# Community Music Therapy & The Winds of Change

## A Discussion Paper

By Gary Ansdell


### Abstract

This article argues for the acknowledgement of a broader practice of Music Therapy, and for the development of a broader theoretical model to support this. I suggest a 'paradigm shift' may be currently underway in the discipline, with the over-arching model which leads, supports and validates practice turning to one best characterised as Community Music Therapy. This is a context-based and music-centred model that highlights the social and cultural factors influencing Music Therapy practice, theory and research.

Evidence of this 'turn' is converging from various traditions of Music Therapy. This article situates Community Music Therapy within the British context and tradition, comparing this at points with accounts from a more international body of literature.

In support of my claim I examine several perspectives. In Section One a historical perspective traces the development of two parallel 20th Century professions for working musically with people: Music Therapy and Community Music. My analysis shows their initial divergence, but recent convergence in similar territory - suggesting possibilities of mutual accommodation in the future. Section Two examines precedents of Community Music Therapy, highlighting the evolution of an ecological and social-psychological perspective. Section Three presents seven vignettes of current international initiatives characterised as Community Music Therapy - outlining work with a variety of client groups in a wide variety of socio-cultural contexts. An analysis of this work in Section Four compares it to the norms of the current 'consensus model' of Music Therapy in the UK and other countries - in terms of: therapist identity and role; sites, boundaries, aims and means of practice; overall assumptions and attitudes.

From this analysis I conclude that the practice and theoretical model of Community Music Therapy is arguably incommensurate with the current 'consensus model', and suggest that a paradigm shift to a new consensual model is both necessary and already underway. The article ends by asking a basic question: Can a Community Music Therapy model help bring about a more fruitful match between what musicians are best equipped to give, and what society in the coming generation will need from them?

I hope respondents to this article will outline, from the stance of their own individual or national contexts, convergent or divergent patterns to those I suggest - in the service of building a more inclusive map of this territory.

## Introduction

Which Flag is Music Therapy Currently Sailing Under?

The dog barks: the caravan moves on. (Sufi saying)

The Mistral and Sirocco were not the only changing winds at the recent 2001 European Congress of Music Therapy in Naples. Many people there were also sensing change in the climate of opinion in Music Therapy - palpable if not yet fully articulated. Presentations, discussions, publications and just casual conversations seemed to indicate that something new is in the air: music therapists with 'unconventional' practices, wondering whether their work was 'really Music Therapy'; therapists questioning how far traditional assumptions of Music Therapy could travel to non-Western and non-conventional situations; theorists suggesting that both the therapeutic and musical discourses on which the discipline has grounded itself up to now are themselves shifting, or else new theoretical models are arriving.

During the preparation of this article seven Music Therapists have described to me how they find themselves working musically with people in very varied contexts - and the questions this work raises in relation to current thinking in Music Therapy[1] :

- *Mercedes* works in a psychiatric medical setting in South Africa. How do cultural factors determine how the patients make music, and what such music means to them? What sense does music *therapy* have for them - as individuals, as a community?
- *Stuart* works in a neurological rehabilitation unit in a small town in Southern England. Is individual therapy enough for his clients, given a major factor in their situation is *social* disconnection? Can Music Therapy help them in their progress from therapy to community?
- *Jessica* works in a hospice in a semi-rural area of Southern England. What is the role of a Music Therapist in a hospice community? Is what she does solely for the patients' wellbeing, or also for the staff or the milieu?
- *Gary* works in a psychiatric hospital in Central London. What responsibility does a Music Therapist have for the 'musical life' of a 'circumstantial community' such as this? Can there be a range of sites and occasions for Music Therapy: from individual work, to groups, to communal performances?
- *Harriet* works in a residential centre for elderly people in a deprived and multicultural area of East London. Can the residents participate in their community more than might be expected? What role does performance have, and how do performance events link the disconnected people and places together?

- *Simon* works in a non-medical mental health day centre in inner-city London. How does Music Therapy challenge social isolation in an area of deprivation and racial conflict? Who decides what Music Therapy is in a non-medical setting? Who decides what it achieves?
- *Oksana* works with traumatised refugees at a Centre in Berlin, Germany: How can music therapy bridge the extreme cultural diversity of the clients? Is a Western model of therapy appropriate? How can music help them re-create community and belonging?

These scenarios, and the therapists' questions concerning them, match many of those I heard in Napoli. To put it simply, people are (after a period of stabilisation of the discipline) no longer always sure whether they know *what Music Therapy is*. Or, rather, whether the diversity of practices and theory they find themselves engaged in can comfortably come under the disciplinary umbrella of 'Music Therapy' any longer. How many times have we heard our colleagues and students describe novel aspects of their work - which have followed from client needs - followed by the caveat "But I'm not sure *this* is Music Therapy!" What they mean is that what they find themselves doing does not seem to fit into the current theoretical model which describes 'what Music Therapy is' - and 'is not'. They are sometimes under the impression their work is professionally unsound or ethically questionable.

In his forthcoming book Brynjulf Stige uses a nautical metaphor to characterise the current situation, asking: *Is Music Therapy currently sailing under the right flag?* Is it perhaps finding itself sailing in a new ship but under an old flag? This questioning of Music Therapy's identity in relatively abstract terms quickly filters down to the everyday dilemmas of a Music Therapist: What is my role? Where should I practice? What are my aims? What are my assumptions - about both music and people? If there is a mismatch between the ship of practice and the flag of theory, what impact does this have for current work, and for future developments?

Another contemporary issue (in the UK at least) follows from Music Therapy's success in becoming an establishment profession - its identity now State Registered. Music Therapists are asked how their practice differs from that of other musicians who work with people - for example 'community musicians'. Do Music Therapists and Community Musicians have different practices, or just different theories? Are their distinct professional turfs always in the service of client needs?

These are difficult, but very contemporary questions. At the dawn of the 21st Century the pace of social and musical change gathers: as a Sufi saying remarks, *the dog barks, the caravan moves on.* Music Therapists are increasingly facing up to these questions, and I hope this article will contribute to the various soundings on which way the wind is blowing.

## A Tale of Two Professions: Music Therapy & Community Music in Britain

## The Music/Healing Tradition & Working with People in Music

As I write this now, the Taliban regime is collapsing in Afghanistan, and with this their fundamentalist-inspired ban on music. Musicians are digging up their buried instruments and resuming where they left off. Music yet again presents itself both as a natural human activity, but at the same time as a symbol of social, political and ideological processes.

Recent critical histories and anthropological accounts (Horden 2000; Gouk 2000; Ruud 1998 & 2001) show how the perennial link between music and healing practices has extended across time and place - be this sometimes a practice in search of a theory, at others a theory in search of a practice. A constant factor, however, is that the link between music and healing has always been heavily reliant on *contexts* (social, political, economic, ideological). The 'music healer' and his patient need a supporting structure to interpret and validate a 'treatment'. It seems there have always been competing views concerning what 'music therapy' is, or ought to be - and, more pertinently, who should control such practices.

In Britain two progeny of this music/healing tradition appeared in the late 19th Century and matured into 20th Century professions. In this section I will outline the development, interaction and eventual divergence of: *Music Therapy*, whose practice became increasingly individual, and *Community Music*, whose practice remained a social one. My aim here is not to repeat recent historical accounts (Gouk 2000; Tyler 2000), but to chart the historical factors which have generated current patterns of practice and thinking in each area[2].

### Towards Music Therapy

From eccentric beginnings in 1890s London, Music Therapy developed through the 20th Century as a specialist profession (Tyler 2000). Its key developments can be divided into three main stages, reaching a definite sense of self-confidence by the end of the century.

***Stage One*** spanned from the 1890s up to the 1940s, with musicians increasingly used within hospitals (which for both physical and psychiatric illnesses were often self-contained communities). The work was mostly non-participatory, music being played *to* patients. Two main models guided it: (i) the 'medical model' - where music was used in a variety of experimental ways within medical treatments; (ii) the 'recreational model' where music was essentially a therapeutic form of entertainment, implicitly addressing the social and psychological aspects of illness. Large hospital communities attempted to mirror the 'outside world', with recorded music, hospital choirs and bands, performances for patients, or sometimes by patients. These in turn linked hospital music-making with the forms of amateur musicianship in Edwardian society (in

turn underpinned by an attitude which considered music a benign social force) (Everitt 1997).

***Stage Two*** was initiated by the Second World War and the social changes which followed it. Entertainers of the troops experienced in fresh ways the perennial relationship between music and morale, whilst musicians at home found a role working in hospitals with returning veterans, who were often both physically and mentally scarred. Musicians played to, but increasingly also *with* patients. Similar developments were happening in the United States, leading to the systematic development of the modern discipline and profession of Music Therapy, based on the prevailing psychological and medical models of the day (Maranto 1993; Gouk 2000).

A decade later, British pioneers made parallel (if more modest) professional initiatives. Juliette Alvin founded the Society for Music Therapy and Remedial Music and, in 1968, the first training at the Guildhall School of Music in London. Clinical work began with mentally and physically handicapped children, and later with adults in psychiatric hospitals.

As with the American situation, the development of Music Therapy in Britain rested on gaining institutional legitimacy by association with a prevailing treatment model (Ruud1980). At first Music Therapy served as an adjunct to a *remedial model* in the therapeutic care of handicapped and autistic children. Through the work of Mary Priestley and others in the 1960s/70s Music Therapy also found a home in the psychiatric establishment and began to assimilate a *psychological model*. A question of the time (for both Music Therapists and their employers) was: Is this work 'therapy' or 'entertainment' - or both? Is it possible for it to be more than one thing? The early pioneers seemed able, however, to maintain a flexible role and to work with a spectrum of musical/therapeutic activities (a situation which increasingly became a dilemma for Music Therapists). Contemporary accounts suggest that medical colleagues considered it an 'ancillary treatment', whilst Music Therapists seem to have expected impending theoretical harmony with the surrounding epistemologies - as a statement by Alvin's shows: ".we can begin to see a synthesis emerging between the medical, recreational, educational, psychological and musical influences on the developing profession" (in Tyler 2000: 386).

Mary Priestley's accounts of her pioneering work in adult psychiatry (Priestley 1975) show these trends clearly. On the one hand she writes in her introductory chapter 'What is Music Therapy?':

".it is toiling round institution wards with baskets of percussion instruments and bags of music wondering how your muscles will adjust to playing Bach's *Air on a G String* when you reach your destination. It is long hours at night arranging a movement from Beethoven's Choral Symphony, on request, for piano, trombone, soprano and cello, only to find next day that the trombonist has been discharged and the cellist transferred to another hospital". (Priestley 1975: 15)

Alongside this highly varied social practice of Music Therapy, Priestley was simultaneously developing her system of Analytical Music Therapy (Priestley 1975; 1994) - attempting to place Music Therapy practice and theory within individual psychoanalytic working methods and theoretical assumptions - not as an adjunct, but as a self-sufficient treatment.

A third pioneer team, Nordoff and Robbins (1971, 1977), worked with handicapped children and moved comfortably between individuals and groups, between intense private work and public performances of musical 'working games' and musical plays. Coming from a background in the Anthroposophical movement, Nordoff and Robbins saw their role as musicians for the special communities they found themselves in, and the individual therapy as a preparation for community life for the children they worked with. As Clive Robbins (forthcoming: 1) writes: 'It is in the nature of music that our musical journeys, from their very beginnings, can be both deeply personal yet have broad social implications.'

Although these pioneering models of Music Therapy had clear identities, there are nevertheless several important shared features:

- Moving from playing *to* people to playing *with* them (from 'receptive' to 'participatory' work)
- The use of improvisation to allow spontaneous *co-musicing*
- A focus on the *interpersonal relationship* within the musical, and the modelling of the work on other therapies
- Increasing concentration on *individual* work with patients
- Alliance with medical and therapeutic theory as explanatory and legitimating devices

***Stage Three*** represents the professionalisation and institutionalisation of Music Therapy in Britain - dating from the establishment of professional associations, training and career structures (in the late 1970s-early 1980s)[3]. This ensuring of the livelihood of the Music Therapist and her professional identity has been followed by the trappings of status: training and curriculum regulation; academic fellowships at PhD level; development of an academic discourse and conference circuit; mandatory schemes of supervision and CPD (Continuing Professional Development programmes). And finally, the icing on the professional cake, in 1999 Music Therapy became a state registered 'Health Profession' in the UK.

***Stage Four*** I take to be beginning now, at the dawn of the 21st Century. This article is perhaps symptomatic of the reflexive stage Music Therapy now finds itself in - asking questions concerning its identity, fitness for purpose and future shape and prospects.

Towards Community Music

A parallel tradition of working musically with people developed in 19/20th Century Britain parallel to Music Therapy - *Community Music*. This rested upon the rich amateur music-making tradition of the country, in particular that which developed in the new industrial cities of the Midlands, with their more socially mobile communities (Everitt 1997).

Not until the 1960s-70s, however, were attempts made to consciously articulate this link between the social and the musical amongst people *not* defining themselves as 'music therapists'. Consequently, unlike the history of Music Therapy, it is difficult to give an organised chronology of Community Music, except on the basis of *before* and *after* its self-definition[4]. Save to remark that in the UK it has followed both the changing patterns of music-making alongside larger changes in society. For example, during the decades following the Second World War British society saw both the weakening of traditional geographical communities, but also the culturally broadening effect of immigrants coming to Britain with a wealth of indigenous musics. Related to this was the rapid explosion of popular music and its musically democratising effect on younger generations. It seems, however, that as important as these concrete events were, it was as much the ideology of a particular time which led to Community Music as a self-defining movement (Everitt 1997: 80). The major factors (originating in the counter-culture of the 1960s and '70s) were:

- An ideological radicalism reflected in 'social art theorists' who advocated empowering people by giving them a voice - especially the estranged or excluded from society. These ideas flowered during the 'arts centres movement' in the 1970s forwards.
- Equal Opportunities politics and culture, fostering dialogue and participation for minority groups (defined by ethnicity, disability or illness).
- Dissolving of rigid boundaries between 'high-brow' and 'low-brow' arts - instead the increasingly democratic meritocracy of 'no-brow'.
- The advent of new kinds of relationships between 'music-makers' and 'music-takers' due to more 'democratic' genres (pop, rock, ethnic musics) and instruments (drum/bass/guitar). New groups of *musical participators* became enfranchised, both socially and aesthetically.

The main agenda of Community Music has been the re-creation of community by providing opportunities for musical participation (Everitt 1997: 31). The discourse is often a social and political one, setting an agenda for work with geographically or socially-defined groups who suffer marginalisation (typically refugee or disability groups). An important strand of this thinking considers how the individual and the group relate in contemporary society, and what role music-making has in the changing relationship between them[5].

A distinction can be made between Community musicians,those who describe their work as music-making for its own sake, and those whose work is 'issue-based' - 'that is, the music-making is the medium through which the Community Musicians work with people to look at the issues they face - usually those of disadvantage' (Atkinson 2000:

19)*! Sound Sense*, the organisation for Community Music gives the widest definition possible: "Making music with people", whilst Southern Arts Community Music Steering Group talks of "All kinds of music for all kinds of people". After talking to many community musicians, Atkinson assembled the following definition:

"Community Music is a participatory music-making activity in which the community musicians work with a given community to enable them to make music which is inspired by their own interests and ideas. Some Community Music activities seek to address the issues of social difficulty experienced by the participating communities, whilst others pursue music-making for its own sake". (Atkinson 2000: 17)

Atkinson's analysis of current Community Music work suggest four key defining features:

1. Community Music is a participatory activity
2. Community Music is an activity that focuses on groups - a 'community'. There is the concept that the participants belong together in this 'community' from the start and the musical activities address the group as a whole.
3. Community Music also seeks to reinforce that 'community' by taking its inspiration from the 'community' and bringing people together.
4. Community Music has spin-offs in the areas of creativity, motivation and access to further opportunities (along with the unspoken attitude that Community Music often seeks to address issues of social exclusion and disadvantage in particular areas and groups of people).

Practically, there are three key characteristics of Community Music work: it is usually 'project work' rather than an ongoing process; it often includes performance aspects and can be user-led rather than expert-led.

Institutionally, Community Music is also an interesting contrast to Music Therapy. Although there are a wide range of trainings, the background and skill level of practitioners is broad. Currently most practitioners seem to agree on the inadvisability of allowing Community Music to become a registered profession, to regulate trainings, engage in research or audit practice.

Music Therapy and Community Music Today: Shared Territory, Different Maps?

Music Therapy and Community Music originated from a common belief in musicing as a means of working with people. Their subsequent divergence into two professional routes has led, however, to some key differences in terms of:

- *Who* is worked with, and *How many* people are worked with
- *Where* the work happens, and what resources are available
- *Why* they work with people (agenda, aims, theoretical assumptions)
- *What* continuity and depth of work is possible
- *What* status is given, what reward received

- *How* far successful practice has led to building a discipline and a professional structure to further the work and its body of knowledge

Presently the division between the two professions concerns working territory, theoretical maps, institutional legitimacy and resourcing. Compared to Community Musicians, Music Therapists have several seeming luxuries: of working largely with individuals, and within relatively protected conditions which guarantee continuity of their work. Music Therapists also have advantages of professional status and established professional structures. On both formal and informal levels there is currently little contact between the two professions - a surprising fact given their basic affinity (though one perhaps easily explained in terms of the lack of equal territory on which to dialogue!). Then, to turn the discussion around, what is Music Therapy missing by having its 'luxuries' (as detailed above)? What could it learn from Community Music? And looking to the future: will Community Music and Music Therapy develop in separate directions or increasingly move into each others' territory? Can they accommodate to each other?

Looking at both traditions, Jessica Atkinson (2000) makes the following comments:

"If Community Music is the making of music with people to meet their needs, it would not be unreasonable to suggest that music therapy falls within this category. In practice, I suspect few music therapists would wish for this as music therapy is a tightly organised profession which is seeking to define its practice, whereas Community Music appears to be avoiding any such move in some quarters.'

However, the notion that participatory music-making can be therapeutic is as old as the existence of music, and certain participatory music organisations are starting to move into the territory traditionally occupied by music therapists - i.e. working intensively with individuals to help them overcome their pathology. One such project is the 'Shimmer Project' in London, in which classically trained musicians from the orchestra Sinfonia 21 are working interactively with patients with dementia". (Atkinson 2000: 22)

The example given by Atkinson is a good one to discuss. An account of a Community Music project was written up as a feature in *The Guardian* newspaper in late 1999, in which musicians (who were part of a professional orchestra) were working with people with advanced Alzheimer's disease as part of a research project into the effects of music. The difference (and controversy) was that these musicians were using not just playing to the old people, but encouraging individual participation and using 'music therapy techniques' to do so. This could be seen as an attempt to work *with* the pathology, not just to encourage social participation. Signs of a blurring of boundaries here and in other projects recently have suggested that the traditional territories of Music Therapy and Community Music are beginning to overlap in practice[6]. Some Music Therapists hearing about the Shimmer project were concerned - were these people *trained* to work in this way? Should Music Therapists be defending their profession? Community Music has also voiced disquiet about the change. In their 'Practice Report' document of January 2000 - *Issues for the Conduct of Community*

*Music* - they ask: 'What is the significance of the boundary between music and music therapy?':

Community musicians frequently have therapeutic effects on individuals, groups and communities. Sometimes they acknowledge this, other times they deny this role - some community musicians cross over formally into music therapy. Does it matter? If community music is being therapeutic ought it to enquire into the norms and customs of therapy? What is happening to music therapy as community music encroaches? Does community music add to the therapy resource or confuse it? Should community musicians care? If not, should anyone? (*Sound Sense* 2000)

The questions are revealing in several ways. Firstly, the terms 'cross over' and 'encroachment' reinforce the impression of separate territories. Secondly - an issue I'll discuss later in Section Four - the linking of Music Therapy with 'the norms and customs of therapy' - suggests there to be a single authority which Music Therapy represents in this respect. There is also the implication that work 'being therapeutic' and 'being therapy' are two different things.

Though Music Therapists have seemed unsure how to react to the apparent 'encroachment' of Community Music into their traditional domain, it is equally true that they have themselves moved away from communal musical activities in the institutions they work in. Music Therapists have tended to move into increasingly 'specialist' fields, working largely with individuals, and appropriating equally specialist models of therapeutic practice.

## The Individual-Communal Continuum

As a conclusion to this historical/comparative perspective I want to suggest a way of illustrating the current relationship between these two different traditions of working musically with people, and possibly for thinking beyond this situation. Figure 1 below shows a simple continuum ranging from the *individual* to the *communal*. Along this continuum could be -placed various approaches to working musically with people. Figure 2 places Music Therapy and CommunityMusic as two relatively fixed positions along this continuum (though the dotted lines indicate provisional positions, the arrows recent movements towards each other).

Though any model of this kind is necessarily a simplification, it suggests how Community Music and Music Therapy have 'colonised' distinct territories along a naturally expansive continuum. What lies between the two positions? Is a less polarised approach possible? Which situation would be in the best interests of clients, or of musicians who train as Music Therapists, or Community Musicians, or the institutions in which any of this work takes place?

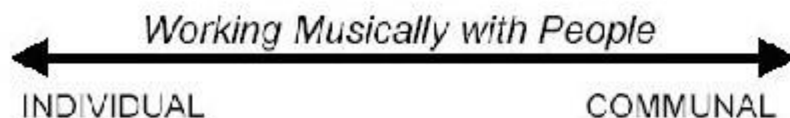


***Fig 1 - Continuum of working musically with people***

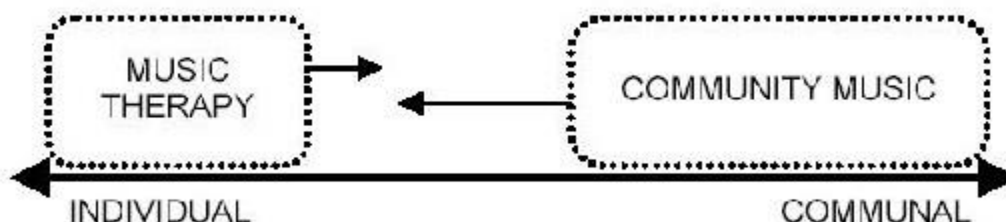


***Fig 2 - Two main traditions of working musically with people - placed along the continuum.***

## Community Music Therapy: A 'Third Way'?

### Defining Community Music Therapy

In practice it would seem that many Music Therapists address the needs of their clients and the situations in which they find themselves by working more broadly across the individual-communal continuum. Recent debate in some quarters of the profession is asking, however, why such work cannot be more publicly acknowledged, and why the model on which Music Therapy is based cannot also be broadened to legitimate such practice, and to explore its implications.

It seems natural to call this broader field *Community Music Therapy*, which - as Figure 3 below shows - would aim to cover as much of the continuum as possible. This does not necessarily have to displace either Community Music or the more individualistic models of Music Therapy. It does, however, suggest a 'third way' for considering both the current situation and future possibilities.

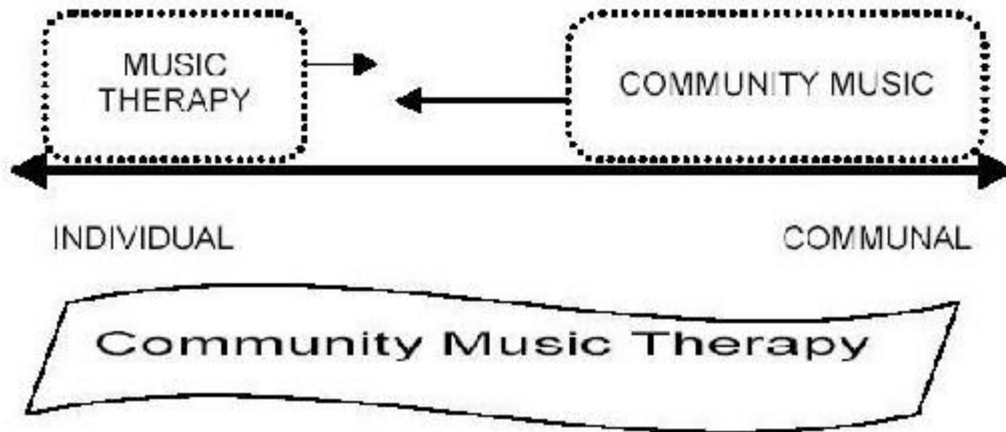


***Fig 3. Community Music Therapy as a 'third way' of working musically with people.***

Here is a suggested working definition of Community Music Therapy:

*Community Music Therapy* is an approach to working musically with people *in context:* acknowledging the social and cultural factors of their health, illness, relationships and musics. It reflects the essentially communal reality of musicing and is a response both to overly individualized treatment models and to the isolation people often experience within society.

In practice *Community Music Therapy* encourages Music Therapists to think of their work as taking place along a continuum ranging from the individual to the communal. The aim is to help clients access a variety of musical situations, and to accompany them as they move between 'therapy' and wider social contexts of musicing.

As such, *Community Music Therapy* involves extending the role, aims and possible sites of work for music therapists - not just transporting conventional Music Therapy approaches into communal settings. This will involve re-thinking not only the relationship between the individual and the communal in Music Therapy, but also taking into account how physical surroundings, client preferences and cultural contexts shape the work.

*Community Music Therapy* aims to develop theory consistent with its view of musicing as an engaged social and cultural practice, and as a natural agent of health promotion. (formulated by Ansdell, Pavlicevic, Procter & Verney 2002)

There are several precedents to this formulation amongst Music Therapy traditions which have evolved in different social and musical milieus. As Brynjulf Stige comments: 'Music therapy grows out of, and interacts with, culture and society. Music therapy is different in different places and at different times, not just because science moves forward, but because therapy is embedded in culture' (Stige, forthcoming). What appears new and contentious within one national group is established and self-evident

in another. In the remainder of this section I will outline some of the precedents of the Community Music Therapy model, as outlined in the Music Therapy literature[7].

Communal 'Possibilities of Action' : Towards Community Music Therapy

A good example of the relationship between cultural politics and the varied complexion of Music Therapy is the Scandinavian tradition. Here, Even Ruud mentored an anthropological and cultural perspective on music and healing, wherein Music Therapy '.understands itself as part of a cultural movement, and not only as a treatment profession'(Ruud, 1980). This fit the political situation in Norway and other Scandinavian countries in the 1970s and 80s, where the handicapped and mentally ill were being moved out of institutions and into community settings, and where their equal cultural participation in the life of the community was considered a right. This situation led to a debate on cultural politics, leading to resources being diverted from the 'high arts' to the community arts, and an emphasis placed on cultural and artistic *process*. In line with much of this, Ruud defined Music Therapy's aim as to "*increase possibilities for action*". He explains:

This did not mean only directing music therapy to the individual needs of clients, trying to empower their developmental skills to increase their personal sense of agency. It also meant that because "possibilities of action" were often hindered by the larger structural barriers in society, I felt the need to establish music therapy as something that could meet the broader sociological and cultural needs of the clients. This meant that therapists could see themselves also as cultural workers, taking music therapy values and approaches into the community [...] My key concepts there are drawn from the use of music as a tool for encouraging participation, networking, opening doors, and empowerment through a strong musical identity. (Ruud 1998: 3)

The main musical tool for this more communal agenda was, as for other traditions of Music Therapy, musical improvisation. Instead of being just a projective or aesthetic device, however, Ruud gives improvisation a communal function - linking-in humanistic and more social theories:

"Instead of 'aesthetic refinement', improvisations in music therapy seek to build a community ("communitas") through a temporary levelling-out of all social roles. During improvisation, all traditional expectations regarding the role of therapist do not apply: music therapists try to build a spontaneous, immediate community through which "free collective improvisations", in which complementary symmetrical forms of social interaction originate spontaneously out of musical interaction. Improvisation becomes a joint project in which emotion is the main measure of the credibility of the experience [...]"

"This liminal experience of closeness and mutuality between people is what Turner called "communitas": "These individuals are not segmented into roles and status but

confront each other rather in the manner of Martin Buber's I and Thou" (Turner 1969: 132). Typical of this experience is the direct, immediate, and total confrontation of identities. Buber also emphasises that an immediacy; a sheer sense of presence; and a lack of aims, means and anticipation are necessary before a "meeting" can take place." (Ruud 1998: 132)

Brynjulf Stige (trained by Ruud) writes explicitly about a 'Community Music Therapy', and outlines a project where it is applied. 'The basis' writes Stige, 'is a conception that man is part of a community, and that this community is cultural in nature' (forthcoming). An important part of the definition of Community Music Therapy is '.the sense that the local community is not only a context for the work, but a context to be worked with'. Notions of health and sickness are seen in terms of the individual-in-context, and consequently the music therapy process is no longer framed only by the walls of the music therapy room:

"It is of specific importance to see the client as a cultural individual in the community. In fact, goals should be defined both for the individual, the music group (if the format is group), the organisations in the community, the public institutions that are involved, the clients' neighbourhood, etc. Of course these goals will be on very different levels. *The point is that it is not possible to work with the client as an isolated individual* [.] The work will therefore be open, flexible and partly public". (Stige forthcoming)

Stige describes in several papers the Community Music Therapy project he and colleagues initiated and researched in a regional community in Norway in the 1980s. A group of adults with learning difficulties were moving into the community, and the project called Upbeat aimed to 'increase their possibilities for action' by helping them access cultural participation through different contexts of music-making. The first meeting of the adults with the music therapists took place in the community music school. One man, Knut, saw a poster of the local brass band on the wall and asked "May we too play in the brass band?". His question became the practical and symbolic aim - the next three years attempting to make this a reality. This involved at first traditional group music therapy sessions - to develop musical communication and skills and personal confidence. But the project also involved liaison with community music activities and the gradual incorporation of the music therapy group into the local musical life of choral and band performances. The aim was eventually met that these adults should participate in the cultural community they shared. The music therapists had to work on more levels than usual: therapeutically with individuals and groups, but also culturally and politically within larger contexts. The therapists became "action therapists" trying to initiate cultural and attitudinal changes. As Stige writes: '.the music therapist could try to help clients through changing the world, if only a bit'.

Stige uses a sociological/ecological model for this and other work, presenting four interlinking layers of context in which Community Music Therapy takes place:

- The immediate *microsystem* of an individual's life
- The mediating *mesosystem* of the individual's communal life

- The social/cultural context of the *exosystem*
- The removed, overlaid cultural/political level of the *macrosystem*

Community Music Therapy is naturally implicated in all of these levels, because clients themselves are. Consequently '.the rationale for ecological music therapy is that it is not always enough or effective to work on a microsystem level':

"All of this invites us to develop an understanding of therapy that supersedes the dichotomy often suggested between the individual and collective aspects of human life. Any individual is a person in context. From this cultural elements are internalised. The human path to individuality thus goes through culture and the collective. The implications I draw from this are more than to advocate the relevance of group therapy. We also need to explore other collective forms of therapy, such as milieu and community music therapy in ecological perspectives, and we need to consider the relevance of cultural processes also when working individually". (Stige forthcoming)

There is a somewhat shifting terminology in the accounts of this tradition: of the 'communal', 'cultural', 'social', 'ecological', 'political'.This perhaps reflects both a developing vocabulary, but also shows how various levels of context overlap in the thinking. Stige also uses the anthropologist Victor Turner's concept of *communitas* to conceptualise the experiential basis of Community Music Therapy work. But he is also careful to relate it to other levels:

".we should not forget that these [experiences of *communitas*] are framed by 'host communities', or *societas*, to use Turner's expression [.]. We must therefore try to avoid Romantic and essentialist interpretations of communitas in music therapy as absolute equality and mutuality in music. Communitas is framed by the scripts, rules and roles of specific communities and I argue for the need to reflect upon the relationships between the therapeutic meeting and the community contexts they belong to.'". (Stige forthcoming)

Another Norwegian, Trygve Aasgaard, has recently published several colourful accounts of work that also explicitly consider context and culture within an ecological model of Music Therapy. Aasgaard works in palliative care settings with adults and children, calling his approach 'Music Environmental Therapy' - which he defines as 'a systematic process of using music to promote health in a specified environment, inside or outside of an institution' (1999: 34). 'Music environmental therapy', writes Aasgaard, 'can take place in corridors, halls or common room, in treatment rooms or out of doors'. He works intimately with clients, but also in and with the *milieu*, aiming also to improve the institutional quality of life. His role and activities are various and flexible - writing songs with children, leading the hospital band or just facilitating for the institution a musical life which might involve patients, parents, staff and visitors. In his article *'A Suspiciously Cheerful Lady'* (2001) he makes a detailed analysis of how a single song written with a single patient began as a private event, then radiated out into the community through various performances, re-interpretations and disseminations. This is a good symbol of his overall philosophy:

In Music Environmental Therapy the individual patient should not be overlooked, but the focus for the interventions should be extended to encompass all present in a defined milieu [.] In the end it is a question about which values shall dominate treatment and care. Music therapy never takes place in a vacuum, in such settings the various professions are really inter-dependent. There are no antagonisms between an individually directed music therapy and one mainly directed towards the environment. The best possible music therapy in hospices and in hospital is probably a combination of the two perspectives. (Aasgaard 1999: 41)

Aasgaard discusses the effects of his work in terms of his patients' experience of: *space* - how music can effect how a person relates to an environment; *time* - how music can help people feel orientated within disorientating environments; *quality* - the overall quality of life possible within an institutional situation. Most importantly, however, musicing enhances the quality of *relationships* within a milieu:

"Musical activities can create new relations between the participants in a milieu.when patients and parents make music together with staff, it is likely that the spirit of community is strengthened within the institution". (Aasgaard 1999: 40)

Though particularly characteristic of the Scandinavian tradition of Music Therapy, 'communal thinking' has also been part of the stance of several other key practitioners in other traditions (though they have often not been part of a larger movement). For example, Carolyn Kenny's work has maintained a context-sensitive understanding of Music Therapy within the North Atlantic community (Kenny 1989, 1996), based on systemic and ecological models. Additionally, recent interesting work on issues concerning performance in Music Therapy has come from Alan Turry (2001), whilst Aigen (forthcoming) has explored the relationships between social/cultural roles and popular music genres within a Music Therapy setting. 'We can then. consider music therapy' writes Aigen, 'not as a specialized service or mode of interaction fundamentally different from normal social processes.'.

Leslie Bunt is one of the few British music therapists to have commented on the links between musical culture, social movements and Music Therapy. He asks in *Music Therapy: An Art Beyond Words* (1994): 'How does music therapy relate to trends in contemporary music and change in the role of the musician in society?', part of his practical response being his nationwide community-based organisation 'MusicSpace'. Yet in his chapter on Music Therapy in Hargreaves and North's (1997) *The Social Psychology of Music*, Bunt does not include or develop a social- psychological model of Music Therapy amongst the four outlined.

Simon Procter (2001) has recently sketched a radical agenda for a Music Therapist involved in non-medical settings such as the mental health drop-in centre he works in. This context has led him to engage with the social, cultural and political issues surrounding 'music therapy treatment' in such a setting. His practice is varied, flexible, and geared to balancing the needs of individuals and the musical life of the community. He characterises his identity and role as primarily a musician equipped with expert skills

to work therapeutically in order to empower and enable others - rather than as a paramedical expert.

"Music therapy has come from the outside, from radical musicianship. We must not merge entirely into a medicalised professional hierarchy: to empower and enable, wherever we work, we need hearing minds and radical hearts. And if that means being regarded as mavericks and naïve, then so be it". (Procter 2001: 11)

It is clear from my brief survey that the concept of Community Music Therapy is not a new one. Many Music Therapists have found the needs of their clients, or their situations, leading them towards this practice. As Music Therapy gradually becomes a more global discourse, the experience and theoretical formulations of these different pockets of Community Music Therapy work are becoming more widely known. It is perhaps time that such work is acknowledged and considered by a wider constituency of Music Therapists.

Symptomatic of this awareness of a new area is Kenneth Bruscia's addition of an extra category - 'Ecological Music Therapy' - to his 1998 Second Edition of *Defining Music Therapy*:

"The ecological area of practice includes all applications of music in music therapy where the primary focus is on promoting health within and between various layers of the socio-cultural community and/or physical environment. While the therapist may work to facilitate changes in the individual or the ecological context, the basic premise is that change in one will ultimately lead to changes in the other. Thus, helping an individual to become healthier is not viewed as a separate enterprise from improving the health of the ecological context within which the individual lives". (Bruscia 1998: 229)

## Community Music Therapy - Current Initatives

The following vignettes present current practice by seven Music Therapists[8] whose work could be characterised as Community Music Therapy. Five take place in the UK, one in Germany, one in South Africa. It happens they are all working with adults rather than children.

Mercedes works in a psychiatric ward in a South African hospital:

In a group session with women in an adult residential psychiatric setting, someone begins to sing, and the group explodes into singing and dancing as one. The music is accessible to my Western ear: the harmonies and rather complex rhythmic patterns are recognisable, the melodies are simple, there is strong beat, and 'joining in' is fairly straightforward - in the musical sense. What soon becomes evident, however, is that the

deep, strong pulse is linked to the womens' body movements. What is equally clear is that neither this pulse, dynamic level nor the phrasing - in fact, no aspect of this collective music - is going to shift at all. The genre has fixed social-cultural associations, and there is precious little I can do in terms of 'clinical interventions', but to 'go with the flow'. which goes on and on, seemingly endlessly.

These women have become a community, in the sense of living together, knowing one another's backgrounds, having similar belief systems, and in considering themselves one another's 'sisters' and 'mothers', as is common amongst African women. They are 'the experts' in terms of the music/dance being 'performed' in the sense that they have a deep understanding of the song's social context, social power and appropriateness. For example, it may be a song that is only sung by women who have borne children; or a song sung by women to the ancestral spirits asking for rain, or a good harvest, and so on. As a woman I would not therefore be transgressing social norms by joining in, and as a musician I apprehend the 'surface structure' of the music fairly quickly. I get a grasp of its phrasing, structure, idiom - also using my body to feel the communal nature of the pulse, phrasing, accents and so on. But in another sense I have to let go of my 'individualistic' way of listening as a music therapist for shifts in the music and for the need for 'clinical interventions' to help change the course of the music. Rather, I have to 'go with the flow' - as indeed most music therapists would do in different socio-cultural settings. What I have to understand, however, is that music here, now - with these people - has specific uses and characteristics, that these are collectively defined, and the music may well go on and on until I think it will never end. I need instead to fit in and become a part of this musical community, at this moment. 'Groups' soon become communities - however unchosen their venue - and this is what I've joined today. I'm naturally assigned a superior role (something akin to a doctor), and must assume this status gracefully out of respect to those who have given it to me. However, there is little that is really negotiated by or with me in terms of what happened musically. I can be a part of what is already there - which partly flows from the women's community, but also from their culture through the generations, finding a voice right here.

Stuart works in a neurological rehabilitation unit in a small town in Southern England:

Joan came to music therapy believing it would help motivate her arm after a stroke. In our first meeting I described how our work might develop: first we would spend time in individual music therapy at the Unit, improvising and building a musical grounding together. If things progressed, she would have the opportunity to move into a music therapy group with other participants in the Unit. Ultimately she and her group members would be able to work with local musicians in the nearby Arts Centre, and develop new musical skills on a renewed personal and social footing. This would provide a pathway 'from therapy to community'.

Through individual music therapy on a range of instruments Joan did find more purposeful movement in her arm. Within this process she also encountered piano music

for the first time. On her move to the music therapy group she came to love playing and inventing tunes with other people. Input from her fellow group members, and from local musicians who joined the project, encouraged her to play more, and her music began to embody some of the wit and charisma that her stroke symptoms had inhibited. By the time of our Christmas celebration she had the confidence to perform her own composition with a small jazz band comprising her other group members as support. In addition to aiding her physical rehabilitation, this approach to music therapy allowed renewed personal and social connection for Joan and gave her new skills for being in community with others. Her musical journey has indeed been one from therapy to community.

Neurological impairment - whether through stroke, trauma or other causes - brings disconnection. Regions of the brain are left isolated or impaired, along with body functions - but also self-image, relationships and social structures. My experience of music therapy is, on the contrary, that it connects things. Music in neurological rehabilitation works both on the connections between brain cells and between people. Music can be a force for change on all levels - individual and social.

Jessica works at a hospice in a semi-rural area of Southern England:

Today at the hospice went like this:

8.50am: Arrive and reply to mail. I busked in town recently to raise funds for a new piano and some kind people saw this in the paper and have sent donations, so I'm writing to thank them.

10.00: *Group Session* (in the sitting room). The patients seem to have boundless energy and I have to suggest we finish after an hour and a half! The cook joins us for a time to work on a song we're rehearsing. J's sister is visiting and joins us too. Often the group feels as important for those close to the patients, or for those working in the hospice, as it does for the patients themselves.

11.30: *Individual Session* (in a private room). Working with an elderly gentleman who's recently lost his wife. We write a song based on a poem he's written about her, and we will perform it soon at the Hospice Remembrance Service.

12.15: See to administration and write some notes on my sessions this morning.

12.30: Before lunch I play my violin to some patients who didn't come to the group session earlier. They often ask me to do this. My playing reaches further than the room of course, and someone stops me later to say how important it is to have music in the building.

2.00: *Exercise & Music Session:* the physiotherapist has suggested easy movements to help the patients loosen up after a morning of sitting and a full lunch. The music seems to help motivate them.

3.00: Meet with fundraiser and local vicar to arrange the music for an upcoming service.

3.30: Find myself advising a volunteer on choosing a piano teacher for her grand-daughter!

3.45: Phone a local sixth-form student who is to 'shadow' me to gain work experience. Write up more notes. I think how varied what I do here is. I also think this is how it should be!

Gary works in a National Health Service mental health unit in West London:

An evening the week before Christmas. The staff of the psychiatric unit have done their best to decorate the cheerless canteen, and I'm trying to organise the 'Willow Christmas Choir' at the front of a roomful of people. The audience includes patients from the wards, day patients, visitors and staff (including no less than three consultant psychiatrists!). The patients sit around the sides of the room, not talking much to each other, the air already filling up with cigarette smoke. The choir have been 'warming up' for the past half hour in another room. We've run through the programme, including the solos. The choir members have dressed up smartly for the performance and, although excited, everyone's (just) keeping their nerve. The manager announces us and we launch the Christmas party.

The choir is one of the weekly groups I run on the unit. It swells at Christmas time or when we do a Beatles or 70s night - people seem to want to perform. Tonight we start with 'The First Nowell' for choir only, but by the second verse I notice most of the room has joined in. Then Ruth and Sam sing a duet together of the 'Drummer Boy Carol', note-perfect, well performed. One of the consultants asks me later: 'Wasn't Ruth very ill just recently?'. This is true, and it's a minor miracle that she is able to sing her solo tonight - which I feel she directs to the staff who see Ruth only not coping. Here she's not just coping, she's shining! I've been working with Ruth in individual music therapy sessions for some time and we trust each other. We've cultivated the strength to manage tonight, though there are times when I feel I am supporting through my piano accompaniment every single note she sings. The response from the audience is extremely appreciative - I think they too are surprised and delighted for Ruth.

Something of the same goes for the other solos: Claire says afterwards that she was 'petrified' at the time, but still manages to bring off a solo verse of 'Long Time Ago in Bethlehem', in itself proof of great therapeutic progress from a time just a month before when she took a succession of overdoses. Again, Claire is perhaps able to sing tonight because of her individual music therapy work. So too for other highlights of the evening:

Joe singing a spirited and professional rendition of George Michael's 'Last Christmas' which gets everyone singing and dancing, then Peter's yearly feature of an over-the-top rendition of 'I'm Dreaming of a White Christmas' in a marvellously croony baritone strongly inflected with Polish. Again here are two people who have worked in individual music therapy, been part of music therapy groups and the choir, but most of all have wanted to share their music with the 'circumstantial community' of the Unit. Finally, we have carols for everyone - the singing's hearty, the feeling in the room is good, perhaps better than at any other time during the year in this stressful place. Another consultant says to me later that he'd really enjoyed singing with these people he knows so well, but has so little chance to do something positive *with* (rather than doing something to). You have to do things with people if you're going to experience community.

Going home I think why the evening worked for the patients, the soloists, the staff, and for me. I'm convinced that if I'd just been hired to lead a Christmas sing-song it would have been very different. I realise that it worked because we already had a 'musical community' in the Unit - tonight was just the demonstration of it. The different things I do there - individual sessions, groups, the choir, occasional performances (the whole continuum between individual and communal work) - these all support each other and enable people to do surprising things. In traditional models of music therapy people sometimes frown on performance as an unnecessary intrusion into the protected 'safe space' of therapy, or suggest it to be 'unsafe' to put ill people in a potentially stressful performance situation in case they don't cope. Why then did the opposite seem true tonight? What I observed was this: that people who could be described as 'vulnerable' or 'incapable' instead found the will and the ability to perform well. These people then got a highly appreciative and supportive reception from the varying members of their community. They felt good about themselves, and, contrary to their habitual states, felt capable and able to share something positive with others. Further, my colleagues - who admit that they can slip into identifying patients with their illness, and thinking of them as difficult and vulnerable - here, tonight, they experienced these people in a very different light, and they shared musical community with them.

At the end of the evening the manager of the unit thanks me simply for keeping music alive in the place. I feel this indeed is my primary role.

Harriet works in a Social Services residential centre for the elderly in a deprived and multicultural area of East London.

An unusual performance took place here recently. The cast were twenty of the residents with dementia, aged between 75 and 95, one family member, twelve of the care staff and myself, the music therapist. The show defies categorisation, but had elements of pantomime, choir concert, cabaret and improvised performance. The residents and the staff related their stories, sang, played and danced to an amazed and moved audience of families and friends.

The production grew from a combination of personal and situational factors. I used both my current skills as a music therapist and my previous experience in community arts. A member of the Centre staff with whom I 'd worked before in a community arts project helped with the initial ideas. Then there were developments made by the residents within both individual and group music therapy sessions which led into the show.

By extending the boundaries of music therapy into corridors, communal areas and even the car park, an all-inclusive and enabling musical atmosphere was created (and is still being created). When live music is made people come out of the woodwork! My role as the music therapist in the Centre has had a cumulative effect of the music linking everyone in the building. It was this which made the performance possible. It brought together residents, staff and families - mixing ages and cultures, building understanding.

Simon works in a non-medical mental health centre in inner-city London.

It's lunchtime, and I'm sitting in the café of a community mental health centre. The café is the hub of the community here, and the familiar faces around me at the table are some of the members of the music therapy group from earlier in the morning. There is an air of excitement as they talk about that morning's session:

'I sang, I actually *sang* - I can't believe it.'

'It sounded good, you know. Almost professional sounding.'

'Now it's just me who won't sing.'

In the session I had felt part of a "buzz" - a shared sense of achievement and hope which came out of the way we had just made music together, and which was founded on a developing sense within the group of belonging, of mutual respect and regard, of tolerance and of humour. And now at lunchtime that same buzz is being conveyed beyond the group to other members of the Centre (the broader community). And this community, whilst circumstantial to an extent, is of value to its members because of this very buzz. Hope, belonging and tolerance matter here, not only in themselves, but because the even broader community - the area surrounding the Centre, the members' daily context - cannot be said to be characterised by any of these. Tower blocks loom over dreary estates; levels of unemployment, crime and incidence of mental illness are amongst the highest in the UK. One of the most ethnically diverse areas of the UK, with many recent arrivals from war-torn parts of the world, racism (both violent and attitudinal) is an everyday part of life. Although many people are socially and culturally isolated in their flats, this Centre draws them in. It is designed to enable people to experience their capacity for well-being rather than their propensity for medical illness, to challenge isolation through social contact. It's a place where people can value themselves as individuals, but also their culture and their sense of community, achieved in many cases against the odds. It is a place where, for me, music therapy seems to fit.

These qualities of the place reflect in how people use music therapy. Fresh out of training, I started working here with an idea of music therapy as being something which happened in closed rooms, and as something markedly different from other forms of music-making. The Centre and its members have taught me otherwise. I still spend much of my time working with individuals who use music therapy as a private space to explore and experience their own potential over months or even years, through an intense music-making relationship. However, other people use the more open, social and performatory aspects of music therapy as a gateway to social interaction within the Centre and beyond - sometimes in a way which is particularly culturally appropriate and supportive for them. Often I have to admit my ignorance and inability - they bring their own cultural and musical expertise. Part of my role is to enable them to pursue and develop this, even if it is beyond what I can offer myself, by linking them up with other people and other forms of provision in the wider local community. Others simply express satisfaction with being part of a place "where music happens".

But the people I'm talking to over lunch have used me in yet another way. They formed the group themselves really: Two of them came for one-off sessions, liked it, talked to others and presented themselves as the basis of an ongoing group. No longer am I the sole arbiter of what happens - there's now a reciprocal relationship between music therapy and the Centre community. Today the group has returned to the café triumphant - other times they may be thoughtful or reflective. But they take back their experience to the wider community of the Centre, sharing not just the music but their experience of its social effects. The fact that music therapy is up for discussion in the café seems to me a sign that it is owned by the community and is of relevance to it. Just as the Centre tries to attract people in so that they can feel more actively involved in society, so too music therapy must understand its role as part of its local community - with its problems and its potential. As music therapists, we try to help people live life to the full. To help them to do this, music therapy itself must participate in its own communities to the full.

Oksana works with traumatised refugees at a Centre in Berlin, Germany:

M., an Angolan woman, arrived in Germany as a refugee. Her husband and son had been killed in front of her because of their political engagement. She had been raped and did not know what had happened to her other children. She spoke no German, feared deportation and was totally disorientated. She weighed just forty kilograms and looked more like a ghost than a person. What use, I asked myself, could music therapy possibly be to her?

After some initial individual sessions M. joined a 'women's group' I had organised with a doctor from my team. I felt M,'s need for contact and recognition in a wider community. The group consisted of five women - refugees from Chile, Bosnia and Turkey, all of whom had experienced violence or rape. Although M. looked at first totally disorientated in the group and sometimes switched off, especially when people spoke, she always

woke up when the women (including myself or the doctor) played or sang the songs from their cultures. There was a feeling that, although at one level we were not sharing the same culture, the music we *were* sharing was a culture of being human and being women together. This was something M. could relate to.

As my colleague sang a German children's song, M. suddenly 'woke up' and joined her (in Portuguese - which is spoken in Angola) with enormous strength. They sang together till the end, in two different languages, feeling part of each other's identity. It didn't seem to matter that one of them was a doctor, the other a patient - they were sharing something equally human together. There was a light in M.´s eyes, a sense of belonging, fitting, of things making sense for a change! When other women sang their songs in their own languages, the members of the group tried with great enthusiasm to learn the melodies and the texts. For all of them there was something very natural about doing this - just picking up a melody and singing it as well as they could in a circle of other women.

Music in these womens' societies is usually a communal expression. It is sung, played or listened to with other people. Now it felt to me as if they were using a repertoire of expression which their home communities had equipped them with in order to create a new meaning, a new identity within their new community. They were bridging the mistrust and misunderstanding so typical between different ethnic groups in exile. It felt as if they brought their communities into the room, sharing them with each other and making this a part of their new community together. They were using what they already possessed of music's healing properties.

The more I work with these people the more I question what music therapy is, and what it can offer. Western concepts of therapy seem not always appropriate for these people, with their vastly different cultural background, traumatic experiences and very insecure current situations as asylum seekers. What they find helpful is often not what I would have expected. What seems clear is that whilst the idea of music therapy is new and strange for most of them, its way of music-making is not, since this is a natural part of communal life in their societies. Given space they show me what their music is, how it is used in their communities and what role it plays there, as well as what it means for them and how it can help them. *They* teach me what they need from music therapy. Because music plays an important role in their communities, giving space and recognising their musical competence activates their own resources. It recognises their natural skill to communicate, connect and to create new meaning. This can help them to overcome the inner isolation and mistrust to the world created by their traumatic experiences at home and in exile. It can also be a stepping- stone in their process of accepting what had happened to them and integrating themselves into new communities and new life.

## DISCUSSION: COMMUNITY MUSIC THERAPY AND THE 'CONSENSUS MODEL'

Some Music Therapist readers of the vignettes in the previous section will have wondered why I need to represent them as 'unconventional', and will ask: Don't all Music Therapists work flexibly according to differing contexts and needs? Another group will possibly consider the practices worrying, as having little to do with the accepted model of theory and practice which has developed over the last twenty years. Community Musician readers may wonder why they warrant description as 'therapy ' at all.

I will argue in this section that the vignettes question many of the assumptions Music Therapists of the current generation have in terms of their identity, role, aims and working practices and underlying attitudes. These assumptions come from what I shall call the 'consensus model' of Music Therapy - as taught in training establishments and legitimated in much of the current literature. I use the term 'consensus model' heuristically here - as a 'thinking tool' to help discuss how during the last twenty years the Music Therapy community in the UK (and in parts of the US and Europe) has gradually drawn towards a consensus in both forms of practice and in the underlying theoretical model which legitimates such practice. The simplest description of the model would be 'improvisational music psychotherapy' (though its relevance to the case in this article is not whether it is psychotherapeutic or not per se - but what its theoretical assumptions suggest in terms of the individual-communal continuum presented in Section Two of this article). I construct the 'consensus model' in an abstract way here and do not imply that individual Music Therapists adhere to it uncritically, but that it has an overall influence on how people think about their work. Consequently I have not referenced the 'consensus model', given it does not represent the views of any one person or group. Its content is derived from a wide range of texts, as well as from my understanding of presentations and conversations on the subject over many years.

I will outline below the key practices and theoretical assumptions of the 'consensus model', then contrast these with those inducted from the vignettes of Community Music Therapy outlined in the previous section. The main themes[9], comprising the sections which follow, are:

- Identities and Roles: *Who am I* as a Music Therapist? What am I expected do I *do* as one?
- Sites and Boundaries: *Where* do I work as a Music Therapist? Where are the limits to this work? What are the limits on *what* I do there?
- Aims and Means: *What* am I trying to do as a Music Therapist, and *Why? How* do I go about achieving these aims?
- Assumptions and Attitudes: On what theoretical assumptions do I base all of the above? How do these ideas affect my attitude towards both people and music?

## Identities & Roles

Key to the 'consensus model' is a relatively exclusive identity of a 'Music Therapist' - who is by definition *not* a musical educator, or community musician, or music healer. The nearest role-model is that of the psychotherapist. A separation of client/therapist roles is maintained by clear personal boundaries - assuring the engagement remains professional and avoiding a social relationship developing. At the same time, however, the Music Therapist's musical and personal roles are inseparable: the aim is to establish a 'therapeutic relationship' through the music by being personally available to the client (which will involve being subject to the patient's transferences, projections, etc). The relationship is characterised in psychological rather than social or cultural terms, with psychological theory often modelling the therapist's role as a symbolic quasi-parental one. The therapist provides a facilitative, empathic accompaniment for clients; 'holding' or 'containing' them and their psychic distress. Therapists aim to preserve this mothering quality, ensuring the physical and 'psychic safety' of the client by maintaining the 'therapeutic frame' in which the therapeutic relationship can develop. The second major role for the Music Therapist in the consensus model is an epistemological one: the therapist should aim to *know* about the client, to decode and interpret the symbolic material accessed through playing with the client, in relation to a body of psychological theory. The client here is an object of the therapist's clinical knowledge, and the therapist's role is to facilitate psychological insight (where possible) in the service of the client processing the therapeutic experience.

Community Music Therapists try to balance an identity both as a musician and as a therapist. As a musician the role is promote music and musicing for individuals and milieus; as a therapist the role is to work with factors which prevent a person's (or community's) access to these. This might involve engaging with pathology which is physical, psychological, social or institutional. A 'therapeutic musician in residence' is how many Community Music Therapists see themselves. They always consider their role *in context* - both in terms of how the material, social and cultural situations influence their work, but also in terms of how their role can be simultaneously for individuals *and* for the 'circumstantial community' where they work. A belief in music as *communitas* involves questioning hierarchical and professional roles, given that music-making naturally leads to experiences of human meeting along the lines of Buber's *I-Thou* encounters. The relationships between Community Music Therapist and clients (and the boundaries to these) are individually and pragmatically negotiated, are in the first place 'moral' rather than 'professional'[10] - and are as equal as is possible under the circumstances. Sometimes the therapist may be a witness to the client, or a 'guest', sometimes the role is to guide or follow clients in any way they choose to use music. The 'semi-outsider' role of a musician-therapist in a medical hierarchy can often be useful to clients. Community Music Therapists see their expertise as primarily musical rather than psychological or medical - though they acknowledge the value of other expertises. They also sometimes take a 'critical' role within the contexts in which they work, aiming to help change the milieu surrounding clients' lives.

## Sites and Boundaries

The consensus model carefully defines where therapy should happen and how the 'security' of the work is ensured by the adherence to physical and personal boundaries (often called 'maintaining the frame'). The sites where Music Therapists work are thus limited and protected, the work being mostly private and behind closed doors. The theoretical assumptions on which these working practices are based are mainly psychoanalytic: the individual intra-psychic focus of therapeutic work, the ethics of confidentiality, the primacy of the therapeutic dyad and the metaphor of the 'containing space'. The therapeutic relationship is itself considered the main context of the therapy - seldom is the physical, social or cultural context of the client theorised or worked with. Following the parenting metaphor, the site of the therapy is seen to maintain qualities of security and lack of disturbance. A room on the margins of the institution is often chosen - with the corridor a symbolic 'transitional space' for the client, moving from the outer to the inner world with which therapy works. The therapeutic value of the site is its separateness, and this 'safe space' is protected by a supporting structure of practice: boundaries of space (reliability), and of time (regularity) reassuring patients. Contexts are often only mentioned when they are 'intrusive' to the therapeutic process. The concept of therapeutic boundaries strongly suggests that should a Music Therapist take 'non-therapy' musical roles in an institution - playing for concerts, or performing with patients - this could adversely affect established therapeutic relationships with clients. In protecting client confidentiality and maintaining the frame a Music Therapist will need to balance the interests of the client-therapist relationship with the demands of the institution and wider context of clients' lives.

The Community Music Therapist typically works wherever music or music-making is needed : privately in a treatment room, or publicly in halls, corridors, bedrooms, or even car parks. Music permeates a building quite naturally, occasionally being a disturbance, but more often giving it life. Equally naturally, musical relationships link-up, connecting people and spaces: clients, staff, families, communities. The work *can* be 'closed-door work' where a protected space is needed for the client. But more commonly there is an 'open door' approach, with a natural yet safe 'permeability' to the therapeutic frame, the safety residing as much with the therapist as the 'space'. The underlying belief in this approach is that the people Music Therapists work with primarily live in 'circumstantial communities' of some sort (hospitals, clinics, schools etc), where people's health and illness is located *between and amongst* the personal, social, communal and institutional context they find themselves in. The Community Music Therapist's job is to work in this web of context, and *with* it - the overall aim being to increase the musical spirit of community, and to enhance people's quality of life within it. Different cultures determine what is considered individual and what communal. Additionally, different illnesses suggest the varying appropriateness of individual or communal interventions. Performance is often a natural event within the communal end of the continuum, bringing to others what has been achieved during more private work. Performance events can also be enactments of the spirit, values and hopes of a 'circumstantial community'.

Aims & Means

The consensus model suggests the Music Therapist's aims be directed towards the individual client (or to individuals within a group). The therapeutic relationship and therapeutic process is the aim, music is the means. More specifically, the aim is to use music to help clients explore their emotional inner life and to facilitate growth through its expression. This enables the processing of feeling or (with verbal clients) the development of verbal insight. Music evokes emotion, whilst at the same time helping to bring clients' unconscious issues to consciousness. Following the basic psychoanalytic hypothesis, music is seen as a port of entry to the unconscious. Using theory from early interaction models, the musical relationship is seen to mirror the underlying process of the non-verbal mother-infant relationship. Music is thus primarily constructed as a natural, psycho-physical phenomenon rather than a social or cultural one. The therapist's clinical aim is therefore to use music to forge an affective therapeutic relationship by attuning to the nature of the client's musical utterances and by 'reading' their affective communications. Music thus prepares the ground for the 'therapeutic relationship', which is seen as the prime healing agent (music itself thus being sometimes regarded as an epi-phenomenon of the therapeutic process). Once the 'therapeutic relationship' has been established the aim is that the client can use the music to function as a quasi-projective device, or the therapist to function as a transferential subject. The therapist's role then becomes a supportive and interpretative one: to both understand the client's unconscious communications, but also to *manage* the often chaotic feelings of the client within the music. A feeding metaphor is sometimes used: of receiving, processing and feeding back feelings to the client, so they can better ingest them. A key aim is that the therapist survive this psychic process. The primary therapeutic aim is that therapy will have effected intrapsychic and relational changes which will help the client live more easily in the external world.

Community Music Therapy has an overall aim to cultivate musical community wherever the therapist and clients find themselves, and to negotiate this with an awareness of social and cultural context. Musicing is the aim, music the means. More specific aims are formulated according to the focus of work across the individual-communal continuum. However, the aims for individual, or group, or community work are not considered independently, but as complementary. Individual sessions, for example, still happen within a context of community and may develop a client's confidence to move to more communal activities. Equally, clients may access individual work through a communal route. The various forms of musicing a Community Music Therapist can facilitate can variously help clients experience different aspects of inter-personal relatedness, emotional exploration, celebration or communal feeling. A client may also enlist the therapist to help them find (or re-find) their own relationship to an instrument, or to music itself. In helping people access music and musicing the Community Music Therapist also uses his or her skill and experience in working directly with the manifestations of pathology - though the ultimate aim is to get *beyond* pathology. Sometimes it will be appropriate to involve other kinds of musicians (community musicians, performers) in the work, also to collaborate across disciplines, where music can be a welcome aid in relaxation or physiotherapy. A main aim is to help people use

music to feel 'weller' - even when they are 'ill'; to use music as a means of finding a qualitative change in people's experience of themselves, and themselves-in-community. Ultimately the aim is to move clients from therapy *to* community.

## Assumptions & Attitudes

The consensus model focuses on clients' problems and their emotional reactions to these. Following the basic assumptions of psychoanalytic thinking, clients' problems are seen as essentially intra-psychic ones, which manifest through emotional and interpersonal difficulties. The priority for the Music Therapist is to help clients with their underlying problems through the means of the therapeutic relationship, and to prevent external intrusions into the process. This therapeutic agenda is supported by an *individual* psychological model, where the client is identified as both the site of the problem and the hope for the 'cure'. Cultural and social determinants of selfhood are seldom theorised or worked with. The consensus model's assumptions about music also follow this model: music is largely seen as an introspective phenomenon, and as a dynamic representation of states of mind, feelings, and patterns of relating. The core analogy underlying this is of musical improvisation being a corollary to psychoanalytic free-association. This leads to the belief that the primary function of music is as an expressive or projective device, or as a container (and possibly re-organiser) of the forces of feeling.

Community Music Therapy derives its assumptions from a social (or perhaps *ecological*) phenomenology of music - believing that Music Therapy must work in the ways in which music itself commonly works in individual and social life. The Community Music Therapist's practice follows where music's natural tendencies lead: both *inwards* in terms of its unique effects on individuals, but also *outwards* towards participation and connection in *communitas*. Community Music Therapy also rests on ecological assumptions: that an individual client is always an individual-in-context. It is not seen as possible to work with an isolated individual, or to locate problems entirely *within* an individual, or to see problems as solely biological, psychological or social. Sickness is seen as sickness-in-context, and consequently any 'treatment' must likewise be in context as far as possible. Rather than focus directly on clients' problems, a Community Music Therapist aims to enlist musicing's ability to generate well-being and potential in individuals, relationships, milieus and communities. Community Music Therapy is seen as part of a cultural movement and not just a treatment profession, and attempts to reflect critically on how its basic assumptions influence attitudes towards people, and ways of being with them.

*

## Five Questions

I anticipate my Music Therapy colleagues to make the following responses to the analysis above. I try to provide some initial answers, though with the caveat that my overall intention in this article is to ask necessary questions, not to suggest that Community Music Therapy can provide all the answers.

*Firstly, am I not ignoring the inevitable gap between theory and practice?* Models and theories are perhaps in the end not what's important. As research on psychotherapy has demonstrated, experienced, compassionate people always do good therapy, whichever model they espouse! There is indeed truth in these statements, and of course experienced practitioners develop their own freedom and flexibility. However, it is harder for trainees and new practitioners not to be influenced by the assumptions and attitudes of the consensus model. It is not uncommon to find colleagues willing to admit a tension between their training model and the kind of work they feel is needed within the situations they find themselves.

*Secondly, don't most Music Therapists already work across the Individual-Communal Continuum?* Though trained in the consensus model (or at least paying lip-service to it when asked what their theory is), many Music Therapists nevertheless *do* arrange performances, work with staff or run a brass group, and tailor their work to be context-sensitive. I hope indeed this is true, in which case it is strange how little such practice is discussed, written about, researched and publicly validated. The current situation seems, on the contrary, to leave many Music Therapists wondering whether a sizeable part of their activity is 'really Music Therapy'. It would be helpful if the core model represented, explored and legitimated what therapists actually *do* across the individual-communal continuum. This is my aim in suggesting a Community Music Therapy model.

*Thirdly, What makes Community Music Therapy different from Community Music?* This question will rightly be asked both by Music Therapists and by Community Musicians. My answer is that Music Therapists have built up a body of experience and expertise in working with pathology and its manifestations in the service of giving people access to musicing. This skill is relevant across the individual-communal continuum. But equally, the skills and knowledge Community Musicians have generated over the years in the areas of their expertise cannot but enrich Music Therapy. Now is the time for dialogue.

*Fourthly, what theory would support a Community Music Therapy Model?* It is perhaps not a question of one discourse 'replacing' another, but of asking more pragmatically which theory is useful for what (whether such theory be generated within Music Therapy, or imported from without). New areas of inter-disciplinary work are now available which were not available thirty years ago. These range across those physiological, psychological, sociological, musicological and spiritual disciplines which interface with how we work musically with people. Their value for Community Music Therapy will rest in how they can help understand the *full* range of the individual-communal continuum. In particular, Music Therapy notably lacks an informing discourse of the relationship between the musical and the social-psychological. In recent years new knowledge has developed in the humanities and social sciences in all of the above areas - and is ready for dialogue with Music Therapy[11].

*Fifthly, Does the Community Music Therapy model compromise client and therapist safety?* Much debate in the Music Therapy discipline has centred on how theoretical models relate to ethical and safe practice. The debate (Streeter 1999; Ansdell 1999; Brown 1999; Pavlicevic;1999; Aigen 1999) clarified how sometimes the very concept of 'safety' is constructed by theoretical models themselves - that is, we must always look at these issues alongside the areas of therapist identity and role, aims and means, assumptions and attitudes. Ultimately, however, it is the skill, training and experience of the Music Therapist, and the supporting structures of the profession which will ensure safe practice - however Music Therapy is defined. This will be helped in the meantime by a closer and more honest fit between the core model and practice.

## Conclusion: The Dog Barks, The Caravan Moves On.

In this article I have tried to present varied material in support of two appeals: for a broader practice of Music Therapy; and for a broader theoretical model to support such practice.

A historical perspective suggests that the work of Music Therapists and Community Musicians grew from a common source, which initially diverged into different territories but which now shows signs of converging again. This leads us to question whether the two traditions can again beneficially share their experience and possible futures? For Music Therapists, a broader model of Community Music Therapy has been developing in some national traditions as a precedent of a flexible and context-sensitive practice and theory. The question here is whether this initiative represents a side-show or a prelude to a developing consensus.

The seven vignettes of current international initiatives in Community Music Therapy I presented demonstrate how innovative work naturally follows from the needs of clients and situations. My comparative analysis of this work, however, suggests it to be incommensurate with the current 'consensus model' of Music Therapy which has established itself in many places in the last decade. Community Music Therapy consequently brings to contemporary Music Therapists questions about their identity and role, aims and methods, attitudes and assumptions. To put it simply, there seems to be a deepening mismatch currently between what many Music Therapists practice, and the over-arching theoretical model which claims to guide and legitimate their work.

About every thirty years most disciplines undergo significant change in the guiding model or metaphor which has led, supported and validated practice. To use Brynjulf Stige's metaphor, they change the flag under which their ship is sailing. This is often called a 'paradigm shift' following Thomas Kuhn's famous formulation of a 'paradigm' as a consensual over-arching model or 'constellation of basic agreements' within a discipline (Sardar 2000). A paradigm shifts when enough people experience a bad fit between the old model and some new reality, and when a new model offers better solutions to current difficulties. Sometimes it takes a while before the guiding model

catches up with what people already do and know (leaving the ship sailing under the wrong flag for a time). As Schopenhauer famously remarked, new formulations are typically ridiculed, then opposed, before finally settling down as self-evident!

Music Therapy has seen the truth of the thirty-year prediction once already, in its change from a behaviourist model towards a humanistic and psychotherapeutic one in the 1970s. Kuhn suggests two criteria for a usefully new paradigm: that it can attract enough people away from the old, and that it is sufficiently open-ended to leave many problems for the redefined group of practitioners to resolve. Importantly, the concept of the paradigm suggests that theory is first and foremost of *its time and place* - never just an objective description of reality, but a pragmatic construction based on the experience and knowledge we currently possess. Its advantage is its usefulness, not its final truthfulness as such. A paradigm shift, and the appropriation of a new model, should have both practical and theoretical consequences: it should mean that more information and more experiences fit into the collectively-held understanding (within and without the discipline). There should be a better alignment of commonly-held knowledge - in Music Therapy's case, about the relationship between people, music and well-being.

It seems to me that Community Music Therapy is a model that offers at least the possibility of a shift in the paradigm for Music Therapy in the 21st Century, and for a re-alignment of its theory and practice. The value in what I write in this article, however, will rest on a simple but basic question: Can a Community Music Therapy model help bring about a more fruitful match between what musicians are best equipped to give, and what society in the coming generation will need from them?

The wind appears to be changing; the dog of social, cultural and musical evolution seems to be barking at the heels of Music Therapy's caravan. Will we lead or follow?

## Acknowledgements

I want to thank Rachel Verney, Mercedes Pavlicevic, Simon Procter, Stuart Wood and Ken Aigen for conversations which have helped clarify some of the arguments in this article, and for reading various drafts.

## Notes

1) These examples will be expanded below in Section 3.

Back to the text

2) The accounts are kept largely to the UK. Although there are parallels to this situation in Europe and the US, there are also clearly different contextual factors at work. I will be interested to learn of similarities and differences to the pattern I outline here.

Back to the text

3) The Association of Professional Music Therapists was established in 1976 in the UK, and in 1982 the Dept of Health and Social Security gave a career and grading structure to music therapy (albeit with initial parity to 'Footcare Assistants' - a timely warning against grandiosity) (Tyler 2000; Wigram 2000).

Back to the text

4) The key sources I have used in this sketch are Anthony Everitt's (1997) Gulbenkian Foundation Report on 'participatory music' in the UK, Joining In, and Jessica Atkinson's (2001) 'Survey of Community Music in the UK' for the Speedwell Trust.

Back to the text

5) Everitt suggests changing 'community music' to participatory music to reflect the changing landscape of 'community': '.we have to redefine the purposes of community music, shifting the emphasis from a territorial definition of community to the multifarious and often provisional forms of socialisation that have emerged in today's climate of shifting allegiances. In fact, it is time to ditch the term and replace it with 'participatory music' (Everitt 1997: 160).

Back to the text

6) The 'encroachment' on Music Therapy territory is moreover not just by Community Musicians. The Shimmer Project came under the auspices of an orchestral 'outreach programme'. Such work (overlapping with traditional Community Music) is fast-expanding, due to a combination of genuine desire to reach beyond social boundaries, but also to fulfil increasingly broad sponsorship criteria.

Back to the text

7) The account here is not intended as a comprehensive international review, but to outline those strands of the discourse which have been key in developing and confirming my own perspective. I hope that respondents to this article will help complete a more comprehensive picture.

Back to the text

8) I am grateful to Simon Procter, Mercedes Pavlicevic, Harriet Powell, Oksana Zharinova-Sanderson, Stuart Wood and Jessica Atkinson for sharing with me their vignettes of practice. The inclusion of their work in this article does not mean, however, that they would wholly agree with my formulation of Community Music Therapy, or with all of the conclusions I come to.

Back to the text

9) Interestingly, the themes are similar to those identified by Gouk (2000) in her analysis of various anthropologically defined music/healing traditions.

Back to the text

10) This useful distinction comes from Spinelli (2001): commenting on the psychoanalyst Leslie Farber's approach, with the implication that they were humanly rather than theoretically generated boundaries.

Back to the text

11) This article is not the place to discuss this material in detail. The following provide a perspective on music, healing and society which Community Music Therapy could draw from, and add to: (i) Social and Cultural perspectives by music therapists: Ruud (1998); Stige (forthcoming) Culture-Centred Music Therapy; (ii) Social Psychology of Music: Hargreaves & North (1997) ; Juslin & Sloboda (2001); (iii) Sociology/Anthropology/Critical Histories of Music& Healing: DeNora (2000); Gouk (2000), Horden (2000); (iv) New Musicology: Cook (1998), Cook and Everist (1999), Small (1998), McClary (2000), Kramer (2002).

Back to the text

## References


Aasgaard, T. (1999) 'Music therapy as milieu in the hospice and paediatric oncology ward', In D. Aldridge, D. (ed) *Music Therapy in Palliative Care: New Voices.* London: Jessica Kingsley.

Aasgaard, T. (2001) 'A Suspiciously Cheerful Lady: A study of a song's life in the paediatric oncology ward, and beyond' *British Journal of Music Therapy 14(2)*.

Aigen, K. (1999) 'The true nature of music-centred music therapy theory' *British Journal of Music Therapy 13(2).*

Aigen,K. (forthcoming) *Playin' In the Band: A Qualitative Study of Popular Music Styles as Clinical Improvisation.*

Ansdell, G. (1997) 'Musical Elaborations: What has the New Musicology to say to music therapy?' *British Journal of Music Therapy 11(2).*

Ansdell. G. (1999) 'Challenging Premises' *British Journal of Music Therapy 13(2).*

Ansdell, G. (2001) 'Musicology: Misunderstood guest at the music therapy feast?' In D. Aldridge, G. Di Franco, E. Ruud & T. Wigram (eds) *Music Therapy in Europe.* Rome: ISMEZ/Onlus.

Atkinson, J. (2001) *Survey of Community Music in the UK.* Unpublished report for the Speedwell Trust.

Brown, S. (1999) 'Some thoughts on music, therapy and music therapy' *British Journal of Music Therapy 13(2).*

Bruscia, K. (1998) *Defining Music Therapy* (2nd Edition). Gilsum, NH: Barcelona.

Bunt, L.(1994) *Music Therapy: An Art Beyond Words.* London: Routledge.

Bunt, L. (1997) 'Clinical and therapeutic uses of music' In D. Hargreaves & A. North (eds) *The Social Psychology of Music.* Oxford University Press.

Cook (1998) *Music: A Very Short Introduction.* Oxford University Press.

Cook and Everist (1999) *Rethinking Music.* Oxford University Press.

DeNora, T. (2000) *Music in Everyday Life.* Cambridge University Press.

Everitt, A. (1997) *Joining In: An investigation into participatory music.* Report for the Calouste Gulbenkian Foundation, London.

Gouk, P. (2000) *Musical Healing in Cultural Contexts.* Aldershot: Ashgate.

Hargreaves, D. & North, A. (1997) *The Social Psychology of Music.* Oxford University Press.

Horden, P. (2000) *Music as Medicine: The History of Music Therapy since Antiquity.* Aldershot: Ashgate.

Juslin, P. & Sloboda, J. (2001) *Music and Emotion.* Oxford University Press.

Kenny, C. (1989) *The Field of Play: A guide for the theory and practice of music therapy.* Atascadero, CA: Ridgeview.

Kenny, C. (1996) 'The dilemma of uniqueness: An essay on consciousness and qualities'. *Nordic Journal of Music Therapy 5(2)*.

Kramer, L. (2002) *Musical Meaning: Toward a Critical History.* University of California Press.

Maranto, C. (1993) *Music Therapy: International Perspectives.* St Louis: MMB.

McClary, S. (2000) *Conventional Wisdom: The Content of Musical Form.* University of California Press.

Nordoff, P. & Robbins, C. (1971) *Therapy in Music For Handicapped Children.* London: Gollancz.

Nordoff, P. & Robbins, C. (1977) *Creative Music Therapy.* New York: John Day.

Pavlicevic, M. (1999) 'Thoughts, words and deeds: Harmonies and counterpoints in music therapy theory' *British Journal of Music Therapy 13(2)*.

Priestley, M. (1975) *Music Therapy in Action.* London: Constable.

Priestley, M. (1994) *Essays on Analytical Music Therapy.* Gilsum, NH: Barcelona.

Procter, S. (2001) 'Empowering and Enabling: Improvisational music therapy in non-medical mental health provision'.[online] *VOICES: A World Forum for Music Therapy Vol.1 (2), 2001.* Available at:http://www.voices.no/mainissues/Voices1(2)Procter.html [Accessed 21. Jun. 2002.]

Robbins, C. (forthcoming) *'A Journey into Creative Music Therapy'*.

Ruud, E. (1980) *Music Therapy and its Relationship to Current Treatment Theories.* St Louis: MMB

Ruud, E. (1998) *Music Therapy: Improvisation, Communication, Culture.* Gilsum NH: Barcelona.

Ruud, E. (2001) 'Music Therapy - History & Cultural Contexts' (essay review).[online] *VOICES: A World Forum for Music Therapy Vol.1 (3), 2001.*Available at:http://www.voices.no/mainissues/Voices1(3)Ruud.html [Accessed 21. Jun. 2002.]

Sardar, Z. (2000) *Thomas Kuhns and the Science Wars.* Cambridge: Icon Books.

Small (1998) *Musicking.* Hanover, NH: Wesleyan University Press.

Spinelli, E. (2001) *The Mirror and the Hammer: Challenges to Therapeutic Orthodoxy.* London: Continuum.

Stige, B. (forthcoming) *Culture-Centred Music Therapy.* Gilsum, NH: Barcelona.

Streeter, E. (1999) 'Finding a balance between psychological thinking and musical awareness in music therapy theory - a psychoanalytic perspective' *British Journal of Music Therapy 13(1).*

Turry, A. (2001) 'Performance and Product: Clinical implications for the music therapist'.[online] *Musictherapyworld.net* (Practice Showcase).

Tyler, H. (2000) 'The music therapy profession in modern Britain' In Horden, P. (ed) *Music as Medicine: The History of Music Therapy since Antiquity.* Aldershot: Ashgate.

Wigram, T. (2000) 'Historical Perspectives Interview Series' *British Journal of Music Therapy 14(1).*