundaried, psychologically available, with the requisite skills and training to tune in to the client's experiences and needs.

The imperative of EBM in its first iterations rode roughshod over many essential dimensions of practice, such as the effects of quality of the relationship between the therapist and client, only allowing services to be provided where reductionist cause-effect studies had shown patient's symptoms had changed significantly. This ignored the value of processes such as those afforded in music therapy practice with people on the margins of healthcare who may not fit a single category of symptomatology and may not benefit from a one-size-fits-all approach when responding to their needs.

In the description in the quote below it can be seen that therapists hold a particular view of their role and the need for their services. By adhering to the core principles of therapy practice the therapist enters an interpersonal space with the client but also shapes that space to be as helpful to the client as possible.

> …the helper believes that by belonging to a particular professional occupation and orientation, s/he is capable of prompting and supporting change in others…by believing that such interventions are necessary, required, and helpful the helper is obliged to take particular actions. When the authors write about these interactions and experiences in music therapy we are not separate from them, but rather are actively engaged in their construction, interpretation, and consequently their meaning, (Edwards & Hadley, 2007, p. 202).

Helen Payne, a Dance Movement Therapist writing about her work with people who have medically unexplained symptoms explained how the therapist as facilitator engages within the therapeutic space. This resonates with us as a way in which the presence of the therapist is enacted in the process of music therapy.

> The facilitator cultivates her sense of purpose, "presence" and non-judgemental attitude. She does not aim to fix anything nor change thought patterns but by "being alongside" makes space for action, imagination, sensations, thoughts and feelings witnessed as they arise and are reflected upon. The facilitator's task is highly complex involving simultaneously the perception of the participants' verbal and non-verbal expressions and the self-regulation of one's own perceptions and counter transferences. (Payne, 2015, p. 20)

Our work often starts before the session, bringing the client or the group to mind and letting any thoughts about them or physical reactions arise and be contemplated. This preparation is valuable to the therapist being ready for the work, especially in complex situations or in group work where the processes can be intense and are necessarily unpredictable.

Using Polyvagal Theory (Porges, 2011) Geller and Porges (2014) illuminated therapeutic presence as a key factor that is reliant on neurophysiological processes by which safety, security, and trust are experienced in the therapeutic relationship. People who seek or are referred to psychological services have often experienced a breakdown of their capacity to cope, or to relate successfully with others. Therefore the ability of the therapist to provide safety and security within a nurturing interpersonal space is crucial.

> Expert therapists have reported that the experience of therapeutic presence involves concurrently (a) being grounded and in contact with one's integrated and healthy self; (b) being open, receptive to, and immersed in what is poignant in the moment; and (c) having a larger sense of spaciousness and expansion of awareness and perception. This grounded, immersed, and expanded awareness also occurs with (d) the intention of being with and for the client in service of their healing process. By being grounded, immersed, and spacious, with the intention of being with and for the other, the therapist invites the client into a deeper and shared state of relational therapeutic presence. (Geller & Porges, 2014 p. 180)

For the music therapist relational therapeutic presence is enhanced by attention to and curiosity about the ways in which the client speaks, moves, creates, and responds vocally, physically, and musically while in sessions. In the case above the music therapist tunes in to the Dad with his son, being sensitive to and appreciative of the minutiae of their interactions. She is heartened when she notices the brief fleeting contact between Pete and Buddy. Her hope for the relationship and its potentials to be enhanced through coming together in music therapy is flourishing. She nurtures this hope between sessions and uses it to be patient and reflective when the sessions are missed, or are multifaceted and confusing in some way and when the ways that the pair interact are disappointing and limited.

# Capacities That Ethnomusicology Training Provides That May Benefit the Further Development of Music Therapy Practice

Explaining some aspects of music therapy briefly above has provided a context for appreciating that a person and a musical instrument are not the only requirements for creating therapeutic opportunities in the relating space of the music therapy encounter. In this next section we turn to some of the capacities of ethnomusicology that we consider are helpful to the development of music therapy and have potential for ongoing collaboration.

An ethnomusicologist is not only interested in the music of the world's cultures but also in the role that this music plays. Through an immersion in music of a particular region or style, whether this be through listening to recordings, analysing transcripts or undertaking fieldwork, an ethnomusicologist seeks to understand and experience the role of music in a social and cultural context. This often although not always involves the ethnomusicologist studying unfamiliar music from a different part of the world from where they grew up. Through understanding and comparing different musics, ethnomusicologists come to new musics with an openness and willingness to accept, to learn, and often can become intrigued and amazed.[6]

# The Development of Research Skills

As the field of ethnomusicology has developed over time, the methods used to collect data and present findings has changed. Whether an ethnomusicologist is engaged in recording music and providing detailed transcriptions of the music, interviewing musicians, or involved in ethnographic study, ultimately ethnomusicologists are required to develop skills in research and fieldwork. The methods used are the most appropriate to time and place, to what is accepted culturally and to what is deemed most appropriate for those involved. Kruger (2009) has stated that ethnographers must "specifically account for the impact of their fieldwork presence on people's rights, interests and experiences" (p. 6). Music therapy research and literature for many decades seemed not particularly interested in client experiences but instead was focussed on outcomes and effects of participation. In the adult mental health area, for example, clinicians in supervision do focus on the experiences their clients describe but until very recently research studies' main emphasis was on proving the utility of music therapy through evidence of symptom reduction (Edwards, 2006). It is interesting and important to consider how being more involved in the interests and experiences of the client in terms of their participation in therapy can be informed and supported by some of the knowledge gained in these areas by ethnomusicologists who have engaged in fieldwork.

A number of researchers have reflected on ethnomusicology traditions in ways that suggest how studying ethnomusicology may be of benefit to someone who goes on to train as a music therapist (for example Babiracki, 2008; Titon, 2008). Titon (2008) has referred to fieldwork as knowing people making music; a highly relevant concept for practice in music therapy. Babiracki (2008) explored the need to bridge the gap between experience and writing about that experience. Bridging this gap is one of

the challenges for music therapists both in practice and in research. Keeping detailed session notes, furnishing reports, writing articles and presenting research findings are part of a music therapist's job. The field of ethnomusicology offers music therapy students and qualified music therapists multiple perspectives in relation to these areas of work.

## Knowledge of Different Types of Musical Instruments

Ethnomusicologists have knowledge and interest in musical instruments from around the world and how they are used in their cultural context. Some music therapists have also explored the influence of musics of other cultures in their practice (for example, Loth, 2006). It is not uncommon for a music therapist to have a collection of what are often described in the music catalogues or web pages from which we choose our purchases as world music instruments. As a result of the pioneering work of early music anthropologists and ethnomusicologists these instruments are now commonplace in music therapy rooms and on music therapists' instrument trolleys. A knowledge of where these instruments come from, how they were made, how and why they were played can help music therapists gain perspective on why they are using these instruments, especially when introducing these instruments to a client for the first time. The field of music therapy has benefited from ethnomusicologists who have taught world music courses in University settings around the world. Many qualified music therapists have undertaken world music performance or study courses in their undergraduate music degree training.

## A Wish to Combat Ethnocentrism

Nettl (2005) made an interesting reference to the distancing of the researcher from ethnocentrism when he states that ethnomusicologists often have a wish to promote intercultural understanding and to challenge mono-cultural world views. Although these attitudes are not a prerequisite of study in his opinion, there are few ethnomusicologist who don't share them. In music therapy it seems to have taken rather a long time for the community to comprehend that cultural understanding involves acknowledgement of our own sensibilities and experiences, not just those of others, and all practitioners have more work to do to recognise and acknowledge the need for greater cultural care in our practice (Mahoney, 2015). For the majority whites among the music therapy communities to which we belong becoming antiracist requires us, as Yancy has described it, to get our "shit together" (Yancy, 2008, p. 229). It starts with knowing that we have much more to learn.

> Culturally competent staff are aware of their own cultural attitudes and beliefs, as well as those of the individuals, families and communities they work to support. They are alert to the legitimacy of inter-cultural difference and able to interact effectively with different cultural groups. Their first responsibility is to refer back to the client. Do they feel safe in how they experience the delivery of the service? Not, "I am now culturally competent, and therefore you will be safe in the service I provide." (Atkinson, Nelson, Brooks, Atkinson & Ryan, 2014, p. 301)

## Ethnomusicology has an Egalitarian Ethos

Ethnomusicologists share the view that all music is a cultural universal (Nettl, 2005) and all types of music are worthy of study. This aligns with music therapy practice in which exploration of clients' musical preferences and previous musical experiences rather than application of music that is considered therapeutic. Conscious of not intimidating a client by appearing as some sort of musical expert, a music therapist encourages clients to express their musicality through genres and styles meaningful for them. A music therapist will always value the music and musical preferences of a client, even if they do not align with the therapists' personal preferences.

## Our Collaboration can be Music Focused

What is music? For an ethnomusicologist their idea of what music is and can be, is turned upside down through the exploration of new musics in unfamiliar cultures. A music therapist's idea of what music is and can be, is constantly re-worked and re-evaluated in the therapeutic space. A single vocalisation, a deep exhalation, a hand stretching out to touch the string of a guitar, or a fleeting moment of eye contact can be observed and reflected. Tiny sonic gestures can become highly amplified and nuanced in the relationship between music therapist and client. Music is no longer confined to structure or form in the music therapy space. Every element of music can be broken down to minute components of rhythm, melody, pitch or timbre. The ways in which any of these elements are expressed form the musical conversations that develops between client and therapist.

Ethnomusicologists and music therapists can find commonalities in the ways we think about music, and will agree that music brings people together, is a form of self-expression that can provide a way for people to come into contact with, and reflect on, their emotional experiences. Both disciplines accept that music is an important part of human culture, and the making of music enhances our inter-connectedness; our humanity. When comparing the two disciplines, ethnomusicology explores the music of people in community, and music therapy supports and enhances people's communicating and community building capacities through music.

## Promoting Inter-professional Learning Through Enhancing Knowledge of Cultural Safety

Cultural safety is a term originating in New Zealand nursing training that describes an approach to healthcare which "takes into account the practitioner's own values and an appreciation of issues of power imbalances as a result of colonization" (Davidson, Hill, & Nelson, 2013, p. 72). Initially it was founded as a response to Maori students' concerns that their cultural identity was insufficiently protected and valued in nursing training procedures. Informed from a critical feminist viewpoint cultural risk or unsafe practice is understood to be occurring when actions of the healthcare professional "diminish, demean and disempower the cultural identity and well-being of an individual" (Whakaruruhau, 1991, p. 7).

Music therapists have worked with people from other cultures and travelled to other countries to undertake work in refugee camps, orphanages, institutions and hospitals where in spite of language and cultural barriers reflective and effective practice has been enacted (Bolger, 2013; Edwards, 1999, 2007; Knoll & Knoll, 2011; Metzner, & Bürger, 2007; Woodward, 2015). So there is a body pf practice experience that could be drawn upon to further develop and explore cultural competency for future work and training. We propose that for music therapists and medical ethnomusicologists exploring how musical experiences can enhance cultural safety in healthcare contexts could be a mutually beneficial area for further study together. Could we prepare a document that outlines how principles of cultural safety can be upheld when providing training and professional services? Through our collaboration can we discover how and where music makes a difference to cultural safety for individuals and for communities as well as reflect on the intersectional aspects of the therapist's culture and cultural identity?

Sangeeta Swamy is a qualified music therapist in the US whose writing and research addresses issues for practitioners in developing skills in culturally competent practice. In her presentation to the New Zealand music therapy conference in 2013 she urged practitioners to sharpen their awareness of issues for immigrants.

> Music therapists...should focus on creating a safe atmosphere and provide potential families with appropriate community resources...Music therapists should also inquire about clients' level of comfort living in their host country and pay attention to how the cultural group they are working with is perceived in the community they live in, such as whether they are welcomed or seen as a drain on the economy, perceived as separatist for socialising with their own cultural group, or judged for not appearing willing to learn the language of the majority. This minority stress can have a tremendous impact on the emotional well-being and mental health of clients. (Swamy, 2014, p. 41)

We suggest there is more to be done in this space. We invite our colleagues in medical ethnomusicology into this collaboration.

# Conclusion

We urge the community of medical ethnomusicologists to resist the seduction of becoming healing practitioners without having training in therapeutic knowledge and presence, and instead lead the way as community activists, theorists, and cultural awareness advocates and advisers. Music therapy training equips the practitioner with the necessary therapeutic skills and increasingly also with the personal and cultural awareness needed so that the work can be carried out in a way that is professional and safe for all parties involved, and this is a lifelong learning process. Medical ethnomusicology has a lot to offer music therapy in terms of broadening and enhancing our cultural competency, and we have a rich vein of practice experience that can be mined through the application of ethnomusicological research techniques.

We consider that music therapy is open to, and would benefit from, the collaborative potentials that could result from an ongoing respectful partnership. To provide healing therapeutic work often engages the vulnerabilities of people who are seeking

or are referred for help even if offered from a strengths, anti-oppressive, or recovery perspective (Baines & Edwards, 2015). It is possible to be unconsciously seduced by the power differential between the therapist as paid professional and the vulnerable client. To avoid this problematic scenario, in which demands might be made unconsciously by the therapist for the client to remain frail and needy - or ever to be magically cured - requires training, regular supervision, and the ability to manage patiently the difficulties of realising that most music therapy work is neither amazing nor immediately life changing. It requires consistent, boundaried supportive interactions that take place over time rather than in short term projects. Therapists' rescue fantasies (Malawista, 2004) are described and carefully examined in supervision, and the therapist's open and curious presence is enhanced through self-development work in personal therapy and other relevant personal growth processes such as body work or spiritual practices. This is an important part of the work in order that the possibility of vicarious trauma be minimised (Cohen & Collens, 2013).

To want to do music based therapy-like work based on enthusiasm, or some kind of personal healing crusade, could potentially lead to compassion fatigue (Figley, 2012) which in turn may lead to compassion failure. By not being able to spot warning signs in mental health contexts, or medical/psychological vulnerability in other clinical contexts, the practitioner can end up creating or participating in a crisis situation, with damaging effects for healthcare recipients that might also compromise the practitioner's confidence and ability in continuing to practice. Additionally clients have the right to know what treatments they are receiving and the qualifications of those who are providing them. By calling music therapeutic and offering sessions in ways similar to music therapists, medical ethnomusicologists can run the risk of confusing clients and service providers as to the programs provided, and in an increasing number of countries may risk prosecution for professional title violation.

# Notes

[1] Please note that we use the terms practitioner, therapist, facilitator, and service provider in this report. They are not always synonymous so we ask the reader to consider the context and nuance of our choice of these terms when they appear.

[2] Jane - I attended a medical ethnomusicology paper at the IAMM conference at University of Toronto in 2014. The presenter described music based work with vulnerable people in a healthcare facility. When asked during question time whether she thought she should gain training and qualifications in order to be able to work in such a therapeutic role she responded "I already have training and qualifications." There did not seem to be any space to suggest that a music degree specialising in ethnomusicology was not a training for therapeutic practice. as an ethnomusicologist).

[3] Supervision involves a supervisor and supervisee thinking about a case together in regular sessions which are paid for by the supervisee or their workplace. Usually supervision is provided by someone with supervision training and experience who does not have line manager responsibilities for the practitioner (Forinash, 2000).

[4] Complex needs is a term used in healthcare where a person accesses multiple sites of healthcare treatment but would benefit from holistic care and support. For

example, Max is homeless and living on the street in rough weather and over the past 12 months has regularly been admitted to hospital for treatment of bronchial pneumonia. Instead of providing services to the Max as if she is a collection of symptoms and treating her hoarseness and chesty cough, a complex care approach would deliver services additional to symptom management to prevent rough living and consider ways to support and help Max with any other mental or physical needs (Parsonage, Hard, & Rock, 2014).

[5] The authors have sometimes encountered the view that music is therapeutic and therefore any attempts to use music therapeutically should be considered music therapy. If this were completely true then music therapists would be unnecessary. Prescriptions for music listening or music playing could be endorsed and either self-help processes or assisted support for music participation could be delivered successfully. Decades of research have shown that although most people experience some reaction when music is played, responses to music are unable to be reliably predicted. In music therapy we are not trying to use the music to be therapeutic. We are creating a positive relating safe place in which music making can be used as a means to communicate and express whatever the client needs in order to resolve difficulties in their current circumstances and experience growth and hope.

[6] Oonagh - From my own personal experience of living with and studying the music and dance of the Ewe people in Ghana in 2001, I was struck by how difficult it was for me to grasp the complex drumming patterns and to remember extended patterns by ear. Yes, I was a skilled musician at that time, but my reliance on writter notation hindered my ability to play from memory. I was amazed by the young boys who could do this with ease. I was also struck by the fact that the young girls did not play the drums at all.

# References

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Atkinson, J., Nelson, J., Brooks, R., Atkinson and Ryan, K. (2014). Addressing individual and community transgenerational trauma. In Pat Dudgeon, P., Milroy, H., & Walker, R. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (pp. 289-306). Online resource: Kulunga Research Network.

Babiracki, C. (2008). What's the dDifference? Reflections on gender and research in village India. In Gregory Barz and Timothy J. Cooley (Eds.). *Shadows in the field: New perspectives for fieldwork in ethnomusicology* (Second Edition)(pp. 121-136). Oxford: OUP.

Baines, S. & Edwards, J. (2015). Considering the ways in which anti-oppressive practice principles can inform health research. *The Arts in Psychotherapy, 42*, 28-34. doi: 10.1016/j.aip.2015.01.001

Barz, G.F. & Cooley, T. J. (2008). *Shadows in the field: New perspectives for fieldwork in ethnomusicology*. Oxford: Oxford University Press.

Beebe, B., & Lachmann, F. (1998). Co-constructing inner and relational processes: Self and mutual regulation in infant research and adult treatment. *Psychoanalytic Psychology, 15,* 480–516. doi: 10.1037/0736-9735.15.4.480

Bolger, L. (2013). Music therapy and international development in action and reflection: A case study of a women's music group in rural Bangladesh. *Australian Journal of Music Therapy, 23*, 22-38.

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5(*6), 570. doi: 10.1037/a0030388

Davidson, B., Hill, A. E., & Nelson, A. (2013). Responding to the World Report on Disability in Australia: Lessons from collaboration in an urban Aboriginal and Torres Strait Islander school. *International Journal of Speech-Language Pathology, 15* (1), 69-74. doi: 10.3109/17549507.2012.732116

Dissanayake, E. (2008). If music is the food of love, what about survival and reproductive success? *Musicae Scientiae, 12*(1 suppl), 169-195. doi: 10.1177/1029864908012001081

Edwards, J. (1999). Music therapy with children hospitalised for severe injury or illness. *British Journal of Music Therapy, 13*, 21-32.

Edwards, J. (2002). Using the Evidence Based Medicine framework to support music therapy posts in health care settings. *British Journal of Music Therapy, 16*, 29-34.

Edwards, J. (2005). Possibilities and problems for evidence based practice in music therapy. *The Arts in Psychotherapy, 32*, 293-301. doi: 10.1016/j.aip.2005.04.004

Edwards, J. (2006). Music Therapy in the treatment and management of mental disorders. *Irish Journal of Psychological Medicine, 23*, 33-35.

Edwards, J. (Ed).(2007). *Music: Promoting health and creating community in healthcare contexts.* Newcastle -Upon Tyne: Cambridge Scholars.

Edwards, J. (2008). The use of music in healthcare contexts: A select review of writings from the 1890s to the 1940s. *Voices: A World Forum for Music Therapy 8* (2). doi: 10.15845/voices.v8i2.428

Edwards, J. (2015). Paths of professional development in Music Therapy: Training, professional identity, and practice. *Approaches: Music Therapy and Special Music Education. Special Issue - Music therapy in Europe: Paths of professional development. 7*(2), 44-53.

Edwards, J., & Hadley, S. (2007). Expanding music therapy practice: Incorporating the feminist frame. *The Arts in Psychotherapy, 34*, 199-207. doi: 10.1016/j.aip.2007.01.001

Figley, C. R. (2012). The empathic response in clinical practice: Antecedents and consequences. In J. Decety (Ed), *Empathy: From bench to bedside* (pp. 263-274). Mass: MIT Press.

Forester, C. (2007). Your own body of wisdom: Recognizing and working with somatic countertransference with dissociative and traumatized patients. *Body, movement and Dance in Psychotherapy, 2*(2), 123-133. doi: 10.1080/17432970701374510

Forinash, M. (Ed.). (2000). *Music therapy supervision*. Barcelona Publishers.

Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration, 24*(3), 178. doi: 10.1037/a0037511

Giallo, R., D'Esposito, F., Christensen, D., Mensah, F., Cooklin, A., Wade, C., Lucas, N., Canterford, L. & Nicholson, J. M. (2012). Father mental health during the early parenting period: Results of an Australian population based longitudinal study. *Social Psychiatry and Psychiatric Epidemiology, 47*(12), 1907-1916. doi: 10.1007/s00127-012-0510-0

Knoll, Š. L., & Knoll, C. (2011). *Short-term music therapy in war-affected areas: Organisational frames and professional practice*. BoD–Books on Demand.

Kruger, S. (2009). *Experiencing ethnomusicology: Teaching and learning in European universities*. London: Ashgate.

Loth, H. (2006). How Gamelan music has influenced me as a music therapist-a personal account. *Voices: A World Forum for Music Therapy 6*(1). doi: 10.15845/voices.v6i1.246

Mahoney, E. R. (2015, June). Multicultural Music Therapy: An Exploration. *Voices: A World Forum for Music Therapy, 15*( 2). doi: 10.15845/voices.v15i2.844

Malawista, K. L. (2004). Rescue fantasies in child therapy: Countertransference/transference enactments. *Child and Adolescent Social Work Journal, 21*(4), 373-386. doi: 10.1023/B:CASW.0000035222.16367.32

Malloch, S. (1999). Mothers and infants and communicative musicality. Rhythms, musical narrative, and the origins of human communication. *Musicae Scientiae*, 13 –28.

Malloch, S. & Trevarthen, C. (Eds).(2008a). Communicative musicality: Exploring the basis for human companionship. Oxford, UK: Oxford University Press

Malloch, S., & Trevarthen, C. (2008b). Musicality: Communicating the vitality and interest of life. In S. Malloch, & C. Trevarthen (Eds.), *Communicative musicality: Exploring the basis for human companionship* (pp. 1–11). Oxford: Oxford University Press.

Maselko, J., Kubzansky, L., Lipsitt, L., & Buka, S. L. (2010). Mother's affection at 8 months predicts emotional distress in adulthood. *Journal of Epidemiology and Community Health, 65*(7), 621-625.doi: 10.1136/jech.2009.097873

Metzner, S., & Bürger, C. (2007). Participation, mutuality, resistance: Intercultural music therapy in a post-war region. Music: Promoting health and creating community in healthcare contexts (pp. 136-153). Newcastle-Upon-Tyne: Cambridge Scholars.

Nettl, B. (2005). *The study of ethnomusicology: Thirty-one issues and concepts.* University of Illinois Press: Urbana & Chicago.

Nöcker-Ribaupierre, M. (2015). Recognition of music therapy in Europe. In J Edwards (Ed.), *Oxford Handbook of Music Therapy*. Oxford: OUP.

Papoušek, M. (1996). Intuitive parenting: A hidden source of musical stimulation in infancy. In I. Deliege, & J. Sloboda (Eds.), *Musical beginnings: Origins and development of musical competence* (pp. 88–112). Oxford: Oxford University Press. doi: 10.1093/acprof:oso/9780198523321.003.0004

Papoušek, M. (2011) Resilience, strengths, and regulatory capacities: Hidden resources in developmental disorders of infant mental health. *Infant Mental Health Journal 32*, 29–46.

Parsonage, M., Hard, E. & Rock, B. (2014). *Managing patients with complex needs: Evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service*. Tavistock & Portman, NHS Trust: Centre for Mental Health.

Payne, H. (2015). The body speaks its mind: The BodyMind Approach® for patients with Medically Unexplained Symptoms in primary care in England. *The Arts in Psychotherapy. 42*, 19-27. doi: 10.1016/j.aip.2014.12.011

Porges, S. W. (2011). *The Polyvagal Theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. New York: Norton & Company.

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 201-269. doi: 10.1002/1097-0355(200101/04)22:1<201::AID-IMHJ8>3.0.CO;2-9

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are*. London: Guilford Press.

Siegel, D. J. (2015). Interpersonal neurobiology as a lens into the development of wellbeing and reslience. *Children Australia, 40(*02), 160-164. doi: 10.1017/cha.2015.7

Stern, D. N. (2000). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic books.

Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), 79-101. doi: 10.1177/1077559511403920

Swamy, S. (2014). Music therapy in the global age: Three keys to successful culturally centred practice. *New Zealand Journal of Music Therapy, 12*, 34-57.

Titon, J. (2008). Knowing Fieldwork. In Gregory Barz & Timothy J. Cooley (Eds.), *Shadows in the field: New perspectives for fieldwork in ethnomusicology* (Second Edition)(pp. 25-41). Oxford: OUP.

Trevarthen, C. (2001). Intrinsic motives for companionship in understanding: Their origin, development, and significance for infant mental health. *Infant Mental health journal, 22*(1-2), 95-131. doi: 10.1002/1097-0355(200101/04)22:1<95::AID-IMHJ4>3.0.CO;2-6

Trondalen, G. (2015). Self care in music therapy: The art of balancing. In J. Edwards (Ed). *The Oxford Handbook of Music Therapy*. Oxford: OUP. doi: 10.1093/oxfordhb/9780199639755.013.19

Whakaruruhau, W. K. (1991). *Cultural Safety Hui of the Whanau Kawa Whakaruruhau*. Apumoana Marae. Rotorua. PSI Solutions New Zealand.

Winnicott, D.W. (1965). The maturational processes and the facilitating environment *The International Psycho-Analytical Library, 64*, 1-276.

Woodward, A. (2015). *Tapestry of tears: An autoethnography of leadership, personal transformation, and music therapy in humanitarian aid in Bosnia Herzegovina*. Doctoral dissertation from Antioch University. Retrieved from http://aura.antioch.edu/etds/192

Yancy, G. (2008). *Black bodies, white gazes: The continuing significance of race*. Maryland: Rowman & Littlefield Publishers.

Zaman, S. (2008). Native among the natives: Physician anthropologist doing hospital ethnography at home. *Journal of Contemporary Ethnography, 37*(2), 135-154. doi: 10.1177/0891241607312495