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Music therapy with children: a complementary service to music education?

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This article is divided into three parts. In Part I a brief description of a music therapy session will highlight some key features of a music therapy approach with children. The session will be used as a springboard for a short survey of some theoretical perspectives that underpin music therapy practice. Part II will outline the development of music therapy in the UK and the current range of work with children. Some evidence of music therapy's effective contribution to the development of the whole child will be drawn from published research and case material. Part III will place music therapy in wider social, musical and cultural contexts, outlining some contemporary challenges including closer collaboration with music educators and researchers.

PART I

Introduction

> To participate aurally in the complex patterns of a piece of music is to enter deeply into an image that conveys sensations and perceptible patterns in life itself. (Moore, 1990: 193)

The positive influence of music on our overall well-being has been recognised for centuries. Links have been drawn between music and our whole development – physical, mental, social, emotional and spiritual. A natural response to music can be viewed as a fundamental part of our development as human beings. Music is a reflection of our social relationships par excellence. It helps us understand these 'perceptible patterns in life itself', having the potential to represent forms of human interaction from the most elemental to the most complex. Imagine a young child turning to listen to the sound of a beautiful bell or to his or her mother's voice. Think of the intricate series of subtle negotiations required to perform as part of a string quartet or jazz group.

A period of music therapy provides opportunities for detailed and ongoing observation, assessment and gradual understanding of an individual's unique patterns of communication. The identity of a person can even be considered as 'a musical form that is continually being composed in the world' (Aldridge, 1996: 23). Music therapy offers the further 'possibility of hearing, in a dynamic way, the individual as a whole self as well as in relationship to another person' (ibid.: 58). The strengths of each individual can clearly be heard and observed within such an interactive and holistic framework. We can also observe how an individual compensates for or adapts to any difficulties or problems. If we are able to regard musical elements as being at the root of our expressive, emotional and communicative life

(a point to be explored later), then

> we see that disorders in any of these realms will have musical correspondences. Disturbances in communication may be seen – and experienced directly – through disturbances in the timing, sequencing, amplitude, energy and fluidity of acts and gestures, as well as in disruptions of inter-coordinating acts with another person. (Pavlicevic, 1997: 114)

Very often observations and reflections from a period of therapy play a part in designing future strategies for educational provision and ongoing care and support. This was the case with Jane, who came for weekly individual sessions to a community-based music therapy centre. She attended a small language unit attached to a mainstream primary school and was referred to music therapy because of her complex social communication needs.

A music therapy session

Eight-year-old Jane (not her real name) arrives with her mother in a highly agitated state at the usual time for her session. She is adamant that everyone in the building hates her, including the music therapist. She wants everybody to go away and refers to herself as stupid. She reluctantly enters the music therapy room. The room is equipped with a variety of tuned and untuned percussion including her usual preferred instruments: the large chromatic xylophone and metallophone, small shaking instruments and some wind chimes. The therapist moves to the piano and Jane sits beside him. He observes her accelerated breathing and agitated hand and body movements. He starts to play a rocking pattern of chords, the harmonies and opening tempo matching some of the intense agitation, over which he adds a half-spoken and half-sung commentary aiming to communicate to Jane that it is perfectly OK for her to express these difficult feelings in this space. As the music slows he adds, with a view to gently reassuring her, that people in the building do like her. He tries to hold her disturbing feelings and to contain them within the musical frame. Jane has sufficient trust in the music and the therapeutic relationship, built up over two years, to feel safe to continue exploring her feelings. Gradually she begins to calm herself and takes up some small shaking instruments. She plays the instruments while continuing to put words to her feelings, now also becoming half-sung and half-spoken. The therapist continues with the chordal accompaniment and singing. They work together synchronising long and deep breaths: they have done this before at similar highly stressed times. Jane physically and emotionally starts to relax. She vocalises spontaneously about the batteries running out on the instrument and the baby slowing down (is this her?). She asks to play the piano by herself. She explores various speeds, levels of loudness and ways of playing: single notes, clusters, scale patterns, glissandi, with a preference for quieter and lower sounds. She accepts the therapist's supportive rhythmic accompaniment on a tambour as he begins to match Jane's playing using the musical parameters of pulse, rhythm, texture and loudness. Her piano playing occupies the central part of the 40-minute session. She then moves across to the wind chimes and suggests improvising an imaginary journey of the sun rising, moving through the day and ending with a quiet sunset. The therapist provides a backdrop soundscape on the piano. At the end of the session Jane verbalises that she is feeling much calmer. She returns to her mother who has been waiting outside.

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Some features of a music therapy approach

We can use this example to explore some key features of a music therapy approach. Jane brought to this particular music therapy space her present feelings and her past musical and personal experiences, including the history of her relationship with the therapist. From the outset she was able to express her needs. The major responsibility of the therapist was to listen to Jane, to attend to her needs and to try to use his musical and personal resources to 'be there' for her. He was 'there' in a 'good enough' way, as paralleled in Winnicott's concept of 'good enough mothering' (Winnicott, 1965: 145). Other 'players' in this space were the instruments and particularly in this session the external influence of the other people in the building. The therapist's action in music in response to what Jane presented was a subtle interaction between his reading of Jane's needs as linked to the ongoing relationship in music therapy, his theoretical orientation and knowledge, his personal value systems and interests, and what he construed as norms (Ruud, 1998: 105–8). He tried to give Jane focused attention, listening to the quality of all the sounds in the room (both verbal and non-verbal), to the pace and to the feelings behind the music. He tried to empathise and resonate with Jane's feelings.

The session occurred at the same time, in the same place and for the same duration each week. These boundaries of time and place help a child to feel secure and to know what to expect. In spite of Jane's difficult start to the session she trusted the situation to the extent that she could use the private music therapy relationship to work through her feelings. She could externalise them with another person who was there to listen, support and help her to work. We are fortunate as music therapists not only to enable children to explore the non-verbal medium of music but also to act as a kind of sounding board, to tune in and reflect back to a child that they have been listened to and heard.

As in any therapeutic encounter the features of containment and holding are important. In Jane's session we can observe how the therapist's singing and supportive playing acted as a means of holding together, in a kind of musical web, Jane's various feelings and at times disparate communications. The therapist tried to match Jane's musical gestures or reflect her music back to her, contributing to her growing awareness and sense of identity (see DeNora, 2000 and MacDonald *et al*., 2002 for further discussion of musical identity). All her contributions were acknowledged, valued and supported, even if slightly more challenging and alternative responses occurred at times, for example regarding her fear of being disliked. Musical interaction provides an ideal setting for the holding of quite complex and at times even contradictory feelings. The therapist also needs to show consistency, and in Jane's session he demonstrated to her, for example with regular repeating musical shapes, that he could stay with and manage whatever she wanted to communicate, however difficult and uncomfortable the feelings. He was able to use the music as co-therapist to contain these projections, unlike in purely verbal work when the therapist alone is often required to hold and contain projected feelings. In the last improvisation Jane could explore the sun's journey and hear her musical and verbal ideas reflected back to her in the joint musical activity.

To end this section, here are two definitions of music therapy. The first is the one most commonly cited by members of the Association of Professional Music Therapists (APMT):

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> Music therapy provides a framework in which a mutual relationship is set up between client and therapist. The growing relationship enables changes to occur, both in the condition of the client and in the form that the therapy takes. . . . By using music creatively in a clinical setting, the therapist seeks to establish an interaction, a shared musical experience leading to the pursuit of therapeutic goals. These goals are determined by the therapist's understanding of the client's pathology and personal needs. (APMT, 2000)

A further definition is: 'Music therapy is the use of sounds and music within an evolving relationship between client/patient and therapist to support and develop physical, mental, social, emotional and spiritual well-being' (adapted from Bunt, 1994: 8 and quoted in Bunt & Hoskyns, 2002: 10–11). These definitions highlight the intentions behind a music therapy approach of developing a mutual relationship and significantly the emphasis on therapeutic goals linked to an understanding of pathology and individual problems and needs. Ockelford (2000) has highlighted this concept of 'well-being' as particularly pertaining to a music therapy approach.

Further observations and links to some theoretical underpinning

Music therapists use a range of theoretical perspectives to frame their work. There are the obvious links to music, in particular the developmental and cognitive psychology of music. Some perspectives will be discussed in this section, particularly how they further understanding of Jane's therapy (for additional discussion see Bunt, 1994, 1997, 2001; Pavlicevic, 1997; Ruud, 1980).

Music's capacity to bring about significant changes across a range of physiological indices (heart rate, breathing, metabolism, muscle reflexes, electrical conductivity of the body, etc.) influenced the early acceptance of music therapy within the medical communities in the USA. In Jane's case she had an acute sensitivity to sounds, being aware of the slightest sound both inside and outside the music room. In this and other sessions sudden intrusions would increase her level of arousal, causing her to block out the sounds by putting her hands over her ears or to scream. She would also communicate her over-aroused internal state with finger and hand wringing. To help her monitor these internal levels of arousal Jane was encouraged to be in charge of any shifts in loudness and pitch. In her spontaneous piano playing during this session she showed a preference for quiet and low sounds. Looking from this physiological perspective (albeit solely with observation, and lacking any sophisticated bio-medical investigation) there appeared to be many shifts and changes in level of arousal, breathing, energy and activity during the course of Jane's session.

It is notoriously difficult to separate a physiological from a psychological response. Reference to the growing disciplines of developmental psychology of music and cognitive psychology has been a further resource for music therapists working with children. Helmut Moog's extensive analysis of young children's developing responses to recorded music was an early influence for many music therapists (Moog, 1976). Both Jane and the music therapist focused their musical interactions on specific musical parameters and structures. Further understanding of the effects and perceptions of pitch, timbre, duration, loudness, interval, melody, harmony, etc. has been aided by research summarised in significant texts

by, for example, Aiello (1994), Deliège & Sloboda (1996), Hargreaves (1986) and Sloboda (1985). Developmental profiles proposed by music educationalists such as June Boyce-Tillman have also been used (Swanwick & Tillman, 1986). Recent reawakening of research interest in emotion and music is a significant resource for music therapists. Jane connected the shifting musical characteristics of the final improvisation to the external features of the non-musical source of reference, the daily passage of the sun. Such a relationship has been described as 'iconic' (Juslin & Sloboda, 2001: 93–4). The same authors also describe intrinsic connections between personal emotional states and the surface and deep structures of the music. It appeared that during moments of spontaneous improvisation Jane was highly motivated to explore these intrinsic connections, particularly in relation to the emotional shifts in response to the expectation or violation of an ensuing musical event. She explored a wide range of emotions in this session, from moments of agitation to calm; feelings in other sessions ranged from fragility and destruction to exuberance and joy.

There has been recent growth in researching connections between biological, social and psychological roots of early infant musicality. The work of Colwyn Trevarthen and his colleagues has been fundamental, with extensive research into early play between mother and child, recognition of babies being born with inborn rhythmic coherence across different expressive modalities, the notion of 'communicative musicality' at the root of all future emotional and social relating, and Trevarthen's theory of an 'intrinsic motive pulse' within the brain that enables early engagement with music to emerge (see summaries in Trevarthen, 2002 and Trevarthen & Malloch, 2000, and related work by Trehub *et al*., 1997 and Papoušek, 1996). William Benzon goes as far as proposing that music is more than communication and a sharing of meanings, namely 'a medium through which individual brains are coupled together in shared activity' (Benzon, 2001: 23).

Trevarthen's work has been linked closely with that of Daniel Stern and his exploration of 'affect attunement', vitality and dynamic affects that shape the interactive play between mother and child. Pavlicevic elaborates from Stern in her notion of 'dynamic form' (Bunt & Pavlicevic, 2001; Pavlicevic, 1990). In Jane's session we can note the cross-modal connections between, for example, her breathing and hand movements and the therapist's piano playing. Stern uses musical terminology to describe communicative events, and we can use these connections between the personal and the musical to further our understanding of how improvisations can be framed (Stern, 1985; Robarts, 1996).

Music therapists whose work is informed by psychodynamic theory would bring the constructs of positive and negative transference and the different levels of counter-transference to describe Jane's session. There were instances of Jane transferring both positive and negative feelings onto the music, the instruments (in other sessions they would often be renamed and given symbolic meaning) and the therapist. Through continuous reflection and supervision the music therapist gained insights from his own counter-transferences (his feelings both about Jane and what she was transferring onto him). In this particular case the therapist did not actively encourage work with the transferences (as if a form of music psychotherapy) but allowed insights to inform the work. He did draw on Jung's work on archetypes, for example Jung's concept of the shadow, in noting how Jane's more difficult and hidden feelings were brought out into

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the open. He was also interested in using patterns from myth to frame the work, for example the chaos and more unbridled energy of Dionysus being held within the form and logic of Apollo (Bunt, 1994; for a summary of archetypal psychology see Hillman, 1977).

The work with Jane was held fundamentally within a humanistic framework, with the emphasis on supporting her as she used the music therapy sessions to move to her potential and to air her difficulties and problems. The therapist aimed to work with the whole child, encouraging freedom of choice and self-growth. Music has been repeatedly recognised as a means of increasing self-esteem, and this was a constant feature of the work with Jane. She used the process as experiences both in self-organisation and -regulation and in relating to another (Sears, 1968). Linking all these processes was a playful use of imagination by both Jane and the therapist and a creative and free use of improvisation. These are two essential features of a music therapy approach, improvisation being recently described as 'at the core of music therapy practice and . . . the action product of our musical imagination and intuition' (Bunt & Hoskyns, 2002: 49). The importance of improvisation has led some therapists to develop specific assessment tools, for example the Improvisation Assessment Profiles devised by Kenneth Bruscia (1987) and their later adaptation by Tony Wigram (2000).

Summary of Jane's journey through music therapy, and future provision

Jane is a highly sensitive child with an acute sensitivity to sound, a rich curiosity and an interest in all things musical, akin to Gardner's (1985) concept of musical intelligence. She used the sessions to self-monitor her own levels of anxiety and to externalise a wide range of feelings. The times when she was aware of producing something quite beautiful in music contributed to her growing self-assurance and awareness.

The insights gained from the period of over three years of music therapy contributed to Jane's case review and plans for educational provision for her at senior school. Besides benefits from music therapy, more regular exposure to individually tailored music-making was considered as an option to aid her general learning, recent research indicating that additional exposure to music can influence other areas of the curriculum (for example, Rauscher *et al*., 1995). Regular sessions, possibly daily and involving different music specialists, could be advantageous to a child with Jane's range of strengths and difficulties. This strategy was proposed as possibly being of more benefit than to continue in a social environment where the main emphasis was on numeracy, literacy and other spatial tasks, the very areas she found confusing. Her subsequent move to a school with smaller classes coincided with a referral to a colleague for a period of individual piano lessons and therapeutic music-making (see Part III).

PART II

The development of the music therapy profession

The development of music therapy in the UK stems from a central focus on the music, all therapists being first and foremost musicians. There are also early links to music education,

the early trainers being also inspiring music teachers. In 1958 Juliette Alvin formed the British Society for Music Therapy and Remedial Music. Her work as a cellist (Alvin was a prize-winning pupil of Casals) and instrumental teacher had led her increasingly to explore a more therapeutic approach to music, introducing music into, among other settings, hospitals, special schools and prisons. Groups of teachers, musicians, other professionals, parents and carers encouraged Alvin to run short courses and training days. Soon the use of the term 'Remedial Music' was dropped and the British Society for Music Therapy (BSMT) began to flourish as the general body open to all interested in the field. Alvin's work was mirrored in the music education field by that of Jack Dobbs and David Ward, in particular the 'Music for Slow Learners project' (see Dobbs, 1966; Ward, 1976, 1979). Ten years later the then Principal of the Guildhall School of Music and Drama, Dr Allen Percival, invited Alvin to set up the first postgraduate training in music therapy at the Guildhall (for a summary of Alvin's approach see Bruscia, 1987, and also Alvin, 1975, 1976).

In 1974 the unique working partnership of American composer and pianist Paul Nordoff and his English colleague from the field of education Clive Robbins resulted in a new training course being available to musicians at Goldie Leigh Hospital, South London. A recent publication documenting Nordoff's teachings on music during that first course (Robbins & Robbins, 1998) adds to the heritage of writings by Nordoff & Robbins (1971, 1977, 1983). Key milestones can be listed so:

- 1958: formation of the British Society for Music Therapy (and Remedial Music)
- 1968: first postgraduate course at the Guildhall School of Music and Drama
- 1974: first course delivered by Paul Nordoff and Clive Robbins
- 1976: formation of the Association of Professional Music Therapists (APMT)
- 1980: new course set up at Southlands College, London
- 1982: award of a Career and Grading Structure within the Whitley Council by the then Department of Health and Social Security
- 1991: first exclusively part-time course set up at Bristol University
- 1994: new full-time course at Anglia Polytechnic University, Cambridge
- 1997: first full-time course in Wales at the Welsh College of Music and Drama
- 1997: granting by Act of Parliament the right of music, art and drama therapists to become state registered
- 2002: development of a Nordoff–Robbins training course in Scotland
- 2002: Health Professions Council becomes the new legislative body for the State Registration of Arts Therapists, protecting the public and guaranteeing the quality of both the practice and the training of music therapists.

It is interesting to note how these milestones reflect a developmental pattern from the early stages of learning the tools of the trade through to increasing public and state recognition as the profession in the UK moves into its early adulthood.

The motivation to train as a therapist can start whilst still at school, and anecdotal reports from heads of university departments of music and conservatoires indicate that training as a music therapist is becoming a serious career option. Training is a life-long

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option and courses are also receiving more applications from musicians working within other traditions besides those with classical roots:

> Music therapy as a career is increasingly appealing to experienced music teachers, other health care professionals who have continued to maintain a strong commitment to music, younger students of music, specialists in psychology and languages, 'returning' mothers and seasoned professional musicians wishing to complement and broaden their work. (Bunt & Hoskyns, 2002: 25)

The range and positive aspects of work with children

Our focus now turns to more specific connections with education. Early in 2000, 93 music therapists (approximately half of all therapists working in schools) from 159 schools replied to a questionnaire organised by the APMT (Strange, 2002). The music therapists worked within a wide range of schools catering for children with:

- severe learning difficulties (64.8%)
- emotional and behavioural problems (49.7%)
- profound learning difficulties (49.1%) (note that 'profound and multiple learning difficulties' is the more customary term)
- physical disabilities (43.4%)
- sensory impairments (42.8%)
- moderate learning difficulties (39%)
- problems coping in mainstream education (11.94%)
- autism and mental health problems attending specialist units (5%).

It is not surprising that most music therapists work with children with severe/profound learning difficulties and emotional and behavioural difficulties. Here the communicative potential of music can be harnessed to great benefit. The high proportion of work within the areas of sensory impairment and physical disability is likewise an expected result. An unexpected and fascinating trend borne out by recent surveys and reports is the increasing amount of work being done in mainstream schools (see below).

The respondents to Strange's questionnaire were also invited to indicate the positive aspects of working in a school. These were ranked as:

- enjoy the clinical work (93.7%)
- generally see the children making progress in therapy (92.4%)
- feel this progress tends to generalise to other settings (89.3%)
- enjoy working in the school (83.6%)
- have good relationships with the head teacher (82.3%)
- feel part of the team (68.6%).

A continuum is implied here from clinical work within the private music therapy space through observation of progress outside this setting to working links with other members of the teaching team.

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A selection of evidence of effective practice from case studies and research

There is much anecdotal evidence of the effects of music therapy as mentioned by the therapists in the survey described above. The early pioneers worked extensively with children, particularly those on the autistic spectrum or with profound learning difficulties (for example see Alvin, 1975, 1976; Alvin & Warwick, 1991; Nordoff & Robbins, 1971, 1977). Case studies form a rich resource of clinical evidence (for a range of studies with children of all ages see Bruscia, 1991; Bunt, 1994; Bunt & Hoskyns, 2002; Hibben, 1999; Pavlicevic, 1999; Wigram *et al.*, 1995; Wigram & De Backer, 1999).

Detailed video analysis and the use of time-based outcome measures have enabled evidence of effective practice to be collated. When compared to both a similar period of music therapy and one without music therapy, plus using individual play with a well-known adult as an additional control, music therapy was found to be particularly effective with children with profound and multiple learning difficulties, for example in the areas of:

- increasing the frequency, length, range and appropriate use of vocal sounds
- increasing the amount of looking to the adult
- increasing the amount of turn taking and the development of a shared repertoire of events
- reducing the amount of non-attentive behaviour
- developing over time a child's imitative skills and ability to initiate an activity. (See summary in Bunt, 1994)

A study by David Aldridge and his team at the University of Witten-Herdecke used both the Nordoff–Robbins scales of assessment ('Child–therapists relationship in musical activity' and 'Musical communicativeness' – see Nordoff & Robbins, 1977) and some of the Griffiths standardised developmental subscales to explore differences between groups of children with developmental delay passing through periods of music therapy and no music therapy. The researchers noted 'a continuing significant difference on the hearing and speech sub-scale and a significantly changing ability to listen and communicate'. Aldridge adds: 'Music therapy seems to have an effect on personal relationship, emphasizing the positive benefits of active listening and performing, and this in turn sets the context for developmental change' (Aldridge, 1996: 262).

Auriel Warwick was one of Alvin's early students and she went on not only to set up a music therapy service within the Oxfordshire Education Authority but also to research how children with autism make use of music therapy (Warwick, 1995). In a further piece of research investigating the effects of improvisational music therapy when working with autistic children, Cindy Edgerton demonstrated clear increases in communicative behaviour (responses and actions) over time (Edgerton, 1994).

Further areas of development

Music therapists are now moving into other areas, including challenging work with, among others: older children with eating disorders (Robarts & Sloboda, 1994); children living with cancer and other life-threatening illnesses (Ibberson, 1996); children with physical

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disabilities (Bean, 1995); and children living with the trauma of abuse (Rogers, 1992, 1993).

Within Birmingham and Worcestershire Education Authorities the mechanism now exists for any school to refer a pupil for music therapy. This has resulted in music therapy in these LEAs moving to occupy a place close to that of clinical psychology in terms of a resource supporting both pupils exhibiting a variety of needs and school staff requesting intervention. Many referrals are received for crisis intervention work or to support integration back into mainstream schooling. Music therapists here work together with the school staff and the wider multidisciplinary team in assessing a pupil's circumstances and providing appropriate therapeutic intervention. Therapists may also follow pupils through school transfer or placement into Pupil Referral Units. Further developments could include work in the areas of 'looked-after' children, post-adoption and exclusion (Tingle, in preparation).

PART III

This final part begins with two imaginary scenarios where closer collaboration between music therapy and music education is proposed.

Scenario 1: a group project

The studies referred to so far have focused on individual work. Music therapists also work in small groups. It is here that work is often carried out in collaboration with other members of the teaching team, including the school's music specialist. Let us imagine a potential scenario in a mainstream school of a group of ten disruptive and disaffected twelve-year-olds from a year group being referred to the visiting music therapist. These students are often excluded for fixed periods. A project is set up with one of the music staff working with the therapist. It is hoped that during the course of this project both therapist and teacher will learn a great deal from each other and develop a joint approach to working with the children. Initially, what are some of the challenges for the music therapist and music teacher as they meet for a preliminary discussion of the aims for the group? The teacher brings to the discussion knowledge of the background of the children, awareness of their difficulties in accessing aspects of the whole curriculum, and knowledge of the children's musical tastes and preferences. The teacher has a particular interest in contemporary song writing. The therapist is open to explore how a term of music therapy sessions could promote increased self-esteem, motivation and the beginnings of some sense of group identity.

The group can meet in a music room equipped with keyboards and facilities for multi-track recording. The therapist suggests that the work could focus on improvising, composing and recording both individually and group-created songs and listening. The issue of assessment is raised and both teacher and therapist note that the proposed musical activities could fall within the current emphasis on listening, composing and performing of the National Curriculum. They also note that the general aims of this proposed music therapy experience are similar to those of the Personal and Social Education (PSE) areas of the curriculum for children aged 5–14. The 'Passport' framework

(an acronym for Personal and Social Development in Schools Progression Organisation Rigour Training) states that 'the personal development of pupils, spiritually, morally, socially and culturally, plays a significant part in their ability to learn and achieve' (Lees & Plant, 2000: 26). Both therapist and teacher agree to maintain a joint record of how each child uses the sessions, noting any significant points in relation to each child's overall personal development and relationship to both the group leaders and other children in the group.

While remaining comfortable with a child-centred approach to learning, the main challenge to the teacher is the therapist's emphasis on working with what is presented each week and having no expectations. The therapist is challenged to consider the relationship between therapeutic objectives and a more educational framework. They agree to read two chapters from recent texts. The first describes how a series of Gamelan workshops met both therapeutic and educational objectives through encouraging links between the 'musical, cognitive and social variables found in group music-making' (MacDonald & Miell, 2002: 167). The second is an account of effective collaboration between therapist and teachers while running a group in a special school (Sutton, 2002).

Towards the end of our hypothetical project plans are made to prepare the children to return to their usual music classes. The music teacher suggests that the children perform some of their music to their peer groups, thus contributing to a sense of ownership. The music therapist agrees to be present for the first few lessons to aid the period of transition and to be available to support both the individual children and the music teacher. This kind of consultative/collaborative model has been introduced into the public school system in a part of Texas where therapists and teaching staff devise interventions based on each student's Individual Education Plan (Chester *et al.*, 1999).

Scenario 2: the individual music lesson

The management at our imaginary mainstream school is very enlightened, as shown by the fact that the visiting peripatetic music staff have timetabled opportunities to discuss any issues and problems arising in their work with the visiting music therapist. The string specialist is concerned that one of her most gifted and advanced students has stopped practising and has begun to share personal problems relating to both school and home. The student has built up sufficient trust with the string teacher over the years that this is the one place in the child's week where it feels possible to share these problems, a safe place to be heard. The string teacher is aware of her role and that she is employed as teacher and not as therapist. She feels out of her depth when the student begins to air problems but is aware of the close working relationship that has developed. In the meeting with the music therapist boundaries and limits to roles are discussed and the therapist is able to support the teacher who in turn is then able to be more supportive to the child. The music teacher is helped to listen non-judgementally to the student, to explore ways in which the student may engage more in the music, and to understand where the student may be referred for further help. It is agreed to recommend a postponement of the forthcoming exam and to start a period of playing duets (something that eased pressure in the past) and of exploring new repertoire, a challenge to both teacher and student.

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Some challenges for the twenty-first-century music therapist

It is a challenging time to be working as a music therapist. In previous sections we have observed how music therapists underpin their work with a variety of theoretical frameworks. There are also practical and theoretical challenges from musical, cultural and moral points of view. Practically there are the challenges of the regular use of improvisation and working with people's own music (see Nachmanovitch, 1990 for a creative exploration of improvisation). Music therapists are adjusting to ever-changing technology, for example the use of *Soundbeam*, an instrument that produces a wide range of sounds by a movement interrupting an infrared beam; a sound-generating programme such as *MidiGrid*; and music writing programmes such as *Cubase Score*. A further major challenge to a classically trained therapist is the awareness of so much music of many different genres from all corners of the globe. This kind of challenge is also being addressed by the steady increase in the number of musicians from non-classical traditions entering the profession. Theoretically there is the challenge of contributing to current debates on how music is perceived, understood and used as an effective means of communication. A reminder of some of these practical and theoretical challenges formed part of the keynote address on music, culture and social action given by Professor Nigel Osborne in Oxford in July 2002 at the 10th World Congress of Music Therapy. He also summoned music therapists to engage in work with traumatised children living in cultures moving through massive periods of transformation. He called this the music therapist's 'moral imperative': 'Music therapy holds the seeds of intellectual, spiritual and moral regeneration' (Osborne, in preparation).

Nigel Osborne is not a trained music therapist yet his music-based community projects in war-torn areas of the world are both educational and therapeutic, his work for many years having gently skirted the discipline of music therapy. He is also a composer and teacher, and currently holds the chair in music at the University of Edinburgh. This balance of performing, composing, teaching and leading exemplifies the changing life pattern of the contemporary musician. Interestingly, these four areas are identical to some of the findings in a recent report commissioned by the Higher Education Funding Council for England, *Creating a Land with Music: The Work, Education and Training of Professional Musicians in the 21st Century* (National Foundation for Youth Music, 2002). In many ways the working practice of a contemporary music therapist reflects some of these different roles and challenges. Roles in addition to that of therapist might include: music arranger/composer, supervisor, consultant, trainer, researcher, writer, workshop leader and performer.

Some final considerations on the overlaps between music therapy and music education

A variety of musical and sound experiences make up a child's day. A child may regard all these experiences as being part of sound and music – music is something to listen to and be enjoyed while alone or part of a group, as an accompaniment to other activities, or something to study, practise and learn about. This very inclusive and holistic view of music is close to Christopher Small's well-known notion of 'musicking' (Small, 1998).

What does a music therapy approach share with a child's general view of music and with 'musicking'? There are features that are common to other musical activities in a child's day – a music therapy session would likely involve some playing on instruments or some

listening to music. A set of relationships is established in the music therapy space where the 'musicking' is happening. Relationships develop with the instruments, with the music, with any other children in the room if part of group work, and with the therapist or teacher. Making music itself is a multidimensional activity with the unique involvement of the whole child – physically, socially, intellectually and emotionally. Such rich and complex interactions and relationships create a grey area between what can be defined as solely the domain of therapy and that of education. The sounds emerging from a music therapy session and a music class may even be similar, particularly if both music teacher and therapist are making use of songs and other composed material. It suffices to say in summary that it is the underlying intention behind the activity that seems to help in differentiating the experience more clearly. As stated in a booklet published by the APMT entitled *Music Therapy in the Education Service*:

> Music Therapy and Music Education are complementary and not to be seen as alternative forms of provision. Music therapists employ techniques specifically for promoting healthy personal and social development. The justification for providing therapy of any kind within the Education Service is that caring for the physical, mental and emotional well-being of the student is a prerequisite to the overcoming of learning difficulties and the development of the child as a whole. (APMT, 1992)

Christopher Polyblank, County Music Inspector for Worcestershire County Council, has commented on the work of the team of local music therapists thus:

> Working in partnership with a music therapy team has reinforced my belief in the power of music. Music therapy has made a great difference to the lives of many pupils across the authority, a part of which is facilitating greater access to the National Curriculum. (Polyblank, 2002)

In the education setting the music therapist has a role to listen to and respond to the needs of the child, to build a therapeutic relationship over time. The process is certainly more the focus of attention than concern for the quality of the musical product, although incidentally regular exposure to musical activity naturally helps a child to practise certain musical skills. Some level of musical curiosity and skill may in some instances be necessary before a child can benefit from therapy (Ockelford, 2000). As described above, there is the added responsibility to help the child use any growth and changes in the music therapy to access the general areas of the curriculum. For example, how can Jane's increase in self-esteem in music therapy generalise to her life in the classroom?

A sign of maturity appears to be the ability to balance any apparent opposites and to live with tensions. There are overlaps between the domains of therapy and education but also specific strengths and contributions in each discipline. But the line has to be drawn somewhere:

> it appears that music therapy more strongly promotes 'well-being' whereas music education more strongly promotes 'development' (of skills, knowledge and understanding); and that therapy has more internally (client-centred) determined goals, whereas effective music education would unashamedly be based on a combination of 'internally' and 'externally' determined goals. (Ockelford, 2000: 215)

Interestingly, there has been a history of close collaboration between music educators and music therapy in the USA. This may be linked to the original mode of training where music undergraduates undertook training in both specialist music education and music therapy. A series of conferences within the remit on 'Music Therapy and Music Education for the Handicapped' continued to promote dialogue and debate (for example Pratt, 1989 – as part of an ISME Commission – and 1993). Some commentators have suggested specific training in 'Special Educational Music Therapy' (Goll, 1994), or further clarification between what is deemed to be 'clinical music therapy' and 'educational music therapy', again with different training options (Robertson, 2000).

Ockelford calls for more music provision of all kinds within his particular area of speciality, namely music for children with learning difficulties (Ockelford, 2000). We also need to ensure that the needs of a child of any age are central to further dialogue and debate on what kind of provision is appropriate. 'Musical participation can help develop an individual's sense of ability in music, and feelings of ownership of a creative product, and this highlights some of the parallels that can exist between therapeutic and educational music interventions' (MacDonald, Hargreaves & Miell, 2002: 17). Finally, the notion of a continuum is proposed from the boundaried private music therapy individual or small group session moving through the overlapping areas of joint projects to the role of the music therapist as consultant or adviser. In this way both music therapists and music educators would be working towards a common goal, namely the use of the powerful art of music to facilitate not only learning but also development of the whole child both within and outside of school.

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