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Forschung und Praxis der Musiktherapie

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Editorial

Language – Linguisticality – Multilingualism

What I particularly love: jumping off the pier of the lake I've known since childhood, diving headfirst into the cool water, submerging, taking my first strokes out of this refreshing plunge, and leaving the shore farther and farther behind. It had never occurred to me that this sensation could be captured by a single word, nor had I searched for one—until I came across the Hungarian phrase *jó úszás* in a novel by Zsuzsa Bánk (2020): »a good, long swim through lake and sky, water and air«[1] (p.13). *Jó úszás* is one of many so-called *untranslatable words*. Do you also know such words—terms that precisely capture specific situations, perceptions, phenomena, or feelings but lack an exact equivalent in other languages and can only be paraphrased? A wonderful collection of untranslatable words can be found in a book by Ella Frances Sanders (2017)—and these linguistic *Schmankerl* (as we call special delicacies in Austria) can even serve as bridges: For example, in the Brazilian Portuguese word *cafuné* (loosely translated: running one's fingers through a loved one's hair), I recognize the tender, soothing feeling associated with my Carinthian grandmother's loving *Beguatn*. And how refreshing is *Auslüften* on a demanding working day at the computer desk and get some fresh air—an activity aptly described in Dutch as *uitwaaien* (loosely translated: taking a break to clear one's head by walking in the wind).

The aim of this year's special issue was not primarily to identify linguistic peculiarities, but rather to make scholarly texts by music therapists from Europe and beyond accessible to each other. In the print edition 2-25 of the German language journal *Musiktherapeutische Umschau*, we've offered our regular readership the contributions in German. Additionally, the texts are now available in their original submitted languages and in English as freely accessible electronic publications in this supplement.

Accessibility—a term that has gained increasing attention and sensitivity—aims to counteract marginalization and the challenges of intersectionality, often exacerbated by special privileges or, conversely, disadvantages. Language itself can also be a privilege.

> »Every language opens ... unforeseen possibilities and many doors—often precisely when one least expects it. Languages enable us to meet other people, to approach them, and to understand them in the fullest sense of the word. The same applies to other cultures and, sometimes, even to ourselves.«[2] (Grjasnowa, 2021, p. 13)

The accessibility of scholarly music therapy texts beyond linguistic barriers has been a longstanding concern for our editorial team. In 2016, during the 10th European Music Therapy Conference in Vienna, we organized the first meeting of European journal editorial teams—both from major international, English-language journals such as the *Nordic Journal of Music Therapy*, *Voices*, and the *British Journal of Music Therapy*, as well as from smaller, language-specific journals such as

[1] Original in German: „eine gute, lange Schwimmerei durch See und Himmel, Wasser und Luft" (Bánk, 2020, p.13).
[2] Original in German: Jede Sprache öffnet … ungeahnte Möglichkeiten und viele Türen – oft gerade dann, wenn man gar nicht damit rechnet. Sprachen ermöglichen uns, andere Menschen kennenzulernen, auf sie zuzugehen und sie im umfassendsten Sinne des Wortes zu verstehen. Dasselbe gilt für andere Kulturen und manchmal sogar für uns selbst. (Grjasnowa, 2021, p.13)

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Dansk Tidsskrift for Musikterapi, *Revue Française de Musicothérapie*, and the German-language *Musiktherapeutische Umschau*. At the next meeting in 2019 in Aalborg, additional editorial teams joined, including the newly founded *Revista Portuguesa de Musicoterapia* and the Norwegian *Musikkterapi*. In addition to exchanging ideas about successful and challenging editorial processes, we always aimed to develop ways to learn more from one another: What topics concern music therapists in different countries? What is being written about, and how can we make content accessible across national and linguistic boundaries?

Of course, English is the dominant scientific language in music therapy and serves as the largest common denominator for international communication. However, it is not always the best solution—especially when the challenges of writing or reading in a foreign language are too great, or when one's native language is needed in its full uniqueness to accurately express nuances and specifics, such as emotions or aspects of therapeutic contact and relationship-building.

> *»Language is the deepest core of our culture; it contains our thoughts, our way of seeing the world.«*[3] — With these words, Gümüşay (2022, p. 18) quotes one of the last speakers of the indigenous Potawatomi language.

This led to the idea and initiative of dedicating the MU special issue in the year of the EMTC Congress—under the theme »Bridges«—to the cultural and linguistic diversity in Europe and providing insights into music therapy across different countries. A Call for Papers was launched in February 2024 via the DMtG website, the EMTC Coreboard networks, as well as social media channels and newsletters, inviting authors from across Europe to submit contributions in their national and/or native languages, initially in the form of short abstracts. From a total of 29 short proposals submitted from 19 countries, in 14 languages, by 42 authors and co-authors, the editorial team selected those that fit the scope of a standard MU print issue. The 19 full-text articles, later developed in their original languages as well as in English, were translated into German using AI-based translation tools (primarily DeepL) and subsequently refined through a four-eyes principle review by the MU editorial team.

At this stage, it was immensely beneficial to draw upon the multilingual competencies of additional colleagues and friends—we extend our heartfelt thanks to Katia Brunner (Spanish), Elsa Campbell (English), Marco Feis (Dutch), Marta Ayerbe Garcia (Spanish), Andrea Intveen (English), Janko Merkač (Slovenian), Julie Nass-Dambach (French), Tomi Mäkelä (Finnish), Montserrat Pamies Vila (Spanish/Catalan), Oliver Schöndube (Italian), and Franziska Rettelbach-Zellner (Italian) for their support!

The project developed into a challenging yet dynamic and innovative undertaking. While AI significantly aids in bridging linguistic gaps, the process still required meticulous fine-tuning and close communication—both within the editorial team and with the authors and supporting colleagues mentioned above. Special attention was needed when cultural differences led to linguistic inconsistencies, and when translatability or adaptability reached its limits. In some cases, we decided to retain established technical terms in their original language or to keep social

[3] Original in German: „Die Sprache ist das Innerste unserer Kultur, sie enthält unsere Gedanken, unsere Art, die Welt zu sehen." (Gümüşay, 2022, p.18)

customs—such as the informal *Du* address used in Dutch—unchanged. At the same time, we incorporated gender-inclusive language conventions used in the German-speaking countries, even if they were not part of the original text (as in Italian or Spanish). We embraced the »charming complexity« (Grjasnowa, 2021, p. 117) that comes with multilingualism and translation processes.

With this special issue, we have taken the plunge into uncharted waters and hope that this *jó úszás*—this good, long swim through different countries and cultures—brings you as much joy and refreshment as it has brought us. By providing access to diverse experiences and professional perspectives, we hope not only to enrich music therapy in its many facets but also to foster communication and dialogue, and to strengthen openness to different forms of expression and approaches.

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»On je bil tiho, jaz pa brez besed …«

Glasbena terapija z dečkom s selektivnim mutizmom v Sloveniji

»He was silent and I had no words... «

Music therapy with a boy with selective mutism

Claudia Knabe

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Povzetek

Članek opisuje glasbeno terapijo osemletnega dečka s selektivnim mutizmom v Sloveniji. Nemška terapevtka govori o svojih jezikovnih ovirah, zaradi katerih pretežno pristopa z neverbalnimi intervencijami. Terapija je usmerjena v izboljšanje samoizražanja in spremljanje čustveno zahtevnih sprememb v dečkovem življenju. Tekom terapije se občutno izboljšata samozavest in socialna interakcija. Ugotavlja se, da so v tem primeru terapevtkine (jezikovne) nepopolnosti omogočile razvoj in preobrazbo.

Ključne besede: selektivni mutizem – jezikovna ovira – neverbalna interakcija – socialna interakcija

Abstract

This article describes the music therapy of an eight-year-old boy with selective mutism in Slovenia. The German therapist talks about her own language barriers, due to which she mainly initiates non-verbal interventions. The therapy focuses on self-efficacy and self-expression as well as accompanying emotionally challenging changes in the boy's life. Over the course of therapy, there is a significant improvement in self-confidence and social interaction. It is considered whether, in this case, the therapist's (verbal) imperfections made transformative developments possible.

Keywords: selective mutism – language barrier – non-verbal interaction – social interaction

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♦ Slovenščina

Alen je bil moj prvi klient v Sloveniji, takrat je bil star osem let, jaz pa petindvajset. Ravno sem zaključila diplomski študij glasbene terapije v Nemčiji in prišla v Slovenijo z zelo slabim znanjem jezika. Alen je pokazal znake selektivnega mutizma. Govoril je le doma z družino, v drugih družbenih situacijah – zlasti v šoli, pa je molčal. Spominjam se, da je v sobo za glasbeno terapijo prišel povsem zadihan in poslušal mojo pozdravno pesem: *Dober dan, Alen. Glasbo igrava*. Ni pel skupaj z mano, ampak je z nogama pozibaval v ritmu. Nato je vstal in raziskoval glasbila. Spremljala sem ga s kitaro. Pozneje sem ga povabila, naj izbere po eno glasbilo zase in zame. Vzel je kalimbo, meni pa je dal zvončke. Tako sva začela. Alen je izbral glasbila in skupaj sva igrala proste improvizacije. To je bilo presenetljivo enostavno z njim. Ni se pogovarjal z mano. Zakaj bi se moral? Takrat bi ga tako ali tako komaj kaj razumela. Lahko sem mu le, v polomljeni slovenščini, ponudila nekaj preprostih namigov za igro. Zagotovo sem naredila veliko slovničnih napak, ko sem mu skušala sporočiti svoje zamisli. Včasih sem opazila, kako se je ob tem nasmehnil.

Alenovi starši so o glasbeni terapiji prebrali v časopisu in me poklicali, če bi delala s sinom. Bilo je tik pred koncem šolskega leta in postalo je jasno, da bo moral Alen ponavljati razred. Povedala sta mi, da je zanj težko, ker v šoli ne pove tistega, kar zna. Alen v šoli že nekaj časa ni spregovoril. Ko je bil vprašan, je bil običajno tiho. Posledično so se njegove ocene močno poslabšale. Starši so ga opisali kot prijaznega in bistrega fanta, ki se bori s svojo sramežljivostjo in pomanjkanjem samozavesti. Z njima sem se lahko pogovarjala v angleščini, Alen pa je razumel le slovensko.

Da bi spodbudila tematske improvizacije, ne da bi mi bilo treba veliko razlagati, sem posamezne besede napisala na kartice. Služile so kot predlogi za najine improvizacije. Najprej so bile to barve, različni vremenski pojavi, nato pa teme, kot so »počitnice«, »šola« in podobno. Ključni trenutek je bila najina improvizacija na temo šole na četrtem terapevtskem srečanju. Alen je izbral karto in nato še glasbila za oba. Zase je pripravil več bobnov in veliko činelo, meni pa je dal kalimbo. Med njegovim igranjem sem se komaj slišala. Na svoja velika glasbila je igral glasno in silovito. Imel je moč, da je lahko »povedal svoje«. Kmalu sem se nehala truditi. Na lastni koži sem občutila, kaj pomeni ne biti slišan. V povezavi z naslovom najine improvizacije »o šoli« je vse skupaj dobilo smisel. Nemoč, ki sem jo doživljala, sem lahko prepoznala kot tisto, kar je Alen morda doživljal v šoli in kar mi je zdaj v najini glasbi pustil občutiti. Obenem je naredil pomemben korak. Sam je preizkusil, kako je biti glasen. Midva z Alenom o tem nisva mogla govoriti. Ostala sva v varnem okviru pozdravne in zaključne pesmi najine skupne izkušnje brez besed. To me je precej skrbelo. Nemoč, ki sem jo doživljala med improvizacijo, se je nadaljevala tudi po srečanju, saj sem se spraševala o pomenu tega glasbenoterapevtskega dela »brez besed«: Kako sem lahko Alena po tej pomembni improvizaciji pustila besedno neizraženega? Kaj to pomeni zanj? Ali sem ga sploh pravilno razumela? Kako je on videl dogajanje? Ko sem naslednjič govorila z njegovimi starši, sem bila presenečena. Njegova mama me je poklicala in se mi zahvalila. Alen se je nenadoma začel pogovarjati s sosedi in zdel se ji je bolj odprt do drugih ljudi. Torej se je po najini improvizaciji nekaj začelo spreminjati. Prav tako je potrdila moje razmišljanje o razmerah v šoli. Njegov razred je opisala kot »zelo problematičen«.

Po poletnih počitnicah Alenu ni bilo lahko začeti v novem razredu. Z njim sem še celo šolsko leto delala v okviru glasbene terapije. Poudarek je bil na doživljanju samoučinkovitosti in samoizražanju. Spremljala sem ga v procesu sprememb, ki so bili čustveno zahtevne. Alen je na najinih srečanjih postajal vse bolj ustvarjalen. V najine glasbene improvizacije je vnesel igrive

vložke, gibanje in dramo. Rad se je prelevil v Frankensteina in Drakulo ter bil zares grozljiv. V svojih vlogah je vedno več govoril in pel ter tako odprl pot k skupnemu jeziku. Tisto leto sem se tudi sama bolje naučila slovensko, tako da sva se končno lahko pogovarjala med seboj. Ne glede na to – Alen nikoli ni želel veliko razglabljati. Čas med pozdravno in zaključno pesmijo je raje izkoristil za obsežne uprizoritve. V pogovorih s starši je postalo jasno, da je Alen v tem letu pridobil samozavest. Lahko se je bolje sporazumeval in med sošolci mu je bilo udobneje. Sama sem se v tem času naučila nekaj, kar sem pozneje večkrat prepoznala v različnih (večinoma mednarodnih) terapevtskih okoljih: Naši klienti ne potrebujejo popolnih terapevtov. Pravzaprav lahko razkritje naše pomanjkljivosti - kot je pomanjkanje znanja jezika - privedejo klienta do olajšanja, kar omogoči, da se zgodijo nepredvidljive reči.

♦ English

Alen was my first client in Slovenia, 8 years old at the time when I was 25. Having just completed my music therapy diploma in Germany, I arrived in Slovenia with very little language skills. Alen had selective mutism. He only spoke at home with his family, in other social situations, especially at school, he remained silent. I remember how he came up the stairs to the music therapy room completely out of breath and listened to my welcome song: 'Dober dan, Alen. Glasbo igrava.' ('Hello, Alen, we're making music'). He didn't sing along, but dangled his legs to the beat. Then he stood up and explored some instruments. I accompanied him with the guitar. Later, I invited him to choose an instrument for himself and one for me. He took the kalimba and gave me the chimes. That's how we started. Alen chose the instruments and we played free improvisations together. It was surprisingly easy with him. Alen didn't talk to me. Why should he? I would hardly have understood anything back then anyway. I could only offer him a few simple suggestions for playing in broken Slovenian. I certainly made a lot of grammatical mistakes when I tried to communicate my ideas to him. Sometimes I saw him smiling about it.

Alen's parents had read about music therapy in the newspaper and called me. It was just before the end of the school year and it became clear that Alen would probably have to repeat the class. They told me that it was very difficult for him because he didn't communicate what he knew. Alen hadn't spoken up at school for some time now. When he was asked a question, he usually kept quiet. As a result, his grades had deteriorated considerably. His parents described him as a friendly, intelligent boy who struggled with his shyness and lack of self-confidence. I was able to talk to them in English, but Alen only understood Slovenian.

In order to initiate thematic improvisations without having to explain much, I wrote single words on cards. They served as suggestions for our improvisations. At first it was different weather conditions, colours, then topics such as 'holidays', 'school' and similar things. Our improvisation on the subject of school in the fourth therapy session was a key moment. Alen had chosen the card and decided on the instruments for both of us. He set up several drums and the large cymbal for himself and gave me the kalimba. I could barely hear myself while he was playing. But he played loudly and powerfully on his large instruments. He had the power and was able to 'have his say'. But I soon stopped trying to make myself heard. I experienced first-hand what it means not to be heard. In the context of the title of our improvisation 'school', it all made sense. I was able to recognise the powerlessness I was experiencing as something that Alen might have experienced at school and was now making me relive in our music. At the same time, he took an important step. He experimented for himself with what it feels like to be loud. Alen and I were unable to reflect on this verbally. We stayed within the safe framework of the greeting and closing song in our shared

experience. But it bothered me a lot. The powerlessness I experienced during the improvisation continued after the session and I questioned the meaning of my music therapy work 'without words': How could I let Alen go without verbal reflection after this important improvisation? What does that mean for him? Did I even understand him correctly? What did he 'understand'?

The next time I spoke to his parents, I was surprised. His mum called to say thank you. Alen suddenly started talking to the neighbours and seemed more open towards other people. So something started to change after this improvisation. She also confirmed my suspicions about the school situation. His class was 'very problematic, with lots of noisy students taking up space'. In addition, Alen was the youngest student in his class because he started school early. It was decided that Alen would repeat the class.

After the summer break it wasn't easy for Alen to start the new class. Fortunately I was able to continue working with him in music therapy for a whole school year. The focus was on experiencing self-efficacy and self-expression as well as supporting him through emotionally challenging transitions. Alen became more and more creative in our sessions. He introduced playful elements, movement and drama into our musical improvisations. He liked to transform himself into 'Frankenstein' and 'Dracula' and was terribly scary. He spoke and sang more and more in his roles, opening the way to a common language. I also learned Slovenian better during that year, so that we were finally able to talk to each other. Nevertheless, Alen never wanted to reflect much. He preferred to use the time between the greeting and the closing song for extensive enactments. In discussions with his parents, however, it became clear that Alen gained a lot of self-confidence this year. He was able to communicate better and also felt more comfortable among his classmates. I myself learned something during this time that I later repeatedly realised in various (mostly international) therapy settings: Our clients do not need perfect therapists. In fact, our revealed shortcomings - such as a lack of language skills - might lead to a relief for our clients that allows unexpected things to happen.

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Dr. Claudia Knabe je glasbena terapevtka in supervizorka v Lipnici, Avstrija. Delno zaposlena je v ustanovi za osebe z motnjami v ravoju, predava in raziskuje (glasbeno terapijo z osebami s težkimi motnjami v razvoju). Njena strast je medkulturno delo.

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Resonant Diversity: Opportunities and Challenges in Music Therapy for Culturally Diverse Populations throughout European Contexts

Barfin Ayse Ünügür

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Abstract

In recent years, the influence of culture on psychotherapy has grown, with a focus on cultural competence in mental health training. Music therapists face distinct challenges and opportunities in diverse settings, as music can transcend cultural boundaries while also reflecting them. This phenomenological study explores how music therapists in Europe adapt their practices in multicultural environments. Through six semi-structured interviews, key strategies emerged, including creating inclusive spaces, respecting cultural preferences, and addressing systemic issues like racism. The findings highlight music's profound ability to foster connections across cultures while emphasizing the need for therapists to be culturally sensitive and adaptive. By embracing diversity and practicing humility, therapists enhance therapeutic outcomes in multicultural settings, ensuring therapy is both respectful and effective.

Keywords: music therapy – cultural background – diversity – inclusivity – cultural competence

♦ English

The increasing diversity among individuals seeking mental health services has intensified the focus on the role of culture in psychotherapy. Mental health training programs now emphasize cultural competence, urging therapists to meaningfully engage with clients from varied backgrounds to provide respectful and effective care (Heppner et al., 2008). Forming a strong therapeutic alliance can be particularly challenging in diverse cultural contexts due to differences in social systems and cultural hierarchies (Corey, 2013).

In therapeutic settings, recognizing cultural differences is crucial for building trust, improving patient satisfaction, and addressing health disparities, especially within marginalized communities (Betancourt et al., 2003). However, it is not easy to discuss issues of diversity, as race, ethnicity, and culture are often linked to sensitive feelings, or in some cases, strong prejudices (Freeman, 2006). To understand and address the challenges individuals face in psychology, it is essential to grasp the intersection of social identities and the broader political landscape. Recognizing these underlying factors allows for more personalized approaches that are attuned to the diverse experiences of clients.

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Modern migration and its impact on ethno-political conflicts highlight the critical role of understanding racism in psychotherapy. Shared genetic interests and power dynamics in multicultural settings shape ethnic cohesion and tensions, complicating unity-based citizenship and reinforcing ethnic ties (van den Berghe, 2002; Salter, 2003). Racism and discrimination deeply affect individuals from marginalized communities, shaping their mental health, identity, and trust in healthcare. For music therapists, recognizing these racial and socio-political dimensions is essential for fostering authentic therapeutic relationships. As music reflects cultural and ethnic identities, therapists must engage with the historical and social contexts clients navigate to enhance therapeutic outcomes.

As music therapy continues to evolve in multicultural settings, the incorporation of multicultural and intersectional perspectives is essential for providing culturally competent care (Helander & Gattino, 2020). Therapists must be attuned to the socio-political and historical contexts that shape racial dynamics (Delgado & Stefancic, 2017). The intersection of historical legacies, economic inequalities, and political structures plays a significant role in shaping ethnic attitudes (Fischer-Tine, 2016; Quillian et al., 2019). Understanding these factors is crucial for effective care in music therapy, where cultural sensitivity is key.

This study aims to recognize the complexities of cultural diversity and the impact of racism, asking: *How do music therapists adapt their practices to accommodate cultural differences?*

Methods

This qualitative study uses a phenomenological approach to explore the experiences of music therapists in culturally diverse European settings, reflecting the increasing diversity in mental health services. Guided by constructivism (Bereiter, 1994), it seeks tp recognize the dynamic nature of cultural interactions in therapy. Semi-structured interviews with open-ended questions facilitated in-depth exploration of participants' perspectives (Patton, 2002) and adhered to the Standards for Reporting Qualitative Research (SRQR) checklist (O'Brien et al., 2014).

Sampling

Purposive sampling was used to ensure diversity in cultural backgrounds and practice settings (Gill, 2020). Participants were approached through personal networks and online outreach, with one case involving snowball sampling.

The study involved six participants aged 30 to 63, with 5 to 25 years of experience in diverse specialties. Their academic backgrounds included bachelor's and master's degrees in music therapy, as well as doctoral degrees in related fields. Participants represented various cultural backgrounds—Dutch, Turkish, Finnish, Brazilian, Austrian, German, and British—and were fluent in multiple languages. Specializations included autism, dementia, trauma, brain injuries, oncology, psychiatric care, and working with displaced communities. Several were also university lecturers, blending academic and practical experience.

Interview Process and Data Analysis

Interviews were conducted via Zoom in April and May 2024, lasting 60–75 minutes by the author. Informed consent was secured, and data was pseudonymized to ensure anonymity and confidentiality. The interview guide focused on themes such as cultural sensitivity and associated challenges, while also gathering demographic data. Transcriptions were made verbatim and analyzed using Mayring's (2015) qualitative content analysis, incorporating both predefined and emerging themes. A coding table (see Appendix A) facilitated iterative revisions of categories through a color-coded system. The author was born and raised in Turkey, her eight years of experience in Europe informed the study, ensuring credibility through regular reflection and consultations to manage biases (Creswell, 2013; Silverman, 2006).

Figure 1. QR-Code: Coding table for the Resonant Diversity study.

Results

Building Trust: Music's universal qualities enable the bridging cultural divides, allowing therapists to build trust without relying solely on verbal communication. Techniques like Carolyn Kenny's *Field of Play* model illustrate how respecting clients' musical preferences and encouraging self-expression promote comfort and reduce shyness.

Cultural Sensitivity: Participants emphasized the need for individualized assessment, awareness of cultural backgrounds, and the importance of cultural humility. They noted the balance between curiosity and the risk of stereotyping, focusing on meeting each client as an individual.

Music's Universal Qualities: Participants highlighted music's role in bridging communication gaps, especially through rhythm and melody, which evoke shared emotions across cultures. Referencing early childhood communication theories, they emphasized that fundamental musical elements like rhythm and dynamics foster empathy. In therapy, participants noted the use of tempo and volume to create safe, expressive spaces, with one referencing Bruscia's improvisation profiles to show how rhythm and melody support cultural narratives and understanding.

Challenges and Limitations: Cultural differences create both opportunities and barriers in therapy. Participants discussed the challenge of balancing clients' musical preferences and cultural expectations, as well as addressing sensitive issues, such as subtle racism in group settings. Western-centric training often limited their understanding, emphasizing the need for culturally resonant instruments and approaches.

Strategies for Inclusivity: Participants used tools like »Music in Everyday Life« (Gottfried et al., 2018) assessment to enhance cultural understanding and incorporated client-preferred music and familiar cultural practices into sessions. They prioritized empathy, authenticity, and flexibility, fostering a sense of inclusion by adapting to clients' unique cultural expressions.

Integrating Cultural Elements: Participants emphasized cultural humility, sensitivity, and competence, recognizing both their own musical realities and the diverse backgrounds of their clients. The focus on empowering clients aims to validate their cultural expressions. By highlighting the significance of client narratives, participants noted that clients' stories and cultural histories enrich the therapeutic process, adding depth to the overall experience. Authentic engagement with

clients' cultural elements is prioritized, while efforts are made to avoid tokenism or exoticism in the use of instruments and practices.

Navigating Cultural Differences: Participants discussed balancing cultural sensitivity with personal authenticity in conservative settings, such as a refugee camp where dressing modestly eased cultural divides. Many shared how they confronted and managed their own biases, whether in religious or generational contexts, to foster acceptance. Embracing family dynamics in therapy, promoting linguistic diversity, and engaging interns from diverse backgrounds were some approaches that enriched both client and team interactions.

Inclusive Practice and Different Social Norms: Ongoing education about discrimination (e.g., related to ethnicity, gender, or disability) and reflective practices, such as diversity groups and structured assessments, enable therapists to navigate cultural complexities. Staying informed about clients' backgrounds, employing intersectionality, and adapting communication styles to client needs help therapists foster an inclusive environment.

Addressing Biases in Culturally Sensitive Practice: Participants stressed the need for self-reflection, particularly when biases around religious practices or unfamiliar cultural elements arise in sessions. Techniques included using clients' preferred music and open-ended questions to reduce judgment, ensuring a culturally responsive and inclusive approach.

Academia Perspectives: Participants highlighted the growing focus on cultural considerations in academic and therapeutic environments. They advocated for culturally diverse music therapy training, critiquing the dominance of Western theories and calling for decolonization. Issues such as language barriers in therapy and regional differences in addressing racism point to the need for literature that addresses specific cultural contexts.

Personal Growth and Insights: Working with culturally diverse clients enriched participants' personal growth, reinforcing the value of authenticity and humility in therapy. They emphasized creating an inclusive vocabulary in music therapy to facilitate international collaboration. The principle of respecting each client's unique cultural background was central to developing a safe and supportive therapeutic space.

Discussion

This study highlights the critical importance of cultural sensitivity, empathy, and humility in music therapy within culturally diverse settings. Music's universal qualities—such as rhythm, familiarity, and emotional resonance—help therapists build trust, facilitate expression, and bridge verbal and cultural barriers. Therapists work to integrate clients' cultural and personal music preferences, which supports authentic self-expression and creates connection. As participants noted, familiar music in clients' native languages can strengthen bonds and foster a sense of belonging, supporting findings by Bruscia (2014) and Preti and Welch (2011) on music's fundamental therapeutic potential. Participants emphasized the importance of cultural humility and flexibility to respect clients' unique identities and values. Self-awareness, especially regarding biases, is vital for establishing rapport and avoiding tokenism. This commitment aligns with theories from Rogers (1951) and Kenny's *Field of Play* (1998), which advocate for an inclusive *cultural field* where clients' diverse experiences are valued and respected. Structured training is essential for enhancing therapists' cultural competence, ensuring adaptable and inclusive therapy. The study emphasizes

the need for diverse perspectives in music therapy education to address gaps in cultural knowledge and language barriers, enabling therapists to better support clients' unique cultural identities and promote equitable mental health care. Altogether, the findings emphasize that culturally responsive, client-centered music therapy, grounded in respect, empathy, and openness, leads to more impactful therapeutic outcomes and equitable mental health support across multicultural contexts.

Limitations and Future Directions

The study is limited by a small sample of six music therapists, affecting generalizability. Self-reported data may introduce bias, and variations in therapists' specializations and cultural competence training impact consistency. The lack of client perspectives restricts understanding of therapy effectiveness, and dual roles in academia may influence therapist viewpoints. Future research should include larger, diverse samples and client perspectives to gain a fuller understanding of therapy outcomes. Expanding studies beyond Europe can highlight how cultural norms influence therapy. Focused research on specific areas could deepen insights. Collaborative coding and demographic analysis can enhance reliability and inform tailored interventions, advancing culturally sensitive practices in music therapy.

Conclusion

Music therapy has the potential to be a powerful tool for bridging cultural divides and creating therapeutic trust through cultural sensitivity. Central to this approach is cultural humility—meeting each client with respect and openness to their unique identity, which deepens understanding and builds validating spaces for expression. By authentically integrating diverse musical traditions, therapists empower clients to share themselves freely, enhancing therapy's impact across trauma, dementia, and autism care. However, the field must confront enduring systemic barriers, including Western-centric education and the influence of racism on mental health care. Addressing these issues requires an anti-racist framework, as well as advocacy for equity and justice beyond the therapy room. Music therapists are called not only to reflect on personal biases but also to challenge societal structures that perpetuate inequality. True cultural competence in therapy is about honoring each person's individuality while celebrating diversity. This approach rejects stereotypes and assumptions, fostering inclusive therapeutic environments where clients feel seen, heard, and empowered. Through ongoing dedication, music therapists can contribute to a more compassionate and inclusive world, using music as a bridge for connection and understanding.

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La musicoterapia come supporto alle cure mediche

Integrazione sociale, culturale e linguistica dei migranti

Music therapy as a support for medical care

Social, cultural and linguistic integration for migrants

Marina Bartucca, Mariarosaria Gilio, Antonella Zenga

CasAmica ODV – CasAmica Impresa Sociale Housing Sociale, Rom

Sommario

L'articolo descrive l'intervento di musicoterapia presso CasAmica di Roma, una casa d'accoglienza per migranti sanitari, adulti e bambini, accompagnati dai loro familiari, costretti a curarsi lontano dalla propria casa. Gli ospiti oltre a vivere la propria malattia o quella del familiare, si confrontano con il disagio di essere lontani dagli affetti e dalle abitudini quotidiane. Le famiglie spesso hanno origini culturali e linguistiche differenti e devono misurarsi anche con la difficoltà di integrare queste diversità. L'intervento di musicoterapia contando sul lavoro in equipe, in una visione biopsicosociale della salute, si pone sia come supporto al trattamento medico e riabilitativo, sia come risorsa per rispondere a bisogni multidimensionali tipici di una realtà come questa. La complessità di questa situazione, grazie alle convenzioni per il tirocinio che CasAmica ha attivato con i corsi di formazione dei Conservatori e di altre scuole è anche preziosa opportunità formativa per futuri musicoterapeuti.

Parole chiave: biopsicosociale – integrazione – migrazione – multicultura – musicoterapia

Abstract

The article describes the role of music therapy at CasAmica, a health shelter in Rome for migrants—both adults and children—accompanied by their families. In addition to experiencing their own illness, or that of a family member, the guests are confronted with the discomfort of being far from home, loved ones, and their daily routines. Since the guests typically come from different cultural and linguistic backgrounds, they need to face the additional challenge of integrating diversities. Music therapy, delivered by teams that share a biopsychosocial approach to health, complements medical and rehabilitation treatments while addressing the multifaceted needs of the context. Through internship programs established in collaboration with conservatories and other schools, our experience offers invaluable training for aspiring music therapists.

Keywords: biopsychosocial – integration – migration – multiculture – music therapy

♦ Italiano

L'attività di musicoterapia rientra nell'insieme delle tecniche dei linguaggi non-verbali e utilizza la musica per arrivare alla relazione in cui privilegiare aspetti empatici e favorire la libertà espressiva dell'individuo. Chi partecipa riflette le sue emozioni nella produzione sonora e riformula il suo modo di sentire in un'ottica relazionale anche interculturale in cui si sciolgono le resistenze, si superano pregiudizi e ci si apre al diverso (Scullica, Del Zanna & Co, 2015).

Come altre forme di arteterapia anche la musicoterapia trova applicazione in vari ambiti: tra quelli sociosanitari vi è Casamica, un'organizzazione di volontariato che da oltre 35 anni risponde al bisogno collettivo della migrazione sanitaria (Cutillo, Reynolds & Madan-Swain, 2015), un fenomeno che riguarda il diritto delle persone di ricevere cure a carico del sistema sanitario anche in un luogo diverso da quello di residenza.

Il flusso geografico che si sposta verso le tre sedi dell'associazione di Milano, Lecco e Roma proviene soprattutto dalle regioni del sud Italia e da alcune parti del mondo (Est Europa, Africa, Sud America) in cui il piano sanitario è meno sviluppato.

CasAmica: migrazione sanitaria e modalità di accoglienza

L'accoglienza offerta è rivolta ai malati e ai loro familiari caregiver (Rosti, 2012), sia adulti che bambini (Pellegrino & Gilio, 2024) e questo avviene per 365 giorni l'anno sapendo che alla problematica legata allo stato di salute si aggiunge un enorme carico psicosociale, poiché la malattia è un evento critico che coinvolge non solo la persona in sé, ma anche tutto il suo sistema familiare il cui ciclo vitale viene interrotto.

Una diagnosi di malattia crea un dissesto nel proprio equilibrio e sconvolge la quotidianità, le abitudini, i ruoli, le relazioni e la comunicazione. Inoltre, a seconda delle risorse interne della persona e del suo contesto di vita, la malattia può essere evento di coesione o di sgretolamento familiare. Chi è ospite a CasAmica è anche lontano da altri affetti e dai suoi punti di riferimento e le emozioni che emergono sono spesso quelle di paura, tristezza e rabbia.

In casa l'ospite si trova a condividere con altre persone spazi ed esperienze, ma anche vissuti emotivi per lo più di ansia e preoccupazione. Per contenere e trasformare questi vissuti CasAmica propone per tutti un servizio di sostegno psicologico (Engel, 1980) e diverse attività di umanizzazione, come quella di musicoterapia, per agevolare una giusta attivazione in uno spazio protetto in cui gestire emozioni e favorire l'integrazione delle diversità. Le differenze culturali e a volte linguistiche che caratterizzano gli ospiti della casa, possono essere barriere comunicative importanti e creare distanze. A volte i momenti di condivisione ed elaborazione sonoro-musicale sono i soli spazi di ascolto e di espressione libera e creativa in cui trovano soddisfazione i bisogni multidimensionali, come quelli dell'inclusione sociale e della mediazione culturale. Si facilita inoltre la comunicazione, la relazione e la consapevolezza di sé in un'integrazione intra ed interpersonale.

In questa complessità di situazioni e diversità di esigenze la musicoterapia è stata inserita presso la sede CasAmica di Roma dal 2018 con lo scopo di accogliere, ascoltare e accompagnare dinamiche familiari, tensioni ed emozioni a volte non esplicitabili, trasformandole, nel senso di dar loro una diversa forma, attraverso il canale sonoro-musicale. La partecipazione di gruppi numerosi e disomogenei per età, origine, lingua e cultura, orienta le musicoterapeute alla

definizione di uno spazio che favorisca l'apertura di un canale di comunicazione alternativo, così da facilitare la relazione fra i presenti grazie all'uso della musica condivisa attraverso il canto, il ballo o il suonare insieme semplici strumenti come idiofoni a percussione e scuotimento. Come principio metodologico si privilegia la flessibilità e la non direttività nella conduzione della seduta, permettendo ai partecipanti, almeno nel setting di musicoterapia, di sentirsi padroni di un tempo altrimenti vissuto fra la sospensione della propria quotidianità familiare e la regolamentazione imposta dalle terapie.

La definizione della modalità d'intervento ha richiesto un periodo di collaudo a causa delle molte variabili presenti all'interno della seduta. Infatti la necessità di mantenere il setting aperto e apparentemente privo di regole e la fluidità del gruppo in continua evoluzione, a secondo delle presenze nella casa e delle contingenze legate alle malattie e alle relative terapie, hanno imposto una fase di sperimentazione per creare dei punti fermi ai fini di una valutazione attendibile dei processi, paralleli e interconnessi, che si sviluppavano durante l'attività di gruppo. Questa fase è stata interrotta dall'arrivo della pandemia che ha cambiato radicalmente le persone e il loro modo di stare insieme. Dopo l'emergenza pandemica la musicoterapia ha dovuto ricostruire le relazioni non solo fra musicoterapeute e partecipanti alle sedute, ma anche fra gli stessi ospiti della casa. I timori del contagio, infatti, con tutte le conseguenze ipotizzabili, erano esasperati sia dalla pregressa situazione di fragilità, sia dall'innata diffidenza dovuta alla coabitazione forzata fra estranei. La fase pandemica è stata importante per la presenza della musicoterapia nella casa, l'attività ha acquisito una sua centralità per la sua capacità di promuovere libertà di espressione e socialità, particolarmente desiderabili dopo l'esperienza d'isolamento e distanziamento post Covid.

Una visione biopsicosociale della salute

A conferma di questa centralità, dal gennaio del 2021 la musicoterapia è entrata a far parte di un progetto finanziato dal Ministero del Lavoro e delle Politiche Sociali terminato a maggio 2024. La musicoterapia con i suoi peculiari aspetti di multidisciplinarietà condivide la visione biopsicosociale della salute propria della mission di CasAmica che pone al centro dell'intervento la persona o i gruppi di persone, nella globalità dei propri bisogni. Il presupposto su cui si basa questa comune visione è che la salute dell'individuo è il prodotto dell'interazione e dell'influenza reciproca di diverse componenti di carattere biologico, ma anche psicologico e sociale. Dunque, viene considerata non solo la persona portatrice di una malattia, ma tutto ciò che le ruota intorno, cominciando dalla presa in carico della sua famiglia, che lo accompagna ed è a sua volta portatrice di un disagio psico-sociale. La musicoterapia si pone come valido supporto al trattamento medico e riabilitativo e come elemento integratore della cura, rispondendo in questo modo ai bisogni multidimensionali (Aldridge, 1996) dei pazienti ospiti di Casa Amica, che specie in età pediatrica e considerato il contesto, coincidono spesso anche con esigenze di carattere educativo.

Organizzazione delle sedute e teorie di riferimento

A secondo di ciò che si delinea nella seduta, la musicoterapia con un linguaggio universale alla portata di tutti, mette a disposizione le esperienze musicali più adeguate alla situazione, dall'ascolto di musica eseguita dal vivo dalla coppia di musicoterapeute, all'improvvisazione (Bruscia, 2011) con strumenti e voce, all'esecuzione di canti e danze che spesso si presentano come una possibilità di ritornare alle proprie radici (Blacking, 1973). Questo *ritorno a casa* è

l'occasione per presentarsi agli altri all'interno della seduta favorendo lo spontaneo scambio di esperienze e tradizioni, particolarmente importante in questo contesto. Gli strumenti utilizzati per le improvvisazioni o accompagnamenti ritmici hanno funzione intermediaria, accelerano l'apertura di canali di comunicazione alternativi, permettendo a ognuno di entrare in relazione con le proprie emozioni, di cui non sempre si ha consapevolezza, e di condividere quelle degli altri. Tutto viene agito attraverso l'esperienza musicale che, a secondo dei casi, può essere valutata per il suo carattere simbolico, catartico, ludico (Delalande, 2003) integratore o altro. Da questo punto di vista molto importante è il lavoro che si svolge all'interno dell'equipe, che vede coinvolti oltre le musicoterapeute, la psicologa di CasAmica, i referenti della struttura e i volontari. A questi si aggiungono i tirocinanti provenienti da diverse scuole di musicoterapia, ma in particolare dal Biennio di II livello del Conservatorio di L' Aquila con cui è attiva una convenzione. Questi supportano la coppia terapeutica e permettono di integrare l'osservazione anche con l'ausilio di specifiche griglie appositamente pensate per situazioni più complesse (Gamba, 2012). La presenza di un'equipe così numerosa e articolata è particolarmente preziosa per diverse ragioni. Innanzitutto, ciascun operatore può condividere con il resto del gruppo di lavoro quanto conosce dell'ospite di CasAmica al di fuori della seduta di musicoterapia, nella multiforme quotidianità del suo tempo vissuto nella casa. Si crea così un reciproco scambio d'informazioni che può integrare diversi punti di vista. Spesso la seduta rivela aspetti sconosciuti di una persona, che emergono inaspettati proprio per quella particolare situazione apparentemente ludica e spensierata, che si realizza all'interno del setting attraverso la comunicazione corporo-sonoro-musicale. Questo può influenzare le relazioni di quella persona con le altre, ma anche orientare diversamente un colloquio con la psicologa della casa o addirittura facilitarne l'avvio. Viceversa particolari resistenze a mettersi in gioco o specifiche dinamiche emerse in seduta possono essere spiegate da eventi accaduti nella casa, di cui le musicoterapeute non sono a conoscenza.

La peculiarità della musicoterapia a CasAmica sta nel fatto che si attivano diversi processi paralleli che sollecitano differenti punti di vista ed esigono un confronto continuo: percorsi individuali, gruppali o anche sottogruppali, all'interno di una visione sistemica che accorpa nel sistema principale dell'intera casa diversi sottosistemi, rappresentati dai vari nuclei familiari, oppure dai bambini o dagli adolescenti, dai genitori o dai *caregiver*, dai gruppi provenienti dalla medesima regione e altro ancora. La complessità dell'utenza e dei processi che si attivano rende particolarmente formativa l'esperienza dei tirocinanti di musicoterapia che si trovano ad utilizzare diverse metodologie e a confrontarsi con differenti tipi di utenza e situazioni. Anche per questo sono state scritte varie tesi di laurea; in alcune sono state definite delle griglie osservative (Raglio, 2008) in grado di oggettivare per quanto possibile i percorsi svolti dagli utenti, specie quelli con specifiche caratteristiche.

Per tutte le sedute di musicoterapia viene utilizzato un protocollo descrittivo del percorso di ciascun partecipante, in cui si individuano i nuclei familiari, le loro origini, i repertori e le modalità sonoro-musicali espresse in seduta. Il partecipante è considerato all'avvio di un processo valutabile solo dopo l'effettuazione di tre sedute. Sui protocolli si basa la stesura di una relazione bimestrale di restituzione all'equipe. Ciò che caratterizza il percorso di musicoterapia a CasAmica è la costruzione di un'identità sonora gruppale che si delinea come un'entità unica, in continua trasformazione secondo quel principio Benenzoniano di ISO inteso come insieme infinito di energie sonore, acustiche e di movimento appartenenti e caratterizzanti un individuo. Il gruppo di musicoterapia a CasAmica sviluppa un suo percorso caratterizzato fin dalla sua nascita da un flusso

infinito di energia sonora formato dalle esperienze sonore di tutti coloro che, per poche ore, a volte minuti o per mesi, depositando frammenti della propria storia sonoro-musicale, contribuiscono alla sua realizzazione. Caratteristico di questo gruppo è il fatto che vi è quasi sempre una sua parte, più o meno numerosa, che spontaneamente svolge il compito di fare da ponte con i nuovi arrivati, favorendone l'integrazione e passando il testimone ad altri prima di lasciare la casa. Si crea perciò una traccia ripercorribile anche a distanza di tempo. Accade così che quando un ospite rientra per un follow-up, a volte anche dopo molti mesi, trova nella musicoterapia l'occasione per ricontattare con la musica particolari situazioni dolorose che hanno segnato momenti delicati della vita passata di cui CasAmica ha fatto parte.

Dal punto di vista delle teorie di riferimento l'intervento di musicoterapia, considerata la variabilità dei gruppi e le diverse situazioni che possono derivare, integra diverse metodologie e tecniche (Volpe, Fiacchini, Magnotti, Diamare, Denti & Viganò, 2016) tra cui la musicoterapia creativa (Benenzon, Casiglio & D'Ulisse, 2005) e alcuni elementi del modello Benenzon, come l'uso delle consegne non verbali e in certi casi anche degli strumenti (Benenzon, De Gainza & Wagner, 1997). Spesso l'eterogeneità dell'utenza suggerisce di porre in relazione di volta in volta i bisogni delle persone presenti in seduta con la qualità dell'esperienza musicale da utilizzare, come suggerisce Bruscia (1995), privilegiando l'improvvisazione, la ri-creazione e l'ascolto di musica, la musicoterapia interviene generalmente a livello ausiliario o accrescitivo. Le sedute durano circa due ore e trenta e sebbene flessibili, hanno una struttura precisa per definire alcune regole del setting senza esplicitarle. All'inizio le musicoterapeute suonano i propri strumenti, una chitarra e un sax tenore, nella sala centrale della casa. Chiunque è libero di accedere scegliendo di fermarsi o andare via. La musica suonata dal vivo agisce come richiamo per coloro che desiderano partecipare; pertanto, l'inizio della seduta è sempre caratterizzata dall'ascolto della musica e per chi è alla prima esperienza, questa è l'opportunità per una prima conoscenza. Definito il gruppo, c'è il momento del canto di accoglienza in cui ci si saluta chiamando per nome ogni partecipante. Segue spesso una parte improvvisativa per lo più percussiva specie in presenza di bambini (Barrera, Rykov & Doyle, 2002) e ragazzi, ma può rendersi necessaria una fase ri-creativa, basata su canti o balli o di ascolto per creare un clima di distrazione e rilassamento. Alla fine, si ripete la melodia iniziale, per salutare ognuno ed invitare chi ci sarà a tornare la settimana successiva.

Conclusioni

CasAmica è come una famiglia molto allargata in cui convivono tanti nuclei familiari, più o meno numerosi che condividono l'esperienza emotivamente molto intensa, di vivere la malattia di un proprio caro. Parallelamente all'interno della casa si confrontano culture e tradizioni in un quadro di promiscuità che può generare intolleranza reciproca considerati gli spazi ristretti. Inoltre, la presenza di età differenti può essere causa di tensioni all'interno di ciascun nucleo familiare fra genitori e figli o fratelli e anche fra gli ospiti della casa se consideriamo specifiche problematiche di certe fasce d'età, come prima infanzia o adolescenza o intergenerazionali data la presenza contemporanea di bambini, adolescenti, giovani adulti e anziani, ognuno con esigenze proprie.

Da gennaio 2021 a maggio 2024 a CasAmica sono stati effettuati 156 incontri di musicoterapia coinvolgendo 561 persone (165 maschi e 396 femmine) tra cui 63 fra bambini e adolescenti da 0 a 18 anni, specialmente dal sud d'Italia, ma anche da Bielorussia, Bulgaria, Romania, Etiopia, Libia, Marocco; Libano, Perù. Facilitando e consolidando la relazione fra gli ospiti e sostenendoli sul

piano emotivo, espressivo e comunicativo l'attività di musicoterapia ha così contribuito al miglioramento della qualità della vita nella casa.

♦ English

Music therapy is a non-verbal therapeutic technique that emphasizes empathy and promotes expressive freedom. Participants express their emotions through music and reformulate their way of feeling from an intercultural relational perspective, aimed at dissolving resistance and prejudices. Music therapy encourages people to become »open to the different« (Scullica, Del Zanna & Co, 2015).

Like other forms of art therapy, music therapy operates across a wide range of domains. CasAmica, a voluntary organization that has been active for over 35 years in the social and health fields, advocates for migrants' right to receive free health care (Cutillo, Reynolds & Madan-Swain, 2015) within the local health system. Migrants hosted at the CasAmica headquarters mainly come from regions in southern Italy and from areas of the world (Eastern Europe, Africa, South America) where healthcare systems are less developed.

CasAmica: Health migration and hosting arrangements

CasAmica welcomes patients as well as their family caregivers (Rosti, 2012) both adults and children (Pellegrino & Gilio, 2024) all year around. The family-extended assistance needs to meet the enormous psychosocial and medical burden faced by family caregivers.

When a guest is diagnosed with a disease, it disrupts the balance of everyday life, habits roles, relationships and communication results, including for relatives. Furthermore, the personal and environmental context, as well as the disease itself may either reinforce or disrupt family cohesion. CasAmica guests are particularly vulnerable, as they are far away from relatives and from emotional references, with the result of experiencing fear, sadness or anger.

During the stay at CasAmica, the guests often need to share negative experiences, such as anxiety and worry. Music therapy, together with other educational and psychological support (Engel, 1980) provided within a protected space, helps to manage emotions and encourages integration. The cultural and linguistic differences are significant communication barriers, which enhance interpersonal distance. Sharing sound-musical experiences, listening, promoting free and creative expressions can facilitate social inclusion and cultural mediation needs. As a result, music therapy may facilitate communication, improve self-awareness and intra- and interpersonal integration.

To improve the management of such diverse needs, CasAmica has included music therapy, among other treatment forms, at the headquarters in Rome since 2018. Music therapy aims to welcome, listen and accompany family dynamics and tensions, to make them emerge when hidden, and to channel emotions into positive feelings. The participation in large and heterogenous groups in terms of age, origin, language and culture - orients the music therapists to define a space, favoring the advancement of alternative, communication channels and that facilitates interpersonal relationships. Music therapy is based on sharing music experiences through singing, dancing or playing together simple instruments such as percussion idiophones and shakers.

The methodological approach fosters flexibility and non-directivity in the session setting to promote, at least in the music therapy setting, a feeling of sovereignty over a time frame that

participants would otherwise perceive as restricted to the daily routine of family life and therapy-imposed regulation. The definition of the intervention modality requires a testing phase due to the many variables present within the session. In fact, the need to keep the setting open and apparently free of rules, together with the fluidity of the group in continuous evolution, imposes an experimental phase to develop a reliable evaluation of the processes.

Unfortunately, the Covid-19 pandemic radically changed people's attitudes and their sense of community and disrupted the experimental project. After the pandemic emergency, it became necessary for music therapy to rebuild relationships, not only between music therapists and participants, but also among the guests themselves. In fact, due to the forced cohabitation among strangers, the fears of infection, with all its conceivable consequences, exasperated inherent fragility and distrust. On the other hand, the pandemic period was an opportunity to reveal the relevance of music therapy as a central program in promoting freedom and sociality—highly desirable during the experience of isolation and post-Covid distancing.

A bio-psycho-social perspective of health

The role of music therapy during the post-Covid period has led the Government Labor and Social Policy Departments to fund CasAmica from January 2021 to May 2024. The multidisciplinary nature of music therapy aligns with the integrated and unifying One Health approach, which is central to the CasAmica mission: it is not only the person carrying the disease, but also, the family and caregivers, who inevitably and indirectly share the consequences of psycho-social distress. Music therapy effectively supports medical and rehabilitation treatments and stands out as an integrative element of care, thus addressing the multidimensional needs (Aldridge, 1996) of CasAmica's patients. Health needs—especially those of early childhood in this specific context—often overlap with educational needs.

Session setup and reference theories

The universal character of the music therapy language enhances the opportunity to tailor the experience to the context. The experiences range from listening to music, performed live by the music therapists, to improvisation (Bruscia, 2011) with instruments and voice, or to the performance of songs and dances that often provide a chance to express one's roots (Blacking, 1973). This *homecoming* is an opportunity to introduce oneself to other participants and to encourage the spontaneous exchange of experiences and traditions, a particularly important aspect in this context. The tools used for improvisations or rhythmic accompaniments serve as intermediaries. They open alternative communication channels, allowing participants to express their feelings or experience unconscious emotions and share them with others. There are no limits to what can be expressed through the musical experience that can be appreciated for its symbolic, cathartic, playful, or integrative qualities (Delalande, 2003). From this point of view, the work within the team involves not only that of the music therapists but also psychologists, representatives and volunteers of CasAmica. The team includes trainees from various music therapy schools, especially from the two-year level 2 course of the Conservatorio de L'Aquila. The trainees support the music therapists and contribute their observations using specific grids designed to assess complex conditions (Gamba, 2012). The presence of such a large and articulated team is particularly valuable for several reasons. Each specialist reports any daily events to the team that might hinder the music therapy setting. This mutual exchange of information provides an

opportunity to integrate different points of view. Often the session reveals unknown aspects of the person, that emerge unexpectedly during what seems like a playful and carefree context, induced by the body-sound-musical communication. This can affect a person's relationships with others and facilitate the contact with the team psychologist. Conversely, resistance to getting involved or specific dynamics that emerge in the session can be explained by events that occurred in the house, which the music therapists are not aware of.

The uniqueness of music therapy at CasAmica lies in the activation of several parallel processes that Stimulate various perspectives and promote continuous exchange. Individual, group or even sub-group paths converge within a systemic vision that brings together different subsystems within the larger CasAmica system. The subsystems are represented by the various families, by children or adolescents, by parents or caregivers, or by groups from the same homeland. The diverse world of participants and contexts makes the experience of the music therapy trainees particularly formative, as they must use different methodologies and consider different problems (Raglio, 2008). Specifically, the music therapy trainees had the opportunity to develop semi-quantitative evaluation approaches. For all music therapy sessions, the music therapists provided a descriptive protocol of the path of each participant, which includes the family units, their origins, repertoires and sound-musical modalities expressed during the session. Only after the completion of three sessions is the participant meant to begin the therapeutic process and assessment thereof. The protocols are the basis for the drafting of a bimonthly report. What distinguishes the music therapy path at CasAmica is the construction of a *sound identity group* that is outlined as a single entity in continuous transformation. According to Benenzon's principle of ISO, such a group should be understood as an infinite set of sound, acoustic and movement energies belonging to and characterizing an individual. The CasAmica music therapy group develops its own path, shaped from its inception by an infinite flow of sound energy built by the sound experiences of all those who, depositing fragments of their sound-musical history for a few hours, or sometimes for minutes or months, contribute to its realization. Group members spontaneously become mentors to newcomers, fostering integration and passing on their role to others before departing. This creates a continuous support, a track that former residents, revisiting the house days or months later, can re-engage, recreating the experience of previous pivotal moments at CasAmica.

The heterogeneity of the session participants often requires music therapists to carefully align their interventions with the varying needs of individuals, aiming to provide a meaningful musical experience. Given the variability of the groups and contexts, music therapists integrate various theoretical approaches (Volpe, Fiacchini, Magnotti, Diamare, Denti & Viganò, 2016), including creative music therapy (Benenzon, Casiglio & D'Ulisse, 2005) and elements of the Benenzon model (Benenzon, De Gainza & Wagner, 1997). The diverse group composition requires tailoring musical experiences to individual needs, as advocated by Bruscia (1995), including improvisation, re-creation, and active listening. Music therapy typically plays a supportive or enhancing role in this process. The sessions last about two and a half hours and although flexible, they have a defined structure based on non-explicit rules. To begin, the music therapists play their own instruments, a guitar and a tenor sax, in the central hall of the house. Anyone can choose to join or leave. Live music serves as an open invitation for engagement. Consequently, each session commences with a period of music listening. This serves as an introduction for newcomers. Once group members have had a chance to get acquainted, music therapists begin with a welcoming song naming each participant. This is usually followed by a percussion-based improvisation that is especially

captivating for children (Barrera, Rykov & Doyle, 2002) and young adults. To foster a relaxed yet focused environment, music therapists may start with songs and dances, especially with adults. The session concludes with a reprise of the welcome song, serving as a warm farewell and an invitation to join us again the following week.

Final remarks

CasAmica functions like an extended family composed of multiple single-family units, united by the profoundly emotional experience of a loved one's illness. The microcosm of diverse cultures and traditions within a shared space can foster mutual intolerance. In addition, the presence of individuals from different age groups can create tensions within each family unit, among parents and children or siblings and guests of the home. The varying needs of different age groups—such as those of young children, adolescents, and the intergenerational dynamics—can further amplify these tensions.

From January 2021 to May 2024, 156 music therapy meetings were held at CasAmica, involving 561 people (165 males and 396 females), including 63 children and adolescents from 0 to 18 years old, specifically from Belarus, Bulgaria, Romania, Ethiopia, Libya, Morocco; Lebanon, Peru and mostly from southern Italy. Through its role in fostering and strengthening relationships among guests and Providing emotional, expressive, and communicative support, music therapy has thus contributed to the improvement of the quality of life of the guests at CasAmica.

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Musiktherapie mit und ohne Musik

Music therapy with and without music

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Zusammenfassung

Der Artikel beleuchtet eine musiktherapeutische Behandlung auf einer psychiatrischen Akutstation. Anhand einer Fallvignette werden therapeutische Haltung und Beziehung sowie undogmatisch an die aktuelle Behandlungssituation adaptierte Interventionen aufgezeigt. Mit dem diagnostischen Instrument *Sieben Stufen therapeutischer Begegnung* von Mössler & Fuchs (2015) wird der musiktherapeutische Prozess eingeordnet.

Schlüsselwörter: psychiatrische Akutstation – paranoide Schizophrenie – therapeutische Beziehung – nonverbale Kommunikation

Abstract

The article examines music therapy treatment on an acute psychiatric ward. A case vignette is used to illustrate the therapeutic attitude and relationship as well undogmatically adapted interventions to the current treatment situation. The diagnostic instrument *Seven Levels of Therapeutic Encounter* by Mössler & Fuchs (2015) is used to classify the music therapy process.

Keywords: acute psychiatric ward – paranoid schizophrenia – therapeutic relationship – nonverbal communication

♦ Deutsch

Einen gut ausgestatteten Musiktherapieraum, eine:n willige:n Patient:in, dazu eine motivierte Musiktherapeutin, das alles braucht es für eine erfolgreiche Musiktherapiesitzung. So dachte ich während meines Studiums und in den ersten Berufsjahren. Mein beruflicher Werdegang führte mich in ein Krankenhaus, in dem es sogar zwei gut ausgestattete Musiktherapieräume gibt. Meiner hohen Motivation stehen oft zugewiesene Patient:innen mit psychotischen, manischen, depressiven oder angstgeleiteten Störungsbildern gegenüber. Sie mögen sich oft nicht auf ein Spiel einlassen. Häufig können sie die Station nicht verlassen oder ziehen es vor, in ihrem Zimmer zu bleiben.

Wie musiktherapeutische Behandlung auch außerhalb eines klassischen Musiktherapieraumes möglich ist, möchte ich hier darstellen. Als wichtiges Handwerkszeug erweisen sich Stimme, Körper, sowie Wissen, Kenntnisse und Haltung, mit der wir unseren Patient:innen begegnen. Besonders wichtig erscheinen mir musiktherapeutische Identität und Bereitschaft zu kontinuierlicher Reflexion unseres theoretischen Wissens, das wir in jahrelanger Praxis ständig verfeinern und erweitern. Für die therapeutische Haltung ist die erwartungsfreie Offenheit für das Gegenüber bei Bereitschaft, kleinsten Impulse aufzugreifen, um damit zu arbeiten, unerlässlich.

In folgender Falldarstellung widme ich mich einer Frage, die mich über die gesamte Zeit meiner Berufstätigkeit beschäftigt: *Ab wann ist Musiktherapie wirklich Musiktherapie?*

Ich arbeite in einem öffentlichen Krankenhaus in Niederösterreich mit Versorgungsauftrag. *Meine* Station umfasst 30 Betten. Neben der ärztlichen und pflegerischen Betreuung gibt es auch psychologische, ergotherapeutische, musiktherapeutische und physiotherapeutische Therapieangebote sowie sozialarbeiterische Unterstützung.

Zur Reflexion meiner Musiktherapiestunden ziehe ich gern das diagnostische Instrument von Mössler und Fuchs (2015)[1] heran, das den Titel *Sieben Stufen therapeutischer Begegnung* trägt. Dieses Instrument dient dazu, das aktuelle musikalische Geschehen in der Musiktherapie in Zusammenhang mit einem Fokus für die Behandlung zu bringen und die einzelnen Stufen »spiegeln die Fähigkeit der Klientinnen, mit der Musik, sich selbst und anderen in Beziehung zu treten« (Fuchs & Mössler, 2016, S. 157). Es gibt sowohl einen musikalischen Fokus als auch einen Beziehungsfokus, auf den man achten kann und für jede Stufe dienen sogenannte *Schlüsselwörter* als Kennzeichen.

Das Behandlungskonzept unserer aktupsychiatrischen Station sieht vor, alle neu aufgenommenen Patient:innen schnellstmöglich mit einer Einzeltherapie zu versorgen. Bei momentan verbal nicht zugänglichen Patient:innen bietet sich Musiktherapie sehr gut an.

Falldarstellung

Frau Schreiner ist um die 40 Jahre alt, als sie auf meiner Station aufgenommen wird. Sie kommt bereits zum zweiten Mal. Ihre Diagnose lautet Paranoide Schizophrenie (ICD 10, F 20.0). Folgende Informationen bekomme ich von der behandelnden Ärztin: »Komplett orientiert ist sie noch nicht, aber eigentlich wissen wir das nicht so genau. Sie spricht nicht. Abgesehen davon scheint sie adäquat in Verhalten, Stimmung und Affektlage.« Ich solle erst einmal mit der Patientin auf der Station bleiben.

1. Musiktherapiestunde

Folgende Informationen stammen aus meinen Aufzeichnungen der ersten Musiktherapiestunde:

> *Im Zimmer ist schwarzes Haarfärbemittel verteilt (die Haarfarbe der Patientin ist unverändert) und ich muss sie die ersten zehn Minuten davon abhalten, in ihr Zimmer zurückzugehen, weil die Reinigungskraft dort beschäftigt ist, den Schaden zu minimieren. Sie möchte etwas bezüglich*

[1] Die hier zitierte deutschsprachige Übersetzung Fuchs & Mössler (2016) basiert auf der im Nordic Journal of Music Therapy erstveröffentlichten Originalarbeit von Mössler & Fuchs (2015).

> *ihrer Arbeit klären, das wiederholt sie, doch ich kann nicht nachvollziehen, ob es sich um ein reales Problem oder psychotische Inhalte handelt. (Ich weiß, dass sie in einem aufrechten Arbeitsverhältnis steht.) Es geht um einen Brief, der sehr wichtig sei. Neben diesen Inhalten erwähnt sie mehrmals einen Krieg und fragt mich, ob wir das Bankkonto schon überprüft hätten, wenn nicht, würde der Krieg fortdauern oder gestoppt werden – auch das ist nicht kohärent. Im Laufe des Kontaktes wird sie ruhiger, wenn ich sie leicht berühre – wir spazieren nebeneinander über die Station und ich berühre sie immer wieder leicht an Schulter oder Oberarm, um sie von ihrer Zimmertüre wegzuschieben, sie lehnt sich immer ein wenig in meine Hand. Sie beendet die Einheit, indem sie mir lange die Hand schüttelt und mich dann entlässt.*

Es dauert eine Weile, bis ich mich wieder sortiert habe. Einerseits bin ich ratlos, weil ich ihr inhaltlich nicht folgen konnte, mir nicht sicher bin, ob sie mich als Gegenüber wahrgenommen hat. Andererseits frage ich mich nach der Stunde, wie musiktherapeutisch dieser Kontakt war. Wenn dann noch Pflegepersonen die Frage »Ach, das war jetzt die Musiktherapie!?« stellen, ist es Zeit, mein Handeln zu reflektieren.

Musiktherapie ohne Musik, wie bereits im Titel angedeutet – es wurde nicht gesungen, keine Musik gehört. Nicht ein einziger winziger Klang ertönte. Es gab kein definiertes Setting, keinen Therapievertrag. Jedoch durfte ich als Musiktherapeutin diese Zeit mit ihr verbringen.

Beginnend mit der Stufe 0 und dem Begriff *Akzeptanz* hat es mir schon oft geholfen, im Nachhinein eine scheinbar nicht musiktherapeutische Stunde eben doch musiktherapeutisch zu interpretieren. Die Schlüsselwörter für diese Stufe lauten *abschalten*, *ausruhen*, *entspannen*, *etwas bekommen* (Fuchs & Mössler, 2016).

Frau Schreiner will etwas von mir. Der Wunsch ist aber unspezifisch, vielleicht psychotisch und eher nicht an mich als Musiktherapeutin adressiert. Weder sucht sie den Kontakt, noch entzieht sie sich. Sie lässt mich gewähren, lässt sich sogar von mir berühren. Auch ohne Musik hatten wir eine Musiktherapiestunde auf Stufe 0.

2. Musiktherapiestunde

> *Die zweite Einheit ist noch schwerer einzuordnen für mich. Frau Schreiner verkennt mich, versucht ständig, mir meine Brille abzunehmen. Sie spricht ausschließlich über die Brille und schubst mich nach kurzer Zeit heftig aus ihrem Zimmer.*

Hier fällt es mir deutlich schwerer, diese Begegnung als Musiktherapie oder Therapie zu benennen – ich bin nicht in der Lage, ihr Unterstützung anzubieten, ein Container zu sein für ihre Monologe. Es fühlt sich an, als würde ich sie zu etwas überreden wollen, was sie nicht annehmen kann. Akzeptanz (Stufe 0) ist nicht spürbar von ihrer Seite. Nach ihrem körperlichen Übergriff beende ich den Kontakt.

3. Musiktherapiestunde

> *Ich komme in ihr Zimmer, sie sitzt auf dem Boden vor einem Schuhberg (die alle ihr gehörten – Turnschuhe, Wanderschuhe, Ballerinas, Leopardenpumps, Stiefel). Sie murmelt vor sich hin, es klingt wie eine Beschwörungsformel und sortiert die Schuhe. Es sieht aus, als suche sie etwas. Ich setze mich zu ihr und nehme ein Paar Schuhe. Auch sie findet ein Paar. Ich beginne, mit den Schuhen zu tanzen, denn ich hatte die roten Ballerinas mit Ledersohle erwischt, die so schön*

> *klappern. Sie macht mit ihrem Schuhpaar, den Wanderschuhen, mit. Ich singe: „Sur le pont, d'Avignon".*
>
> *Etwa 15 Minuten singen und tanzen wir – mit unterschiedlichen Schuhpaaren – die einzelnen Strophen des Liedes: die Herren, die Damen, die Soldaten, die Kinder. Die letzte Strophe wiederholen wir viele Male.*

Jetzt ist es endlich Musiktherapie. Oder etwa nicht? Wir haben in dieser Stunde Stufe 2 – *Kontakt* erreicht – gekennzeichnet durch die Schlüsselworte *Zusammenspiel, Begleitung, gemeinsames Tun* (Fuchs & Mössler, 2016). Wir haben gemeinsam gesungen und »getanzt«. Es gab zwar kein Kontaktangebot seitens der Patientin, aber eine Reaktion auf mein Angebot. Laut Definition der Stufe 2 sollte das Angebot der Musik allerdings von der Patientin ausgehen, also passt es nicht ganz, aber doch am besten von allen Stufen.

4. Musiktherapiestunde

> *In der vierten Einheit klagt Frau Schreiner über Ganzkörperschmerzen, da sie aufgrund medikamentöser Nebenwirkungen fast einen Tag lang seitlich gebeugt gehen musste, und es scheint mir unangebracht, Lieder oder Tanzspiele anzubieten. Sie stellt mir viele Fragen bezüglich unseres Settings, erkundigt sich nach dem Musiktherapieraum. Jetzt können wir eine Struktur für die kommenden Einheiten festlegen. Wir haben einen Behandlungsvertrag.*

Somit ist Stufe 1 – *Orientierung* mit den Schlüsselwörtern *Instrumente ausprobieren, Musik lernen, therapeutischer Rahmen Grenzen* erreicht (Fuchs & Mössler, 2016).

5. Musiktherapiestunde

Ab der fünften Stunde können wir den Musiktherapieraum nutzen. Sehr schnell finden wir uns in einem »klassischen« Setting wieder: Musiktherapieraum, Singen, Spielen, Improvisieren, verbal reflektieren – all das ist nun möglich.

> *Während unserer ersten Einheit im Musiktherapieraum geht es zurück auf Stufe 0. Die Patientin bittet mich, das Lied Über den Wolken für sie zu singen. Anschließend wünscht sie, ihr das Märchen Rotkäppchen zu erzählen. Den Liederwunsch kann ich nachvollziehen. Ich weiß bereits, dass dies eines ihrer Lieblingslieder ist. Warum sie Märchen wählt, bleibt unklar.*

6. Musiktherapiestunde

In der sechsten Stunde gelangen wir zur Stufe 3 – *Vertrauen* mit den Schlüsselwörtern *Teilen, gemeinsames Erleben* (Fuchs & Mössler, 2016).

> *Die Patientin intensiviert den Kontakt. Sie bezieht mich als Person in ihre Aktivitäten ein. Sie gewährt mir Einblicke in ihr Innenleben: Sie sei beunruhigt über Veränderungen ihrer Sprache: Klang und Aussprache hätten sich verändert.*

Wir streifen Stufe 1 – *Orientierung*: Die Patientin beginnt, Musikinstrumente auszuprobieren und anzumerken, sie bräuchte erst noch Musikunterricht, da sie nicht »richtig« spiele. Es ist jetzt möglich, das Lied *Über den Wolken* gemeinsam zu singen.

7. bis 11. Musiktherapiestunde

Von Einheit sieben bis elf reisen wir gemeinsam über die Stufen 2 – *Kontakt*, 3 – *Vertrauen*, 4 – *Ausdruck* und 5 – *Abstraktion*. Auf Stufe 4 geht es um den musikalischen Ausdruck von Emotionen oder Impulsen. Das ist der Zeitpunkt, an dem Musik zum Ausdrucksmittel wird.

> *Immer wieder spüre ich Traurigkeit, die die Patientin verbal nur schwer vermitteln kann. In ihren Klängen wird der Affekt deutlich spürbar.*

Stufe 5 beinhaltet die Schlüsselwörter *Wahrnehmen, Verändern, Konfrontation* und *Reflektieren* (Fuchs & Mössler, 2016). Die Traurigkeit, die bereits Ausdruck in ihrer Musik gefunden hat, kann nun aus einer gewissen Distanz heraus etwas differenzierter betrachtet werden. Eigeninitiativ spricht die Patientin jetzt bewusst ihre Bearbeitungsthemen in der therapeutischen Beziehung an.

Fazit

In vielerlei Hinsicht ist das eine sehr besondere Fallgeschichte, weil sich der Beziehungsaufbau so schwierig gestaltete, weil mich die Patientin psychotisch verkannte, mich schubste – als kaum mehr möglich war, als bei ihr zu sein. Doch es ist auch eine typische Fallgeschichte, denn auf der Akutpsychiatrie habe ich es immer wieder mit ähnlichen Verläufen zu tun. In dieser von Gefühlen des Nicht-Wissens geprägten akutpsychiatrischen Fallvignette erwies sich das diagnostische Instrument der *Sieben Stufen der therapeutischen Begegnung* nach Fuchs & Mössler (2016) als hilfreich zur Einordnung der Phänomene und des Behandlungsprozesses sowie daraus folgend zur Entwicklung situationsadaptiver Interventionen.

Zusammenfassend kann ich resümieren: Offenheit für diese Art des Intervenierens erlaubt Musiktherapie auch *ohne* Musik.

♦ English

A well-equipped music therapy room, a willing patient, and a motivated music therapist are all needed for a successful music therapy session. That's what I thought during my studies and in the early years of my career. My professional path led me to a hospital that even offers two well-equipped music therapy rooms. My high level of motivation is often confronted by patients with psychotic, manic, depressive, or anxiety-related disorders. They often don't want to get involved in a musical play. They are often unable to leave the ward or prefer to stay in their rooms.

I would like to show here how music therapy treatment is also possible outside a traditional music therapy room. Our voice, body, knowledge, skills and the attitude with which we approach our patients prove to be important tools. The identity as a music therapist and a willingness to continuously reflect on our theoretical knowledge, which we constantly refine and expand over many years of practice, seem particularly important to me. An expectation-free openness toward the other person—paired with the readiness to pick up on the smallest impulses in order to work with them—is essential to my therapeutic approach.

In the following case study, I address a question that has preoccupied me throughout my professional career: *When is music therapy really music therapy?*

I work in a regional hospital in Lower Austria with a care mandate; the ward I am assigned to has 30 beds. In addition to medical and nursing care, patients receive support through psychological, occupational, and physiotherapeutic services, as well as social work.

To reflect on my music therapy sessions, I often draw on the diagnostic instrument developed by Mössler and Fuchs (2015) entitled Seven Levels of Therapeutic Encounter. This instrument is used to relate the current musical events in music therapy to a defined treatment focus. The individual stages reflect the client's ability to relate to music, themselves and others. It considers both a musical and a relational focus to pay attention to, and each level is accompanied by specific »keywords« that serve as markers for orientation.

The treatment concept of our acute psychiatric ward aims to provide all newly admitted patients with individual therapy as early as possible. Music therapy proves to be a very good option for patients who are currently not verbally accessible.

Case Study

Ms. Schreiner is approximately 40 years old at the time of her admission to our ward. This is her second inpatient stay. Her diagnosis is paranoid schizophrenia (ICD-10: F20.0). The referring doctor provides the following information: “She's not completely oriented yet, but we don't really know. She doesn't speak. Apart from that, she seems adequate in terms of behavior, mood and affect.” The doctor advised that, for the time being, I remain on the ward with the patient during our sessions.

1st music therapy session

The following observations are taken from my notes of the first music therapy session:

> *There is black hair dye all over the room (the patient's hair color is unchanged) and I have to prevent her from returning to her room for the first ten minutes, as the cleaner is busy minimizing the damage. She wants to clarify something regarding her work, she repeats, but I can't determine whether her concern reflects a real issue or psychotic content. (I know that she is in an upright employment relationship.) It is about a letter that is very important. In addition, she mentions a war several times and asks me whether we have already checked the bank account, if not, the war would either continue or stop – this is also not coherent. As the contact progresses, she becomes calmer when I touch her lightly – we walk side by side across the ward corridor and I keep touching her gently on her shoulder or upper arm to guide her away from her room door, and each time she leans into my hand a little. The session ends with Ms. Schreiber shaking my hand for an extended moment before letting me go.*

It takes me a while to get my bearings again. On the one hand, I'm at a loss because I couldn't follow her content; I'm not sure whether she perceived me as a counterpart. On the other hand, after the session, I ask myself how *music therapeutic* the contact actually was. When a nurse asks, “Oh, that was music therapy!?”—it's time to reflect on my actions.

Music therapy without music, as already indicated in the title—there was no singing, no music was heard, not a single sound was made. There was no defined setting, no therapy contract. And yet, I was allowed to spend this time with her as a music therapist.

Starting with Level 0 and the concept of *Acceptance*, it has often helped me to reinterpret a seemingly non-music-therapeutic session as music therapy after all. The keywords of this stage are *resting*, *relaxing*, and *receiving* (Mössler & Fuchs, 2015, p. 329).

Ms. Schreiner wanted something from me. But the request was unspecific—perhaps psychotic—and not clearly directed at me as a music therapist. She didn't actively seek contact, yet she didn't withdraw either. She allowed me to be present with her, even permitted touch. Even without music, we engaged in a music therapy session at level 0.

2nd music therapy session

> *The second session is even more challenging for me. Ms. Schreiner misjudges me and repeatedly attempts to remove my glasses. She only talks about the glasses, and after a short time, she violently pushes me out of her room.*

It is much more difficult for me to describe this encounter as *music therapy*— or even as *therapeutic*. I was not in a position to offer her support or to act as a container for her monologues. It felt like I was trying to persuade her to do something she couldn't accept. *Acceptance* (level 0) was not noticeable. After her physical assault, I ended the contact for that day.

3rd music therapy session

> *When I enter her room, I find her sitting on the floor, in front of a mountain of shoes. All of them are hers—sneakers, hiking boots, ballet flats, leopard-print pumps, and boots. She mumbles to herself, it sounds like an incantation, as she sorts through the shoes. It looks like she's searching for something. I sit down beside her and pick up a pair of shoes. She finds a pair as well. I start to dance with the shoes I've chausen—the red ballet flats, which have leather soles that clatter so beautifully. She joins in with her pair of shoes: the hiking boots. I start singing Sur le pont, d'Avignon. For about 15 minutes, we sing and dance, with different pairs of shoes, the different verses of the song—the gentlemen, the ladies, the soldiers, the children. We repeat the last verse several times.*

Now it was finally music therapy. Or was it not? In this session, we reached Level 2 – *Contact*, characterized by keywords such as *playing together*, *accompaniment*, and *shared activity* (Mössler & Fuchs, 2015, p. 331). We sang and »danced« together. Although there was no explicit offer of contact from the patient, there was a reaction to my offer. According to the definition of level 2, however, the offer of music should come from the patient, but even if the offer initially came from me, this level aligns most closely with this session.

4th music therapy session

> *In the fourth session, Ms. Schreiner complains of full-body pain, as she has been walking bent over sideways for almost a day due to side effects from her medication. It seems inappropriate for me to offer songs and dance games. She asks me lots of questions about our setting, asks*

> *about the music therapy room. Now we are able to define a structure for the upcoming sessions: we have a treatment contract.*

Level 1 – *Orientation* is reached, characterized by the keywords *trying out instruments*, *learning music*, *therapeutic framework*, *boundaries* (Mössler & Fuchs, 2015, p. 330).

5th music therapy session

Starting with the fifth session, we are able to use the music therapy room. We quickly find ourselves in a »classic« music therapy setting: a designated music therapy room, singing, playing instruments, improvising, and verbal reflection—all become possible.

> *Our first session in the music therapy room brings us back to level 0. Ms. Schreiner asks me to sing* Über den Wolken[2] *for her. Afterward, she wants me to tell her the fairy tale Little Red Riding Hood.*

While I understand the song request (I already knew that this is one of her favorite songs), it remains unclear, why she chose the fairy tale.

6th music therapy session

In the sixth session, we reach Level 3 – *Confidence*, as defined by the keywords *sharing* and *experiencing community* (Mössler & Fuchs, 2015, p. 332).

> *The patient intensifies the contact. She involves me as a person in her activities and offers insights into her inner life: she is worried about changes in her speech, noting that both the sound and pronunciation have changed.*

At the same time, we touch Level 1 – *Orientation*: The patient begins experimenting with musical instruments and remarks that she still needs music lessons because she doesn't yet play »properly«. It is now possible to sing *Über den Wolken* together.

7th to 11th music therapy session

Between sessions seven and eleven, we travel together through Levels 2 – *Contact*, 3 –*Confidence*, 4 – *Expression*, and 5 – *Abstraction*. Level 4 is about musical expression of emotions or impulses. This is when music becomes a means of expression.

> *Again and again, I feel sadness, which Ms. Schreiner finds difficult to convey verbally. The affect is clearly perceptible in her sounds.*

Level 5 is marked by the keywords *perceive*, *change*, *confrontation*, and *reflecting* (Mössler & Fuchs, 2015, p. 334). The sadness that had already found expression in her music can now be viewed in a more differentiated way from a certain distance. On her own initiative, Ms. Schreiner now consciously addresses her processing issues within the therapeutic relationship.

[2] *Über den Wolken* [*Above the clouds*] is a song written by a German singer/songwriter about the feeling that high up above the clouds in a plane you can forget your sorrows.

Conclusion

In many ways, this is a very *special* case example, because building a therapeutic relationship with Ms. Schreiber was very difficult. At times, she misjudged me psychotically, pushed me away, and often left me in a situation where it was hardly possible to do more than be with her. And yet, it's also a *typical* case because I have to deal with similar processes again and again on acute psychiatric wards. Since I've been using Mössler's and Fuchs' *Seven Levels of Therapeutic Encounter* to reflect on my sessions, it's also easier for me to report confidently on my work to the interdisciplinary treatment team.

When dealing with this case and thinking about my current patients on the acute psychiatric ward, I can summarize: Openness to situationally adaptive intervention also allows music therapy *without* music.

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»How should I address you?«

Reflections on the language and culture attuning process in online music group sessions with six young Indonesian autistic women

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Abstract

This paper will examine how attuning to the autistic participants' preferred languages in online music therapy sessions helps establish trust. The process involves not only understanding how the participants prefer to be addressed as autistic individuals, but, moreover, the author's openness as a non-autistic facilitator. The author proposes that learning and adapting the language of the facilitating therapist to that of the participants could bridge differences, serve to demonstrate the facilitating approach, assess therapeutic intentions, and foster mutual self-disclosure. While switching between languages - in this case between Indonesian and English - seems desirable, what matters most, especially when working with marginalised groups, lies behind the words.

Keywords: music – language – culture – attunement – autism

♦ English

In this reflection paper, I drew on my experience working with six autistic young women as part of my PhD project. We met online as a music group weekly for 12 weeks during the COVID-19 pandemic. The participants were six young autistic women aged 20-24. Four of them were university students, while the other two were professionals in the creative industries. Although most of these women had a diagnosis of autism in their childhood, their experiences with the diagnosis varied. Some parents did not disclose the autism diagnosis to the participants, while others repudiated the diagnosis once the participants entered mainstream schooling. The strong cultural and religious beliefs, paired with disparate understandings of autism, have somehow complicated these women's relationships with autism. While some women were comfortable enough to reveal their autistic identity in contexts that they considered safe, others remained reluctant, avoiding being further othered or excluded.

»How should I address you?«

In my previous clinical work, I primarily worked with children on the spectrum and their families. This prompted a desire to do a research project that could contribute to the autistic community. After moving to Australia in 2019 to begin my PhD, I was exposed to more varied models of disability. I was particularly inclined toward the social model and the Neurodiversity movement, which subsequently inspired my project with autistic young adults. A new understanding of

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neurodiversity also made me more mindful in addressing autistic participants, especially regarding the implications of language use. I became more aware of the nuanced differences between person-first and identity-first language and what each signifies in terms of respect and autonomy.

With this increased awareness and a spirit of collaboration, I asked participants at the beginning of the project, »How should I address you?«. In their replies, they did not mind being addressed as *autistic people* or *people with autism*, but unanimously rejected the label of *autism sufferers* (in Indonesian: *penderita autisme*), as often described in the Indonesian media and society. Their answer confirmed these women's general outlook on autism, which they subsequently reflected in the group discussions.

The question didn't stop there. It motivated me to review other aspects of communication relating to language use. While initially planning to conduct sessions in Bahasa Indonesia, the sessions naturally evolved into a fluid mix of Bahasa Indonesia and English. Each participant's Bahasa Indonesia and English levels also varied, resulting in varying confidence levels. Due to the young women's exposure to English environments, education, and social media, they were comfortable switching between Indonesian and English. The use of English among young Indonesian people, particularly those in major cities, is widespread. Using foreign languages, however, is not always appreciated and may be viewed as a potential divide between people with and without access to education and resources. The participants' varying levels of familiarity with particular languages and skills did not seem to obstruct the group communication, allowing them to communicate and express themselves in languages and ways they found comfortable, without passing judgment, which helped them feel more confident and included in the group interactions. As a group facilitator, I sometimes took the initiative to translate or clarify the participants' statements or extended this task to the group members, providing them an opportunity to support their peers in constructing their understanding.

How participants addressed me

In Indonesia, we usually address older people younger than their parents with *big sister/brother* (in the original language, *Kakak*) before their name. The practice also applies in our group interactions. My geographical location when running this project and the individualistic culture, positioned me as a person who increasingly strives for equality. In contrast, the participants' location and the surrounding hierarchical environment inevitably shaped their decision to put a label they deemed appropriate in our group context. Although the gesture is intended to show respect and relation, it poses some hierarchical implications, such as roles and expectations in the group. Although I would rather have them call me solely by name in my attempt to flatten the hierarchy, imposing my ideal would create uneasiness for the participants. While interacting online may blur the context, cultural norms still hold significance.

As these women shared their life stories and music in the group, a participant suggested I could be more open to them, shifting the focus from merely themselves. When I heard this request, I was caught off guard. Traditional, Western-oriented therapy might have influenced my tendency to maintain boundaries and limiting disclosure of personal information to participants. However, the practice might not entirely fit the collective society, as people often desire to be relational by getting to know each other personally. Consequently, sharing personal information is considered a common way to build trust and cohesion. In addition, reciprocity in sharing stories seemed to be

an aspect that affirmed my trustworthiness, intention, and probably view toward autism as a non-autistic group facilitator.

Due to my overseas training and limited resources in Indonesian, I have also incorporated numerous English and Western-oriented music therapy theories and literature in my clinical practice and teaching. Despite not designing this project as a traditional therapy space in a clinical context, I have consciously prepared myself to offer support, serving as the group's *container*. However, community support in a collectivist community often relies on mutual actions rather than singular efforts. When stories are invited and shared solely in one direction, there seems to be a missing mutual exchange of support, resulting in subtle dissonance.

Multimodal communication and digital culture

Along the way, I also reflected on several tensions relating to our methods of communication in the digital space. As a facilitator, I was initially often uncomfortable with the group's simultaneous use of multiple communication modalities. While discussing a topic on Zoom video, some participants sometimes exchanged remarks or had a mini discussion on the side by typing in the text chat box. I was worried that the partial engagement in the group might affect the group dynamic, such as when a participant sharing their story would feel not fully attended to. However, I observed that the young women did not seem bothered by this dual channel. In fact, this complimentary chat appeared to allow participants to express their thoughts and comments immediately and sometimes process what we discussed in the main room.

Multimodal communication was not just accommodated by the text chat feature on Zoom but also commonly accepted by many online communities. At the beginning of the project, a participant was apprehensive of the risk of overlapping speech when speaking on Zoom. Utilising the side chat could minimise this risk. In addition, refraining from interrupting the main discussion may also be seen as a more polite gesture in many Indonesian social contexts. Therefore, participants may choose to share their thoughts or ideas in the chat while the primary conversation continues, allowing them to contribute without disrupting the flow of the discussion. As the facilitator, I often brought those side chats to the main room for the other participants to comment on or further discuss, creating a new or additional discussion topic. With their differences in communication style, most women in this group have often misunderstood and been misunderstood when speaking with non-autistic peers. Escalating each woman's little comments or ideas to the group seemed to encourage them to speak up and share more.

The young autistic women were more highly accustomed to navigating the internet and social media. In contrast, as a person from an earlier generation, my use of chat messengers and social media is relatively different from and not as intensely as theirs. I enjoyed chat messengers to socialise and expand my networks. Unlike the common practice of today, and particularly during the COVID-19 pandemic, my use was considerably less frequent. This contrast in digital habits seemed to shape our differing perspectives on navigating the online environment and defining relationships within the group.

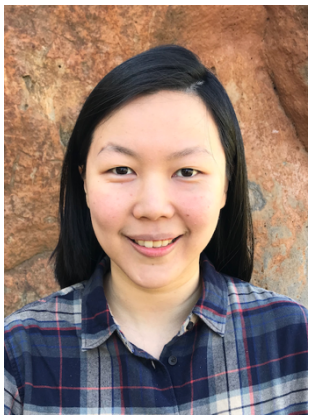
Reflecting on the language and culture attuning process

The language and culture attuning process that I described earlier is twofold. First, by collaboratively exploring these women's preferences and cultures, which were informed by their

lived experiences of being autistic people growing up in a world lacking autism acceptance and their resources as young people. Second, by embracing their preferred ways of communicating and recognising them as strengths. The process involved reviewing my assumptions of various aspects of our communication: the interplay between language use, cultural understanding, and effective interaction in a digital environment. This attempt was prompted by an acknowledgment of my limited understanding – as a non-autistic facilitator – of my participants' autistic and youth cultures.

I propose that learning and adapting our language to our participants could bridge differences and help us connect better with them by demonstrating our approach, assessing our intentions, and revealing our identity. Nevertheless, while adapting to their languages seems desirable, what lies behind them matters the most: our genuine intention to make them feel heard, accepted, and understood. This notion is crucial, especially when working with marginalised groups. »How should I address you?« should not just be asked at the beginning of the session. The question should go beyond the name we use to call our participants. It should reflect an invitation to collaborate with our participants in revealing who they are and who they long to be.

Author



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Musicoterapia, bilingüismo y autonomía personal en niños con Síndrome de Williams

Music therapy, bilingualism and personal autonomy for children with Williams Syndrome

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Resumen

Aproximadamente 480 personas con síndrome de Williams viven en España, 80 de ellas en Cataluña, donde coexisten dos lenguas: el catalán y el castellano. Como consecuencia, la mayoría de los niños crecen con una lengua materna e interiorizan la otra en su entorno social y educativo. En este contexto, música y musicoterapia constituyen un sistema de comunicatión no verbal que favorece el desarrollo del lenguaje y la comunicación verbal. A través de la descripción de dos casos prácticos, se pretende mostrar cómo la música y el lenguaje están intrínsecamente relacionados con el síndrome de Williams y cómo la musicoterapia es una excelente herramienta, no solo para la estimulación temprana, sino también para el desarrollo personal en la adolescencia. El estudio remarca la importancia de tener en cuenta la realidad sociolingüística y la cultural del lugar donde realizan las sesiones de musicoterapia para entender su efecto en los resultados y conclusiones de estas.

Palabras claves: síndrome de Williams – musicoterapia – social – educativo – lenguaje

Abstract

Approximately 480 people with Williams syndrome live in Spain, 80 of them in Catalonia, where two languages coexist: Catalan and Spanish. As a result, most children grow up with one mother tongue and internalise the other in the social and educational environment. In this context, music and music therapy constitute a non-verbal communicative system that helps the development of language and verbal communication. Through the description of two case studies, the aim is to show how the concepts of music and language are intrinsically related to Williams syndrome and how music therapy is an excellent tool, not only for early stimulation, but also for personal development in adolescence. Important consideration is given to music therapists' knowledge of both the local sociolinguistic and cultural reality of the therapeutic setting, and its impact on therapy results and conclusions.

Keywords: Williams syndrome – music therapy – social – educational – language

♦ **Español**

El síndrome de Williams es un trastorno genético causado por la micro delación de aproximadamente 25-28 genes del cromosoma 7Q 11.23. Su tasa de prevalencia varía entre 1 y 7500 nacimientos y se asocia a una discapacidad intelectual de leve a moderada, rasgos faciales distintivos, anomalías cardiovasculares, dificultades visoespaciales, laxitud e hipotonía. Además de una personalidad amigable, entusiasta, desinhibida y gregaria (Mervis & Becerra, 2007).

Aproximadamente 480 personas con síndrome de Williams viven en España, unas 80 de ellas en Cataluña, donde coexisten dos lenguas: el catalán y el castellano (Informe Reer, 2023). Un modelo lingüístico definido por un conjunto de leyes que determinan el catalán como lengua propia de Cataluña. Además, el catalán también es la lengua normalmente empleada como vehicular y de aprendizaje en la enseñanza (Generalitat de Catalunya, 2006).

Adquisición y desarrollo del lenguaje

Según un estudio realizado en 2006, las habilidades lectoras de las personas con síndrome de Williams se encuentran por debajo de lo esperado para su edad cronológica. Sin embargo, destacan positivamente en comprensión auditiva u oral, presentan un buen estado de conciencia fonológica y parecen procesar la información semántica de un modo distinto a como hacen las personas neurotípicas, utilizando así palabras más inusuales (Laing et al., 2001).

En estos niños, la adquisición del lenguaje se retrasa respecto a los niños con desarrollo típico, pero no se altera fundamentalmente y las características específicas de su procesamiento lingüístico son consecuencias indirectas de otros aspectos inherentes al síndrome. Son sus dificultades visoespaciales y el interés los que parecen condicionar realmente la adquisición del lenguaje y del uso de este. Por otro lado, en general, los niños con síndrome de Williams tienen un vocabulario normal para lo que cabe esperar en función de sus habilidades no verbales (Brock, 2007).

Dicho de otro modo, las personas con este síndrome presentan un amplio vocabulario y una construcción sintácticamente correcta, por lo que suelen ser locuaces, aunque en ocasiones no contextualizan adecuadamente el contenido de su discurso. Por ejemplo, son más eficientes en la comunicación afectiva y hacen un uso del lenguaje más adecuado que cuando la comunicación requiere mayor complejidad técnica o hace referencia a contenido visoespacial (Aguilera-Valera & Caycho-Rodríguez, 2017).

Todo esto parece indicar, que los niños con síndrome de Williams poseen habilidades relativamente fuertes en conceptos lingüísticos simples, aunque dichas habilidades son más débiles en áreas más complejas del lenguaje, como sería el caso de la comprensión y la pragmática (Don, Schellenberg & Rourke, 1999).

Habilidades musicales

Los estudios más antiguos citan, que las personas con síndrome de Williams, especialmente los niños, tienen grandes habilidades musicales (Blomberg, Rosander & Andersson, 2006). Sin embargo, estudios más recientes son más específicos. La habilidad rítmica de estos niños parece

ser comparable a la de los niños con desarrollo típico, pero existen diferencias en cómo se desenvuelven frente al estímulo musical y son más eficientes resolviendo sus propios errores. En ocasiones, dado dificultades de procesamiento, cometen más errores, pero presentan un mayor índice de musicalidad (Levitin et al. 2004).

Las habilidades musicales de los niños con síndrome de Williams son relativamente fuertes en comparación con sus déficits en otras áreas. Son buenos cantando y pueden aprender canciones con facilidad. Además, muestran una fuerte respuesta emocional al estímulo musical y facilidad para aprender motivos rítmicos relativamente complejos (Don, Schellenberg & Rourke, 1999).

Según nos cuentan Lense, Shivers y Dykens (2013), las personas con síndrome de Williams perciben con más fuerza características del sonido que las personas con desarrollo típico. Lo que parece tener relación con su fuerte respuesta y conexión emocional con la música.

Una revisión de la literatura más reciente nos muestra que las fortalezas de este síndrome respecto a la música se basan más en la musicalidad y la expresividad que no en sus habilidades musicales formales. Estos niños presentan una mayor respuesta emocional a la música que sus pares (Ng, Lat at al., 2013). Fundamentalmente, muestran un mayor compromiso, creatividad, expresividad y sensibilidad. Presentando interés por la música a una edad muy temprana, dedicándole más horas a su práctica y escucha y manifestando una mayor aptitud que otros usuarios con trastornos del desarrollo neurológico (Thakur et al., 2018).

La relación entre música, lenguaje y Síndrome de Williams

Gracias al fuerte interés que suscita y a sus habilidades relativamente bien preservadas, la música supone un refuerzo extremadamente positivo y una motivación estimulante para las personas con síndrome de Williams. Es por esto por lo que la música resulta idónea para el refuerzo de aquellas áreas en las que muestran más dificultades.

Música y lenguaje auditivo comparten aspectos de procesamiento como tono, intensidad o duración. Del mismo modo, la prosodia del lenguaje y la música comparten las mismas propiedades melódicas y temporales. Es por eso que el entrenamiento musical puede mejorar el desempeño prosódico, cosa que cobra relevancia en el caso concreto de las personas con síndrome de Williams (Martínez-Castilla & Sotillo, 2014) quienes demuestran un fuerte sentido del fraseo y de la métrica, además de una gran sensibilidad a los cambios rítmicos y gran expresividad creativa (Thakur et al., 2018).

La música supone una forma de expresión, una forma de comunicación tanto verbal como no verbal. Y precisamente esta característica comunicativa de la música es la que nos sugiere que la música y el lenguaje presentan una fuerte relación entre sí. De hecho, tanto el habla como el canto son formas de expresión inherentes al ser humano y comparten elementos en común como son la intensidad, la frecuencia, el ritmo o el tono. El canto no supone únicamente una forma de expresión y drenaje emocional, sino que también supone una manera de mejorar nuestras habilidades sociales y lingüísticas. De igual modo, cantar nos ayuda a mejorar la dicción, a tener un mejor control de la respiración, a trabajar la musculatura y mejorar la posición corporal. Es por todo esto por lo que las canciones, originales o no, son fundamentales en la relación musicoterapia y el desarrollo del lenguaje (Cohen & Masse, 1993).

La canción popular o tradicional, supone una excelente herramienta para mejorar las habilidades expresivas creativas y lingüísticas dentro de las sesiones de musicoterapia, sobre todo en las edades más tempranas. No debemos olvidar, que se trata de canciones incluidas en el currículum escolar y fuertemente relacionadas con las festividades y las tradiciones locales. Por lo tanto, se trata de melodías y letras fácilmente reconocibles y muy presentes en su día a día (Decret 175, 2022)

Método

Participantes

A continuación, se describen dos casos menores con síndrome de Williams que realizan sesiones de musicoterapia de manera periódica. Ambos llegan a la musicoterapia después de que la familia observase en ellos una fuerte vinculación e interés por la música. Estos estudios de casos se refieren a: 1) una niña de 4 años y 2) un adolescente de 14 años. Se escogen dos edades tan diversas para mostrar como las necesidades cambian según el periodo de crecimiento, pero no por ello disminuye la capacidad de la musicoterapia para ayudar a mejorar las habilidades lingüísticas y comunicativas de los niños con este síndrome.

La niña vive en un entorno multilingüe, siendo la pequeña de tres hermanos en un núcleo familiar en el que convergen tres lenguas: catalán, castellano y alemán. Su diagnóstico aparece a los tres meses de edad, pocos días antes de la crisis sanitaria desatada por la COVID-19 que acaba paralizando durante bastante tiempo cualquier posibilidad de estimulación temprana.

Por recomendación tanto del centro como de la psicopedagoga, su asistencia al jardín de infancia se prorrogó un año y, a continuación, fue admitida en preescolar con un profesor de apoyo. En la actualidad practica equinoterapia, musicoterapia y tiene visitas bisemanales con la psicopedagoga.

El adolescente de 14 años fue también diagnosticado en la primera infancia. Convive con su hermana pequeña y sus padres y fue estimulado de manera precoz. Realizando desde pequeño sesiones de logopedia, psicoterapia, terapia ocupacional y musicoterapia. Actualmente practica fútbol, danza jazz, mantiene las sesiones de musicoterapia y cursa la secundaria (Enseñanza Secundaria Obligatoria ESO) en un instituto ordinario con una datación curricular individualizada (Pla de suport individualitzat PI).

Procedimiento

La evaluación y el registro de las sesiones se hizo mediante diarios de campo y hojas de seguimiento diseñadas especialmente para los objetivos predeterminados. Hojas que se completaban tras la posterior revisión de videos y audios de las sesiones. Además, se evaluó mediante entrevistas con el centro educativo y los padres si se había percibido mejora en las habilidades comunicativas.

Las sesiones se realizaron de manera semanal, sujetas al calendario escolar de Cataluña, pero sufrieron cambios y cancelaciones por cuestiones logísticas. Se realizaron un total de 27 sesiones por caso, pero se han tomado como muestra diez, cuyos objetivos específicos se centraron en mejorar el lenguaje y la comunicación. La razón es que ambos usuarios se encuentran en un

proceso terapéutico largo que no tiene fecha prevista de finalización y en el cual trabajan diversos aspectos. Los objetivos específicos trabajados en estas diez sesiones fueron:

- Mejorar la vocalización
- Mejorar el canto
- Aumento del vocabulario específico
- Uso de agrupaciones semánticas correctas
- Disminución de interferencias lingüísticas
- Uso correcto de estructuras gramaticales
- Mejorar la comunicación verbal
- Fomentar la expresión de sentimientos, inquietudes y emociones

Todas las sesiones se estructuraron de manera similar. Se iniciaron con una canción de bienvenida o una actividad introductoria. Continuaron con la selección y canto de piezas musicales seleccionadas por los usuarios, actividades de composición, sustitución lírica y/o improvisación. Centrándolas en el canto como herramienta de expresión musical sin excluir el uso de otros instrumentos como el piano o los instrumentos Orff.

Resultados

En el caso de la niña de 4 años, al iniciarse las sesiones, el vocabulario que dominaba era escaso y la vocalización estaba poco definida aún, de modo que, en ocasiones, era difícil identificar la palabra. Y aunque se mostraba tremendamente receptiva al estímulo musical y con una gran memoria para las melodías, el canto se centraba mayoritariamente en un tarareo.

Con el transcurso de las sesiones, comenzó a pedir ella misma las canciones que quería cantar. Casi siempre canciones relacionadas con el cancionero tradicional catalán, la cultura popular y las festividades locales. Esto es algo significativo, ya que de las tres lenguas que conviven en el hogar el catalán es la minoritaria, pero es, por otro lado, el contenido que se trabaja en la escuela infantil. La repetición de estas temáticas, tanto en la escuela como en las sesiones de musicoterapia, evidenció un aumento considerable de vocabulario específico y un uso correcto de los grupos semánticos. A medida que crecía el léxico, mejoraba la vocalización y la dicción, disminuyendo el tarareo. De modo que cuando se inició la composición de pequeñas letras, estas eran coherentes en su contenido léxico e inteligibles fonéticamente. Si bien es cierto que la estructura de las frases no siempre era la correcta y omitía sintagmas.

Además, se observó una disminución de las interferencias lingüísticas a lo largo de las sesiones. Sobre todo, fue evidente en la canción de bienvenida donde dejaron de mezclarse tres idiomas en una sola frase, para convertirse en una canción en tres idiomas diferentes.

En el caso del adolescente, se compusieron dos canciones (letra, armonía y melodía) con estructura ABABABB y se realizó la sustitución lírica de dos canciones completas, *Starman* de David Bowie y *Go West* de Pet Shop Boys, donde no se detectó prácticamente ninguna interferencia lingüística.

Se pudo observar una clara evolución en la expresión de sentimientos e inquietudes en el contenido de las letras. Que al paso de las semanas fueron cada vez más profundas, tanto en contenido como en forma. Figuras retóricas cuyo contenido semántico podía haber sido

interpretado como erróneo, pero dentro del concepto sociolingüístico de Catalunya tenían sentido porque hacían referencia al folklore y la canción popular. Ejemplo:

Composición original del usuario	**Canción tradicional catalana**
La vida és com un dia que plou i fa sol	Plou i fa sol
Sortirà l'arc de Sant Martí	Les bruixes es pentinen
La vida és com un dia que plou i fa sol	Plou i fa sol
Las bruixes portaran dol	Les bruixes porten dol
Traducción	**Traducción**
La vida es como un día que llueve y hace sol	Lluve y hace sol
Saldrá el arco iris	Las brujas se peinan
La vida es como un día que llueve y hace sol	Lluve y hace sol
Las brujas llevarán luto	Las brujas visten de luto

Se pudo observar una mejora no solo en las estructuras morfosintácticas, sino en la propia vocalización y dicción a la hora de cantar. Aunque se trata de un adolescente con buena vocalización en el habla, en ocasiones el estímulo musical le distraía. Pero parece que cantar propias letras le hacía focalizarse más en estas.

Conclusiones

Si bien es cierto que se trata de dos casos muy concretos, de dos edades muy distintas, se puede observar que en cuanto a lo referente a mejoras en las habilidades comunicativas de expresión verbal en el síndrome de Williams la musicoterapia es una buena herramienta. La más que evidente predilección de las personas

que padecen este síndrome por la música le otorga a esta la posibilidad de ser usada como una herramienta de trabajo que ellos perciben de manera lúdica. Resulta algo estimulante y atrayente que les facilita el proceso de aprendizaje y resulta una ayuda para mejorar su desarrollo atípico de lenguaje. Sobre todo, en un contexto de bilingüismo, dado que más lenguas suman mayor dificultad en el proceso de aprendizaje. Y para poder aprovechar al máximo la ventaja que nos da la musicoterapia, resulta indispensable conocer de primera mano el sistema educativo del lugar, su cultura, su folklore, su cancionero tradicional y dominar a la perfección ambos idiomas, comprendiendo en su contexto el bilingüismo. Del mismo modo, resulta también una gran herramienta trabajar la comunicación a nivel social y el autoconcepto en la adolescencia. Trabajando mediante la composición aspectos relativos a la pragmática del lenguaje, como son los enunciados, el contexto y la relación con los interlocutores. Ayudando así a mejorar su autonomía personal.

♦ English

Williams syndrome is a genetic disorder caused by the micro-deletion of approximately 25-28 genes on chromosome 7Q 11.23. Its prevalence rate varies between 1 and 7500 births and is associated with mild to moderate intellectual disability, distinctive facial features, cardiovascular abnormalities, visuospatial difficulties, laxity and hypotonia in addition to a friendly, enthusiastic, uninhibited and gregarious personality (Mervis & Becerra, 2007).

Approximately 480 people with Williams syndrome live in Spain, of which approximately 80 live in Catalonia, where two languages coexist: Catalan and Spanish (Reer Report, 2023). An existing linguistic model, defined by law, has determined Catalan as the language of Catalonia, as well as the language normally used as a vehicular and learning language in education (Generalitat de Catalunya, 2006).

Language acquisition and development

According to a 2006 study, the reading skills of people with Williams syndrome are below what is expected for their chronological age. However, they excel in auditory or oral comprehension, have good phonological awareness skills and seem to process semantic information in a different way than neurotypical people, by using more unusual words (Laing et al., 2001).

In these children, language acquisition is delayed compared to typically developing children but is not fundamentally altered and the specific features of their language processing are indirect consequences of other aspects inherent to the syndrome. It is their visuospatial challenges and interest that seem to really condition language acquisition and language use. In general, however, children with Williams syndrome have a normal vocabulary for what would be expected, based on their non-verbal skills (Brock, 2007).

In other words, people with this syndrome have a large vocabulary and a syntactically correct construction, so they tend to be loquacious, although sometimes they do not adequately contextualise speech content. For example, they are more efficient in affective communication, using language more appropriately than for communication requiring greater technical complexity or in reference to visuospatial content (Aguilera-Valera and Caycho-Rodríguez, 2017).

This suggests that children with Williams syndrome have relatively strong skills in simple linguistic concepts, although these skills are weaker in more complex areas of language, such as comprehension and pragmatics (Don, Schellenberg & Rourke, 1999).

Musical abilities

Past studies cite that people with Williams syndrome, especially children, have strong musical abilities (Blomberg, Rosander & Andersson, 2006). However, more recent studies are more specific: The rhythmic ability of these children appears to be comparable to that of typically developing children, but there are differences in how they cope with musical stimuli and are more efficient at resolving their own errors. Occasionally, given processing difficulties, they make more errors, but have a higher rate of musicality (Levitin et al., 2004).

Children with Williams syndrome often possess musical skills which are relatively strong compared to their deficits in other areas. They are good at singing and can learn songs with ease. In addition, they show a strong emotional response to musical stimuli and facility in learning relatively complex

rhythmic motifs (Don, Schellenberg & Rourke, 1999). According to Lense, Shivers and Dykens (2013), people with Williams syndrome perceive characteristics of sound more strongly than typically developing people. This appears to be related to their strong emotional response and connection to music.

A review of the most recent literature shows that the syndrome's strengths in music are based more on musicality and expressiveness than on formal musical skills. These children show a greater emotional response to music than their peers (Ng et al., 2013). Fundamentally, they show greater engagement, creativity, expressiveness, and sensitivity. They show an interest in music at a very early age, spend more hours practising and listening to music and show greater aptitude than other users with neurodevelopmental disorders (Thakur et al., 2018).

The relationship between music, language and Williams Syndrome

Because of their strong interest and relatively well-preserved abilities, music provides extremely positive reinforcement and stimulating motivation for people with Williams syndrome. This explains how music is ideal for improving areas which present the greatest difficulties.

Music and auditory language share aspects of processing such as pitch, intensity and duration. Similarly, the prosody of language and music share the same melodic and temporal properties. This is why musical training can improve prosodic performance, something that becomes relevant in the specific case of people with Williams syndrome (Martínez-Castilla & Sotillo, 2014) who demonstrate a strong sense of phrasing and meter, as well as a great sensitivity to rhythmic changes and great creative expression (Thakur et al., 2018).

Music is a form of expression, a form of both verbal and non-verbal communication. It is precisely this communicative characteristic of music that suggests that music and language are strongly related. In fact, both speech and singing are forms of expression inherent to human beings and share common elements such as intensity, frequency, rhythm and tone. Singing is not only a form of expression and emotional release, but also a way to improve social and linguistic skills. Singing also helps to improve diction and breathing, increase muscle tonus and improve body posture. This is why songs, either self-composed or not, are fundamental in the relationship between music therapy and language development (Cohen & Masse, 1993).

Popular or traditional songs are an excellent tool for improving creative and linguistic expressive skills in music therapy sessions, especially at an early age. It is important to consider that these songs are included in the school curriculum and are related to local festivities and traditions. Therefore, the melodies and lyrics are easily recognisable and very present in the daily lives of children (Decret 175/2022).

Method

Participants

The following is a description of two children with Williams syndrome who attend music therapy sessions on a regular basis. Both began music therapy after their families observed a strong attachment to and interest in music. These case studies involve: 1) a 4-year-old girl and 2) a 14-year-old adolescent. Two very different ages are chosen to show how needs change according to

the developmental stage, which does not diminish the capacity of music therapy to help improve the linguistic and communicative skills of children with this syndrome.

The child lives in a multilingual environment, being the youngest of three siblings in a family nucleus in which three languages converge: Catalan, Spanish and German. She was diagnosed at the age of three months, a few days before the health crisis unleashed by COVID-19, which put a stop to the possibility of any early stimulation for a great length of time.

Upon recommendations from both the centre and the psychopedagogist, she attended kindergarten an extra year and was then admitted to pre-school with a support teacher. At present, she undertakes equine therapy, music therapy and has bi-weekly visits with the psychopedagogist.

The 14-year-old adolescent was also diagnosed in early childhood. He lives with his younger sister and parents and was stimulated at an early age. He has received speech therapy, psychotherapy, occupational therapy and music therapy since he was a child. He currently practices football, jazz dance, maintains music therapy sessions and attends secondary school (Compulsory Secondary Education ESO) in an ordinary secondary school with an individualised curriculum (Pla de suport individualitzat PI).

Procedure

The evaluation and session recordings were carried out through field diaries and monitoring sheets, especially designed for the predetermined objectives. These sheets were completed after the subsequent review of video and audio material with which the sessions were partially recorded. In addition, interviews with the school staff and parents were used to assess whether there had been a perceived improvement in communication skills.

The sessions were held on a weekly basis, subject to the Catalan school calendar but were subject to changes and cancellations due to logistical reasons. A total of 27 sessions were held per case, ten of which were selected as a sample with specific objectives focused on improving language and communication. The rationale for this was that both cases involve a long therapeutic process without a scheduled end date, and for which they are working on various issues. The specific objectives for these ten sessions were:

- Improve vocalisation
- Improve singing
- Increase in specific vocabulary
- Use of correct semantic groupings
- Reduction of linguistic interference
- Correct use of grammatical structures
- Improve verbal communication
- Encourage the expression of feelings, concerns and emotions

All sessions were structured in a similar way. They started with a welcome song or an introductory activity and continued with the selection and singing of musical pieces selected by the users, composition activities, lyrical substitution and/or improvisation. Focus was placed on singing as a

tool for musical expression without excluding the use of other instruments such as the piano or Orff instruments.

Results

In the case of the 4-year-old girl, at the beginning of the sessions, her vocabulary was limited, with poorly articulated vocalisation, so that it was sometimes difficult to identify the word. In addition, although she was tremendously receptive to musical stimuli and had great melodic memory, the singing was mostly focused on humming.

Over the course of the sessions, she began to ask for the songs she wanted to sing herself. Almost always songs related to the traditional Catalan songbook, popular culture and local festivities. This is significant, as Catalan is the minority language of the three languages spoken in the home, but it is also the content that is worked on in the nursery school. The repetition of these themes, both at school and in the music therapy sessions, showed a considerable increase in specific vocabulary and correct use of semantic grouping. As her vocabulary increased, vocalisation and diction improved, with a noticeable decrease in humming. When the composition with short words and short lyrics then began, they were coherent in lexical content and phonetically intelligible. Sentence structure, however, was not always correct and sentences were morphosyntactically incomplete. In addition, a decrease in language interference, i.e. when one language affects the use of another, was observed over the course of the sessions. This was especially evident in the welcome song, where three languages were no longer mixed in one sentence, but became one song in three different languages.

In the case of the adolescent, two songs were composed (lyrics, harmony and melody) with ABABABB structure and the lyrical substitution of two complete songs, *Starman* by David Bowie and *Go West* by Pet Shop Boys, where practically no linguistic interference was detected.

A clear evolution could be observed in the expression of feelings and concerns in the content of the lyrics. Week by week, the lyrics of the compositions became more profound, both in content and form. The use of rhetorical figures of speech, with seemingly erroneous semantic content, made sense within a Catalonian sociolinguistic framework. In this context, they referred to folklore and popular song. An example:

Original user composition	**Traditional Catalan song**
La vida és com un dia que plou i fa sol	Plou i fa sol
Sortirà l'arc de Sant Martí	Les bruixes es pentinen
La vida és com un dia que plou i fa sol	Plou i fa sol
Las bruixes portaran dol	Les bruixes porten dol
Translation	**Translation**
Life is like a rainy and sunny day	It's raining and it's sunny,
The rainbow will come out	Witches comb their hair
Life is like a rainy and sunny day	It's raining and it's sunny,
Witches will wear mourning	Witches wear mourning

An improvement could be observed not only in morphosyntactic structures, but also in vocalisation and diction when singing. Although this is an adolescent with good vocalisation in speech, the musical stimulus sometimes distracted him. But it seems that singing his own lyrics made him focus more on them.

Conclusions

Even though these are two very specific cases from two very different age groups, it can be stated that music therapy was a good way to improve the verbal communication skills in Williams syndrome. The obvious musical preference of both participants offered the opportunity to use music as a working tool, which was perceived in a playful way. The stimulation and engagement facilitated the learning process and helped to improve their atypical language development. This is particularly notable in the context of bilingualism, when multiple languages increase the difficulty of the learning process. In order to fully benefit from music therapy, knowledge of the local education system, culture, folklore, traditional songs and a perfect command of both languages proved to be essential: In short, a thorough understanding of bilingualism within a given context.

Music therapy also proved to be an effective tool in facilitating social communication and self-concept in adolescence. The song compositions helped to develop aspects of language pragmatics such as sentences, context and the relationship with interlocutors. This contributed to increasing personal autonomy.

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The logic of the case

Lacanian theoretical concepts in music therapy

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Abstract

This article draws attention to the Lacanian perspective within psychoanalysis. Its aim is not to summarise Lacan's concepts but to highlight Lacan's three dimensions of the subject to arrive at the concept of *Jouissance*. It also focuses on how the subject's relationship to these dimensions influences how the music therapist relates to the subject and the choice of intervention. Clinical vignettes will demonstrate how Lacan's theoretical framework inspired the first author's work (referred to as first-person hereafter) as a music therapist.

Keywords: Lacan – jouissance – psychoanalysis – music therapy – transference

♦ **English**

A challenging case early in my career led me to seek guidance from a psychoanalytic, Lacanian-oriented supervisor. I was not sure how to support a particularly paranoid client who I suspected would drop out after a few sessions. Lacan's concepts helped me establish a therapeutic relationship with this client and made me aware of the potential issues. Our encounters and therapeutic alliance became an anchor for him to facilitate relationships with other healthcare counsellors as well.

Background

»Lacan distinguishes three dimensions within the subject: the *Imaginary*, the *Symbolic* and the *Real*. The Imaginary pertains to the body, the Symbolic to language and the Real to the impossible« (Demuynck, 2016, p. 16)[1].

The term *subject* refers to a longing human individual in Lacanian psychoanalytic.

[1] The original quotations from J. Demuynck and A. Geldhof were translated from Dutch into English by the first author (C. C.).

- *The Real:* A child is born into a state of nature, where there are only needs and nothing else. The Real represents this state of nature that is not yet processed, not yet symbolised and not yet bounded by language.
- *The Imaginary:* Before the child identifies with its mirror image, the child experiences its own body as fragmented. Through the image of others (including the mother) with which the child identifies, a consistent illusory self-image emerges. Therefore, the order of the imaginary is how the subject relates imaginatively to itself and the world.
- *The Symbolic:* The subject is inscribed in language through the mirroring of others and their words. It gives the subject identity, on the one hand, and provides the necessary distance from The Real on the other.

The raw, unprocessed stimuli are translated by matched parental interventions (The Imaginary). Through the reactions and interpretations of others, these stimuli are symbolised and become linguistic (The Symbolic). However, there is always a small part, a remainder of it, that does not get inscribed into the Symbolic, and that's the *Jouissance*. It is a surplus excitation or bombardment of stimulation – *arousal* – (Leader, 2013) and refers to extreme pleasure that transgresses the law of homeostasis. The Real, the Imaginary and the Symbolic are inextricably linked and form a systemic whole. Only when the three dimensions are firmly intertwined can the subject regulate Jouissance, and whenever a shift occurs within one of them, it disrupts this mechanism, causing inadequate regulation of Jouissance and producing symptoms.

The logic of the case: When clients come to the practice, they have already found ways to cope with the impediments in their lives. These unique solutions made it possible to move on and survive and are attempts to deal with The Real.

As a psychoanalytic-oriented therapist, I am interested in discovering how my clients relate to The Real and their solutions to manage the Jouissance. The solutions clients have found inform me about what had affected them and where the opportunities, pitfalls (e.g. in transference) and starting points lie in the therapeutic process. However, these solutions do not reveal themselves easily. They lie hidden in the singular details, in the things the clients are saying and doing, and in what repeats itself. Lacan called them »Divine details« (Demuynck, 2017, p. 68)[1]. Together with Lacan's psychoanalytic concepts, these small peculiarities in the client's story become *the logic of the case*.

The aim of the encounters between client and therapist is to utilise verbal and non-verbal interventions to possibly shift something via the symptom into a new solution. This is not a solution that results from a rational insight but rather from the operations of the unconscious. It is a personal solution, a solution that the client discovers and works only for that client.

I meet my clients in an open space without any plans or focus on a specific theme or goal. Inspired by their questions and preferences, I offer open musical forms. Details emerge in the way they participate in the offer. This could be in the way they play, for example, the musical interaction or the lack of it, the timing, the musical forms, the musical dynamics or what they tell me afterwards. I would go into those details which appeared unique to me. After each session, I wrote down a description of the music we had played and, to the best of my ability, the exact sentences that were said during the most remarkable moments. By writing this down, the puzzle of the *logic of the case* begins to piece together.

Clinical vignettes

Patricia

> *At the start of the therapy process in my private practice, I often had little or no information about the clients and their stories. As in the case of Patricia, who had, besides emotional problems, chronic fatigue syndrome and fibromyalgia, her body ached most of the time. At home, she would listen or sing along to music as she tidied up. Thus, Patricia came to do music; she did not want to talk about her biography or even what happened in the past week. The sessions evolved quickly into singing and vocal improvisations. I suggested moving while she was singing to open up her voice. That shifted into singing and dancing. She improvised vocally with piano accompaniment, and we also danced and did vocal improvisation to recorded music. During these music interventions, she proposed songs, and she would instruct me, for example, to dance while she was dancing or to sing more softly so that she would not be distracted. She created a very unique way of working, a practice driven by her deep personal underlying dynamics. It seemed very clear that Patricia needed me, as a therapist, to dance and sing with her, even though I could distract her, and she would ignore me most of the time. There were times when I did not fully understand what we were doing, but I observed that she seemed more alive and awake.*
>
> *One day, Patricia recalled that she used to dance and sing in the fields by herself when she was eight years old. Those were good moments; she could be herself. At home, however, she could not be the playful girl who loved to sing because her mother was very ill, and her father had »escaped« to work. She had danced and sang to keep herself alive. It was a solution from the past, which she repeated in music therapy, but it evolved into a practice that allowed others in. To be heard and seen by someone gave her a place in the human world and her existence. I became aware of what we were doing. There were many sessions where she needed me to dance and sing with her. There was seldom contact, which lasted only briefly. Nevertheless, in those moments where visual or musical contact emerged, we would get ourselves engaged in little vocal dialogue. These could be seen as the first steps towards holding and containing Patricia.*

Here, we see how a shift took place in the *Real dimension*: from a body full of pains (physical pain as pleasure phenomena) to having fun. In the *Imaginary dimension*, from a fragmented body that wriggles and is divided, into a body that dances, thus becoming cohesive. On the *Symbolic dimension*, from all alone to a practice that allows connection with others.

This way of working encompassed many uncertainties: what would happen, what would be asked of me as a therapist, and would there be any result? The therapist is present, and together with the client, they create a path. An unknown road that could feel very uncomfortable. Supervision and a psychoanalytical foundation helped me to find the key details and orientated me on how to relate (transference) and intervene. It might take several sessions to find a hypothetical *logic of the case* and a part of this search is to allow myself (the therapist) to be taught by the client.

Liam

> *Liam came to therapy during the coronavirus pandemic. He could talk for hours about his music genre. He had an enormous knowledge of heavy metal music; he also knew much about the performers, their singing techniques, and how they threw themselves on stage and writhe (illustrated*

with YouTube videos). Liam came to each session with a new piece of music, but they always had a common theme: dying or nearly dying. Dying was present sometimes in the lyrics and sometimes in the performative elements. He explained to me how certain words or phrases greatly affected him emotionally. Gradually, it became clear that the music was a reference to the death of his little sister, who was strangled at play. Liam had been repeatedly evoking this scene, re-enacting this traumatic event. »Lacan will formulate it as 'un bout de réel' a piece of the Real that falls outside the structure.« (Demuynck, 2016, p. 31)[1]

In the intense, passionate way he talked about it, and in the difficulty of stopping, I felt the necessity of his speech. Before the corona pandemic, Liam had found himself a solution to adapt the trauma into his life, by speaking about heavy metal music with others, he was connecting with others. Unfortunately, this solution was partially disrupted by corona.

The *logic of this case* emerged. I became aware of my position: a listener he could connect to. With me being in this position of transference, Liam could continue his work of editing the Real. I listened with great attention and tried to find, in the details, places where I could intervene; accentuating the opportunities that would allow him to discover other living focus. Doing it in a way without giving insights or explaining patterns.

»The analyst's interpretations are not judged by their 'truth', but rather by their 'effects'. The analyst's interpretation may be strictly 'true' and yet, at best, change nothing or even further burden and screw the subject. This is why Lacan once said that interpretation must be 'lighthearted'. It should not try to capture the core of the patient's being but should offer an opening in its ambiguity and playfulness. Only in this way can it, in an expression of Miller, »disturb the subject's defences in such a way that a vividness becomes possible« (Geldhof, 2017)[1].

Mary

Mary often talked about longing to be dead and said that she was not worth the therapist's time. However, talking more about it seemed to block her even further, and the musical aspect of the therapy was stuck as well. The only time she would come alive was when she spoke about her work; Mary worked with people with severe disabilities. When she spoke about her work, she would talk about it with passion, taking time to describe in detail how she would care for them. She even demonstrated to me how she would tickle reactions, be a smile or a small movement, out of those she worked with, by letting them experience the physical effects of vibrating guitar strings. Later in the music therapy process, she would find another musical instrument, a Shruti box, that would also have a strong effect on her. The vibratory quality of the instrument shifted her to do something she had stopped doing. It awakened her to sing again, just like she used to with her sisters.

Working closely with Mary's psychologist, the logic of the case became clearer to me. Mary had lost her disabled sister in an accident when she was about 8 years old. As they were very close to each other, Mary felt as though she had died along with her sister. Thus, whenever she could evoke a reaction from those she worked with, by using her voice and musical instruments, it would be as if she was bringing not only them back to life but also herself. For 40 years, this solution had kept her going, so when the facility suggested her retirement, she was lost.

There were two important therapeutic interventions made in this process. First, I began to give her the role of a *music therapist* even before there were music therapists in Belgium, and that gave her a symbolic place. Second, I emphasised the importance of a music therapist's work and how many others could benefit from it, including people with dementia. I showed her videos of music therapists at work with persons with dementia which moved her deeply and motivated her to want to start right away. The *logic of this case* was that Mary needed her job to revive herself and a new practice to limit the Jouissance.

Conclusion

In this article, I have tried to demonstrate how the *logic of the case* took shape in my music therapy practice. I have highlighted a few elements, such as giving an open space, the divine details and letting oneself be taught by the subject. All with the aim of allowing *The Real* and the *Jouissance* to appear first, and then formulating a hypothesis about the logic of the case to find the anchor points for me as a music therapist to relate to the clients and to find appropriate interventions.

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Improvisatsiooniline mina-kolmnurk (IST)

Ekspressiivne meetod emotsioonide peidetud põhjuste avastamiseks individuaalses psühhodünaamilises muusikateraapias täiskasvanutele

Improvisational Self-Triangle (IST)

A method for uncovering hidden causes of emotions in psychodynamic individual music therapy

Alice Pehk

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Abstrakt

Üks peamisi probleeme, millele ennast otsivad täiskasvanud teraapiasse tulles keskenduvad, on ootamatud emotsionaalsed reaktsioonid, mille põhjuseid kliendid ei näe, kuid mis ilmnevad ikka ja jälle ning mõjutavad ebameeldivalt nende elukvaliteeti ja toimetulekut. Selliste emotsioonidega töötamiseks olen välja töötanud psühhodünaamilise muusikateraapia meetodi Improvisatsiooniline mina-kolmnurk (IST). IST töötab kliendi, tema emotsioonide ja *salapärase kolmanda* vahelise suhtega läbi muusikaliste improvisatsioonide. Selle *salapärase kolmanda* avastamine ja uurimine on sageli olnud võtmeks nende emotsioonide põhjuste mõistmisel, võimaldades selle nähtuse teadvusse toodud aspektide edasist integreerimist. Artiklis avan meetodi teoreetilist tausta, kirjeldan samm-sammult selle praktilist rakendamist ja toon näiteid teraapiajuhtumist, mis illustreerib meetodi rakendamist teraapiaprotsessis.

Võtmesõnad: psühhodünaamiline muusikateraapia – emotsioonide uurimine – *salapärane kolmas*

Abstract

One of the main problems that adults in search of themselves focus on when they come to therapy is unexpected emotional reactions, the causes of which the clients cannot see, but which repeatedly manifest themselves, unpleasantly impacting quality of life and coping. The psychodynamic music therapy method, *Improvisational Self-Triangle* (IST), was developed to work with such emotions. IST works with the relationship between the client, their emotions and a *mysterious third* through musical improvisations. Discovering and exploring this so-called *mysterious third* has often been the key to understanding the causes of these emotions, allowing further integration of the aspects of this phenomenon brought into consciousness. This paper provides a theoretical background of the method, describes its practical application step by step and illustrates its application in therapeutic process via case study.

Keywords: psychodynamic music therapy – exploring emotions – the *mysterious third*

♦ Eesti

Oma pikaajalise psühhodünaamilise muusikateraapia läbiviimise kogemuse põhjal saan väita, et üks peamisi probleeme, mille ennast otsivad täiskasvanud teraapiasse jõudes fookusesse tõstavad, on ootamatud emotsionaalsed reaktsioonid, millede tekkepõhjuseid kliendid ei näe, kuid mis ikka ja jälle ennast ilmutavad ning mõjutavad ebameeldivalt elukvaliteeti ja toimetulekut. Sageli on need emotsioonid, millede päritolu on seni olnud turvalisem hoida teadvustamata, põhjustades ärevuse kasvu, meeleolu alanemist ja sügavat rahulolematust, mis omakorda on viinud sagedaste konfliktsete olukordadeni, seisakute kogemiseni, suhete püsimatuseni, töövõime vähenemiseni või isegi välismaailmast irdumiseni.

Tuginedes kogemusele ja seda toetavatele teooriatele olen emotsioonide tekkepõhjuste ja psühhodünaamika uurimiseks välja töötanud muusikateraapia meetodi *Improvisatsiooniline mina-kolmnurk* (IST). IST-s töötatakse suhetega kliendi, tema emotsiooni ja "salapärase kolmanda" vahel läbi metafooriliste muusikaliste improvisatsioonide. Selle niinimetatud *salapärase kolmanda* avastamine ja uurimine on sageli võtmeks nende emotsioonide põhjuste taipamisel ja nendega seotud psühhodünaamika mõistmisel.

IST teoreetiline aluspõhi

IST tugineb tunnetekesksele kiindumuspõhisele lähenemisele psühhoteraapias. Tunnetekeskne teraapia (Emotionally Focused Therapy, EFT; Johnson, 2019) on kiindumuspõhine psühhoteraapia, mis keskendub emotsionaalsele dünaamikale. Selle teraapiavormi aluseks on kiindumusteooria (Bowlby, 1988), mis on fokuseeritud sügavatele emotsionaalsetele sidemetele inimeste vahel, eriti imikute ja nende esmaste hooldajate vahel. Bowlby järgi tulenevad kiindumussuhted bioloogiast, sest imikud otsivad instinktiivselt oma hooldajate lähedust ja kaitset, et tagada ellujäämine. Varaste sidemete kvaliteet sõltub suuresti sellest, kui järjekindlalt ja tundlikult hooldaja lapse vajadustele vastab. Kui hooldaja on vastutulelik ja hoolitsev, areneb lapsel tõenäolisemalt turvaline kiindumussuhe, mis soodustab turvatunnet ja usaldust. Kui aga hooldajad on ebajärjekindlad või hooletusse jätvad, võivad lastel tekkida ebaturvalised kiindumusmustrid, mis võivad väljenduda ärevuse, vältimise või segadusena. Need varajased kogemused loovad Bowlby sõnul *sisemised töömudelid* – mentaalsed raamistikud, mis kujundavad inimese taju ja suhtumise suhetesse kogu oma elu jooksul. Lapsepõlves kujunenud kiindumusmustrid kanduvad sageli edasi täiskasvanuikka, mõjutades seda, kuidas inimesed emotsionaalselt suhestuvad, teisi usaldavad ja suhetes lähedusega toime tulevad. Bowlby teooria rõhutab, et varajased emotsionaalsed sidemed mängivad otsustavat rolli inimese arengu kujundamisel ja selles, kuidas me suhtleme teistega kogu elu jooksul.

EFT keskendub sellele, kuidas inimesed suhtuvad oma emotsioonidesse ja kuidas need emotsioonid mõjutavad nende isiklikku heaolu ja suhteid teistega. EFT aitab oma emotsionaalseid kogemusi uurida ja arendada oma tunnete sügavamat mõistmist. Selles lähenemisviisis peetakse emotsioone oluliseks tervenemise ja arengu seisukohalt, rõhutades, et kui inimesed suudavad oma põhitunded »kätte saada«, neid mõista ja väljendada, saavad nad muuta oma elu negatiivseid mustreid (Johnson & Campbell, 2021). Muusikateraapia on väga kohane ja efektiivne niisuguse sisemise protsessi võimaldamiseks.

IST protsessi käivitamisel on oluliseks tugitalaks Magda B. Arnoldi (1960) emotsioonide põhielementide määratlus, mis leiab rakendust ka EFT-is. Arnold iseloomustas emotsioone kui tegevussuundumusi: emotsioonid ja tegevused on seotud motivatsiooni kaudu ning motivatsioon peegeldub emotsiooni hindamise käigus (Mooren & Krogten, 1993). Arnoldi emotsioonide põhielementide teooria on mõjus vahend, mis võimaldab avastada, avada ja piiritleda kliendi emotsionaalset reaktsiooni selle olemuse avamise kaudu. Emotsioonide elemendid määratles Arnold järgnevalt: 1) emotsiooni päästik; 2) esialgne arusaam; 3) kehareaktsioon; 4) tähenduse loomine; 5) tegevuse tendents. Selle teooria kohaldamise võimalusi IST-s näitan allpool meetodi kirjelduses.

Meetodi rakendamise juures ei saa kuidagi mööda minna ka ühest olulisest tingimusest selle toimimise eeldusena: muusikaterapeut peab IST-d rakendades kehastama »piisavalt head ema« (Winnicott, 1971), võimaldades positiivset ülekannet (Freud, 1912/1958) – kliendi poolt terapeudile ülekantud turvalist kiindumust, armastust, hoolimist või teisi positiivseid emotsioone, mida klient algselt on kogenud või oleks ideaalis võinud kogeda lapsepõlves vanemate või teiste oluliste isikute suhtes. Samas töö teraapiaprotsessis emotsioonide ja/või kujuteldavate persoonidega toob tahes-tahtmata esile negatiivseid ülekandeid (Ibid.), mida terapeut peab olema võimeline adekvaatselt käsitlema ja asjakohaseid sekkumisi kasutama.

IST samm-sammuline rakendamine

IST rakendamisel peaks teraapiakohtumise pikkus olema vähemalt 90 minutit, et oleks võimalik läbida kõik vajalikud sammud. IST-s kasutatakse Analüütilisest Muusikateraapiast tuntud splitting-tehnikat (Priestley, 1994), mille raames rakendatakse vaba improvisatsiooni tehnikat (Bruscia, 1987; Wigram, 2004). IST struktuur koosneb järgmistest etappidest:

Samm 1: Terapeut võimaldab kliendil lahti mõtestada antud emotsiooniga seotud teadvustatud temaatikat, tuginedes emotsioonide hindamise teooriale (Arnold, 1960).

Samm 2: Klient valib muusikainstrumendi sellele emotsioonile, lähtudes eelmises sammus käsitletust ning asetab pilli enda vastas olevale toolile või istub ise pilli ette, kui pilli ei ole võimalik liigutada. Kliendile tuleb anda piisavalt aega, et selle pilliga/emotsiooniga suhestuda. Klient avab verbaalselt pillivaliku tagamaid.

Samm 3: Klient valib endale muusikainstrumendi, mille abil saab selle emotsiooniga suhelda. Klient avab verbaalselt pillivaliku tagamaid.

Samm 4: Klient lähetab emotsioonile oma spontaanse muusikalise sõnumi ilma, et ta sellele eelnevalt teadliku sisu annaks. (Selliste improvisatsioonide ajal on soovituslik kliendil sulgeda silmad, et vähendada väliseid stiimuleid, mis seda protsessi võiksid segada ning võimaldada liikuda sügavamale enesesse.) Klient võtab kogemuse vastu ja reflekteerib seda verbaalselt. Terapeut teeb asjakohaseid sekkumisi, et seda kliendile võimaldada.

Samm 5: Rollimäng: Klient võtab emotsiooni instrumendi, istub emotsiooni toolile, kehastub selleks emotsiooniks, väljendab emotsiooni olemust muusikaliselt. Klient võtab kogemuse vastu ja reflekteerib seda verbaalselt. Terapeut teeb asjakohaseid sekkumisi, et seda kliendile võimaldada.

Märkus: Samme 4-5 võib vajadusel korrata kui terapeut näeb vajadust selle *suhte* edasiseks uurimiseks või klient teeb ise ettepaneku dialoogi enda ja emotsiooni vahel jätkata ning seda nii mitu korda, kui terapeut peab otstarbekaks.

Samm 6: Klient tuleb emotsiooni rollist välja, istub tagasi enda kohale ja reflekteerib seda, mida on just värskelt kogenud ja teada saanud. Seejärel saab klient võimaluse tuua sellesse ringi veel üks tegelane: *salapärane kolmas*. Klient valib sellele tegelasele pilli, paigutab selle jaoks lisatooli käesolevasse *pilti* sinna, kuhu see tunnetuslikult sobiks ja asetab pilli sellele toolile. Kliendile tuleb anda piisavalt aega, et *salapärase kolmandaga* suhestuda. Klient avab verbaalselt pillivaliku ja enda tunnetuses toimuva tagamaid. Terapeut teeb asjakohaseid sekkumisi, et seda kliendile võimaldada.

Samm 7: Rollimäng: Klient võtab emotsiooni instrumendi, istub emotsiooni toolile, kehastub selleks emotsiooniks, võtab tunnetuslikult kontakti *salapärase kolmandaga* ja lähetab *salapärasele kolmandale* enda muusikalise sõnumi ilma, et ta seda eelnevalt sõnastaks. Klient võtab kogemuse vastu ja reflekteerib seda verbaalselt. Terapeut teeb asjakohaseid sekkumisi, et seda kliendile võimaldada.

Märkus: Kui selle sammu käigus saabub taipamine emotsiooni päritolu kohta, muutub samm 8 ebavajalikuks. Sel juhul tuleks võimaldada kliendile piisav aeg refleksiooniks ning liikuda seejärel sammule 9.

Samm 8: Rollimäng: Klient võtab *salapärase kolmanda* instrumendi, istub tema toolile, kehastub *salapäraseks kolmandaks*, väljendab selle olemust muusikaliselt. Klient võtab kogemuse vastu ja reflekteerib seda verbaalselt. Terapeut teeb asjakohaseid sekkumisi, et seda kliendile võimaldada.

Märkused: Samme 7-8 võib vajadusel korrata kui terapeut näeb vajadust selle *suhte* edasiseks uurimiseks või klient teeb ise ettepaneku antud dialoogi jätkata ja seda nii mitu korda, kui terapeut peab otstarbekaks.

Sellest sammust edasi ei ole mõistlik protsessi kulgu kindlaks määrata. Terapeudil tuleks edasiste sekkumiste valikul lähtuda käesolevast olukorrast, hinnates, millisesse rolli oleks otstarbekas klienti suunata, et ta otsitavale taipamisele lähemale jõuaks. Ideaalis lõpeb protsess siis, kui klient on saanud ahaa-elamuse ja emotsiooni tekkepõhjuse avastanud. Selleni jõudmiseks võib eelnevaid samme teha läbi nii palju, kui on vajalik, sellises järjekorras, nagu on terapeudi hinnangul otstarbekas ja nii palju, kui ajaline raam võimaldab.

Samm 9: Kokkuvõtte suunas liikumine: vastavalt vajadusele pakub terapeut kliendile võimaluse minna veelkord mõnda kolmnurgas rakendatud rolli ja sellega seonduvat mõne teise kolmnurga rolli suhtes edasiselt läbi töötada.

Samm 10: Kokkuvõte: Klient istub tagasi enda toolile, võtab kogu protsessi käigus saadud kogemuse vastu. Klient reflekteerib kogetut 1) muusikaliselt ja 2) verbaalselt (muusikalise osa võib ära jätta, kui aega napib, verbaalne refleksioon on hädavajalik, et saadud kogemust võimalikult hästi mõista ja endasse integreerida).

Juhtumi näide: Paula

Järgnevalt tutvustatakse IST-meetodi rakendamist 35-aastase kliendi Paula (nimi muudetud) juhtumi näitel. Meetodi rakendamise protsessi kokkuvõtlik kirjeldus on esitatud tabelis 1.

Paula on intelligentne, hea analüüsivõimega ja teraapiaks hästi motiveeritud naine, kelle peamiseks probleemiks on erinevates elu olukordades ilmnev sageli näiliselt põhjendamatu ärevuse tunne. Terapeut on protsessis seni rakendanud peamiselt toetavaid ja kliendi jaoks võrreldes musitseerimisega turvalisemana tunduvaid retseptiivseid sekkumisi. Paula on jõudnud oma protsessis nii kaugele, et soovib ja julgeb seista silmitsi oma seletamatu hirmuga ja on selleks valmis kasutama muusikainstrumente.

Paula kogeb hirmu eriti suhetes meestega, olenemata sellest, millises rollis nad Paula suhtes on või millisel tasemel Paula neid tunneb ja teab. Klient tunneb hirmu ka enda elukaaslase suhtes, sealhulgas nii läheduse kui hülgamise hirmu, aga ka hirmu elukaaslase võimaliku pahameele pärast. Need hirmud on ühtlasi pannud Paula käituma partneri ootuste järgi või eelduste järgi, mida partner võiks temalt oodata. Terapeut teeb ettepaneku uurida just selles suhtes tekkivat hirmu, sest see kogemus on kliendi jaoks iseäranis arusaamatu, kuna objektiivselt ei ole tema arvates hirmuks mingit põhjust. Kogetav tunne mõjutab aga tugevalt suhte kvaliteeti ja see teeb Paula murelikuks ja loob omakorda hirmu, et partner võiks ta maha jätta.

Tabel 1

Paula juhtum: näide IST samm-sammulise rakendamise kohta

Samm nr	Kliendi reaktsioonid ja tegevused
1	Paula määratleb emotsiooni elemendid nii: 1. emotsiooni päästik: elukaaslane vastab Paula küsimusele või repliigile tõrksalt, põrnitsedes teda altkulmu 2. esialgne arusaam: ta on Paula peale pahane, kuigi Paula ei saa aru selle põhjusest 3. kehareaktsioon: külmavärinad, kõhus hakkab keerama, lisaks on tunne, et ta on mõõtmetelt väike (palju väiksem kui partner) 4. tähenduse loomine: Paula on midagi valesti teinud ja peab karistust kandma 5. tegevuse tendents: Paula tõmbub endasse, võimalusel eemaldub teise tuppa, ei julge partneriga pärast seda intsidenti juttu ise alustada, vaid ootab, kuni partner ise seda teeb
2	Paula valib hirmu pilliks klaveri, põhjendades seda sellega, et klaver on talle tundmatu pill ja juba mõte sellest, et ta peaks seda puudutama, on hirmutav. Klient kogeb külmavärinaid sarnaselt paarisuhtes ilmneva hirmutunde ajal kogetavaga.
3	Paula otsib kaua sobivat instrumenti. Ta kuulab maraka kõla, puudutab kõuepilli, toob kuuldavale arglikke helisid djembel. Lõpuks jääb ta peatuma raamtrummi juures ja valib selle. Klient põhjendab pillivalikut sellega, et trummi kõla on piisavalt vali, et hirmule vastu astuda.
4	Paula ei soovi musitseerimise ajaks silmi sulgeda, sest olukord on tema jaoks liiga hirmutav. Ta hoiab trummi vasakus käes ja mängib seda parema käega. Järsku peatab ta mängu, tõuseb ja võtab appi trumminuia. Mäng jätkub nuiaga intensiivseid arütmilisi trummihelisid esile tuues. Improvisatsioon kestab kokku umbes 2 minutit. Improvisatsiooni lõppedes paneb Paula silmad kinni, tema keha läbivad mõned visuaalselt tajutavad värinad. Silmi avades ütleb ta, et ei saa aru, kas ta mängis hirmule või ta tunneb hirmu. Ta mõtleb ja sõnastab lõpuks selle nii: tunnen hirmu hirmu ees. See on talle üllatav taipamine ja

	ajab teda segadusse. Terapeut mainib kliendile muuhulgas, et sellesse segadusse võiks aidata tuua selgust see, kui hirmu lähemalt uurida.
5	Paula ongi valmis astuma hirmu rolli. Seekord ta suleb silmad. Ta kombib algul klaverit ettevaatlikult parema käe ühe sõrmega, puudutades klahve, nagu nad võiksid puruneda. Ajapikku võtab ta kasutusele ka vasaku käe. Sõrmede vajutus klahvidel intensiivistub, klient toob kuuldavale hüplikke staccato-klastreid, mis kõlavad üsna kriipivalt, kõrvale valusalt. Vahetevahel jääb ta hoidma mõlemat kätt pikalt sõrmede alla juhtunud klahvidel, justkui hetkeks kangestudes, kuid jätkab seejärel mängu. Muusika ei moodusta fraase, helid ja akordid on pigem juhuslikud ja kaootilised. Paula lõpetab mängu ootamatult keset valju helivoogu ja ütleb: „Ei jaksa praegu rohkem." Ta ütleb, et koges imelikku tunnet: mäng justkui avanes järk-järgult rohkem, klaver sai järjest kodusemaks, kuid seespool miski justkui pigem tõmbas järjest koomale, kuniks oli selline tunne, et enam rohkem koomale see tõmmata ei saa. Seda tunnet ei olnud ta valmis kauem kogema ja otsustas seetõttu mängu lõpetada. Samuti mainib ta, et nägi mängimise ajal oma vaimusilmas mingit ruumi, mis oli üsna hägune, aga see tekitas tunde, nagu ta oleks kunagi elus seal varem olnud.
6	Terapeut peab otstarbekaks tuua klient hirmu rollist hetkeks välja, et võimaldada talle puhkepausi. Paula toob kuuldavale küsimuse: „Mida see siis nüüd tähendab?" Terapeut laseb kliendil endal sellele küsimusele vastuseid otsida. Klient vajub mõttesse ja ütleb lõpuks: „Mul on selline tunne, et ma olen millelegi väga lähedal. See hirmutab väga… ja samas erutab ka, tekitab uudishimu. See ruum mu kujutluses… see on tuttav, aga mul ei tule meelde, mis ruum see on, ei näinud seda ka hästi, justkui udu oli seal ruumis." Terapeut teeb ettepaneku: „Sul on võimalus tuua nüüd sellesse pilti veel üks tegelane, nimetagem seda *salapäraseks kolmandaks*. See on keegi või miski, mis võiks aidata sellesse olukorda tuua täiendavat selgust. Sul ei ole tarvis välja mõelda, kes või mis see on. Püüa lähtuda enda tunnetusest. Võta selleks rahulikult aega ja kui oled valmis, vali sellele *salapärasele kolmandale* üks pill." Paula esimene, vastupanu väljendav reaktsioon on: „Aga ma ei näe ju, kes selles ruumis veel on või kas seal üldse kedagi on." Terapeut selgitab, et selleks seda *salapärast kolmandat* tarvis ongi, et oleks võimalik seda kedagi või midagi sealt udust tuvastada. Paula ei liigu kaua paigalt. Ta paneb silmad kinni ja jääb nõnda mõneks ajaks istuma. Toolilt tõustes läheb ta otsejoones kõuepilli juurde, võtab selle ja asetab kolmandale toolile. Paula põrnitseb pilli ega ütle midagi. Pärast terapeudi peegeldavat sekkumist ütleb ta õlgu raputades: „See on vali, see pill ja see traat teeb niisugust häält, et juuksekarvad tõusevad püsti. Huhhh… Ei tahaks seda puudutada."
7	Terapeut väljendab mõistmist ja uurib, kas Paula oleks valmis uuesti astuma hirmu rolli ja hirmuna selle kolmandaga muusika kaudu ühendust võtma. Klient kõhkleb veidi, kuid ütleb siis, et see on veidi kergem kui *salapärase kolmanda* rolli minna. Paula soovib endiselt hirmu pillina kasutada klaverit. Klient istub klaveri taha, suleb silmad ja hakkab parema käega mängima minoorset aeglast meloodiat keskmises tessituuris. Paula silmist hakkavad voolama pisarad. Ta mängib peaaegu 3 minutit ühehäälset katkematut ebamäärast kurblikuna kõlavat viisi. Lõpetades istub ta veel mõnda aega kinnisilmi. Silmi avades ta küsib: „Kas ma võin selle kolmanda rolli minna?"
8	Paula ilme muutub *salapärase kolmanda* rolli minnes sõjakaks, ta ajab selja sirgu ning hakkab otsustavalt ja valjusti kõuepilli mängima. Mäng kestab vaid paarkümmend sekundit, misjärel klient ütleb: „See on mu isa." Selgub, et isa on kliendi lapsepõlves tarvitanud Paula suhtes nii psüühilist kui füüsilist vägivalda. Enamasti oli tegemist sõnalise alandamisega, mõista andmisega,

et Paula on saamatu ja laisk. Kui Paula julges välja öelda enda, isa omast erineva arvamuse, võttis isa seda kui vastuhakku ja karistas Paulat sageli kas nurka panemisega või pidi Paula püsima oma toas suletud ukse taga mitu tundi ega tohtinud sealt kusagile liikuda. Vahel tõusis isas nii ohjeldamatu pahameel, et ta sakutas Paulat tugevalt juustest või pigistas teda nii tugevalt, et Paula kehale jäid sellest sinised vorbid. Isa olevat olnud karistamises üsna leidlik ja Paula ei teadnud kunagi, mida sealt oodata võis.

Kokkuvõte

IST käigus mõistis Paula, kus on tema ebaturvaliste kiindumusmustrite juured. Samuti sai tema jaoks nähtavaks tõsiasi, et ta kannab hirmu isa suhtes üle enda elukaaslasele, teadvustamatult eeldades, et kui tema näoilme räägib pahameelest, võiks sellele järgneda midagi väga ebameeldivat ja hirmutavat. IST järgselt on Paulal isa suhtes ambivalentsed tunded ja nende läbitöötamine jätkus edasises teraapiaprotsessis.

Täiendavad tähelepanekud ja selgitused

Enamasti omistatakse *salapärase kolmanda* roll „olulisele teisele“ (Sullivan, 1938), näiteks emale, isale, tegelikule hoolekandjale vms. Sageli järgneb taipamine, et käesoleval ajal see isik enam niisuguseid emotsioone kliendis ei põhjusta, et klient on selle rolli endasse integreerinud ja põhjustab neid emotsioone nüüd endale ise. Saab lisanduda mõistmine, mille tõttu see „oluline teine“ minevikus niisuguseid emotsioone kliendis põhjustada võis. Sellele mõistmisele võib järgneda aktsepteerimine ja andeks andmine. Niisugused taipamised on sageli põhjapanevad ja võivad olla elu muutvad. Kui klient jõuab arusaamisele, et emotsioon või sellest tulenev seisund tuleneb iseendast, on seda võimalik ka juhtida ja muuta. Seega järgnev samm teraapiaprotsessis võibki olla selle muutuse läbiviimisega tegelemine.

Meetodit rakendades peaks terapeut olema võimalikult avatud ja paindlik ega liigselt klammerduma ülalkirjeldatud sammudesse. Iga kliendi teekond on unikaalne ja vahel ei ole kõikide sammude läbimine otstarbekas. Kui klient on valmis ja hästi motiveeritud emotsiooni päritolu mõistma ja ei rakenda enam tugevaid kaitseid, võib otsitav taipamine saabuda juba palju varasemas etapis, kui seda kirjeldab antud juhtum, näiteks juba 4. sammu vältel.

Terapeut peab olema valmis kliendi emotsioonide vallandumiseks ning omama piisavaid oskuseid klienti protsessis toetada, vajadusel reguleerida töö tempot või hoopis vahetada kasutatavat metoodikat. Samuti on hädavajalik, et terapeut oleks võimalikult eneseteadlik ning suudaks ja oskaks rakendada võimalikke vastuülekandeid teraapiaprotsessi edenemise heaks püstitatud eesmärkide suunas.

Terapeut peab suutma hinnata meetodi rakendamise otstarbekust käesolevas teraapiafaasis. Kui klient kogeb arvestatavat vastupanu või on liialt haavatav, ei pruugi IST olla parim vahend teraapias edasi liikumiseks ja vajalik on rakendada pigem toetavaid tehnikaid, et klient tasapisi, endale vajalikus tempos avaneda saaks, misjärel on alles võimalik võtta kasutusele IST.

Kui ühe teraapiasessiooni vältel ei jõuta soovitud tulemuseni, saab protsessi IST toel jätkata järgmisel korral, kui käsitletud teema siis veel aktuaalne on.

BMGIM-terapeudina näen IST ühe efektiivse rakendusvõimalusena ka BMGIM-teraapia kujutluslike protsesside vältel niisuguste üles kerkinud emotsioonide edasist läbitöötamist, mis kujutluse käigus veel juurtaipamiseni ei viinud.

Kokkuvõtteks

IST näol on tegemist efektiivse ja kiireid taipamisi võimaldava psühhodünaamilise muusikateraapia meetodiga. IST annab võimaluse läbi töötada erineva intensiivsuse ja iseloomuga emotsioone, olgu need siis inimesse talletunud varasemate pikaajaliste negatiivsete mõjutuste või traumaatiliste kogemuste endasse sulgemise tagajärjel, või lähiminevikus kogetu toimel. See, kui tulemuslik kirjeldatud sekkumine on, sõltub paljuski kliendi valmisolekust enda teadvustamata aladele liikuda ja ennast süvatasandil reflekteerida, aga loomulikult ka terapeudi tarkusest rakendada sobivaid sekkumisi sobival ajahetkel.

Meetodit rakendades on võimalik turvalisel ja efektiivsel viisil avastada ja uurida emotsioonide tagamaid ja tekkepõhjuseid, mis saab olla võtmeks nende emotsioonidega seotud psühhodünaamika mõistmisel, viies paremale eneseteadvusele, süvendades kontrollitunnet, vähendades reaktiivsust ning andes võimaluse paremaks enesejuhtimiseks üldiselt.

♦ English

In the course of providing psychodynamic music therapy, I have observed that one of the frequently encountered concerns for adults seeking self-discovery in therapy is their unexpected emotional reactions. These reactions, whose causes remain unclear to the clients, repeatedly surface, negatively affecting their quality of life and ability to cope.

Based on my experience and supporting theories, I have developed the music therapy method *Improvisational Self-Triangle* (IST) to explore the origins and psychodynamics of emotions. IST works with the relationship between the client, their emotions and a *mysterious third* through metaphorical musical improvisations. Discovering and exploring this so-called *mysterious third* often holds the key to understanding the causes of these emotions and the psychodynamics associated with them.

Theoretical basis of IST

IST is based on emotion-focused, attachment-based approach in psychotherapy. Emotionally Focused Therapy (EFT; Johnson, 2019) is an attachment-based psychotherapy that emphasizes emotional dynamics and is based on Bowlby's attachment theory (1988). The focus of attachment theory is on deep emotional bonds between individuals, particularly those between infants and their primary caregivers. According to Bowlby, attachment relationships have a biological basis, as infants instinctively seek proximity and protection from their caregivers to ensure survival. The quality of early attachments depends significantly on how consistently and sensitively a caregiver responds to the child's needs. When the caregiver is responsive and nurturing, the child is more likely to develop a secure attachment, fostering a sense of safety and trust. However, if caregivers are inconsistent or neglectful, children may develop insecure attachment patterns, which can manifest as anxiety, avoidance, or confusion. These early experiences create *internal working models* — mental frameworks that shape an individual's perception and attitude toward relationships throughout life. Attachment patterns formed in childhood often carry over into adulthood, influencing how individuals emotionally relate to others, trust others, and manage closeness in relationships.

EFT focuses on how individuals relate to their emotions and how these emotions influence personal well-being and relationships. EFT aims to enable clients to explore their emotional experiences and thus develop a deeper understanding of their feelings. This approach regards emotions as central to healing and growth, emphasizing that when people can access, understand, and express their core emotions, they can change the negative patterns in their lives (Johnson, 2019). Music therapy is highly suitable and effective in facilitating this inner process.

The IST process is also supported by Magda B. Arnold's (1960) definition of the fundamental elements of emotions, as also applied in EFT. Arnold described emotions as action tendencies: emotions and actions are linked through motivation, which is reflected in the appraisal of emotions (Mooren & Krogten, 1993). Arnold's theory is a powerful tool that enables the discovery, opening, and delineation of the client's emotional responses through the unveiling of their nature. Arnold defined the elements of emotions as follows: 1) the trigger or cue of the emotion; 2) initial perception; 3) body response; 4) meaning creation; 5) action tendency. The applicability of this theory in IST will be demonstrated in the method's description and in the case study below.

In implementing the method, one important condition must be met. The music therapist must embody the “good enough mother" (Winnicott, 1971), enabling positive transference (Freud, 1912/1958) – the client's projection of secure attachment, love, care, or other positive qualities toward the therapist that they initially experienced or ideally should have experienced toward parents or other significant individuals in childhood. At the same time, the therapeutic work with emotions and/or imagined figures inevitably brings forth negative transference (Ibid.), which the therapist must be capable of handling adequately and addressing with appropriate interventions.

Step-by-step implementation of IST

In IST, the therapy session should last at least 90 minutes to allow all the necessary steps. In IST, the splitting technique known from Analytical Music Therapy (Priestley, 1994) is used, employing the free improvisation technique (Bruscia, 1987; Wigram, 2004). The methodical structure provides for the following steps:

Step 1: The therapist enables the client to articulate the conscious themes related to the emotion in question, based on the theory of emotion appraisal (Arnold, 1960).

Step 2: The client chooses a musical instrument to represent the emotion, based on the discussion in the previous step. The client places the instrument on the chair opposite or sits in front of it if the instrument cannot be moved. The client should be given sufficient time to relate to this instrument/emotion and explains their choice of instrument.

Step 3: The client selects a musical instrument through which they will communicate with the emotion. The client explains their choice of instrument.

Step 4: The client sends his spontaneous musical message to the emotion without giving it any conscious content beforehand. (It is recommended that clients close their eyes during such improvisations to reduce external stimuli that may interfere with the process and to facilitate deeper introspection.) The client processes the experience and verbally reflects on it. The therapist makes appropriate interventions to facilitate this process.

Step 5: *Role-play:* The client takes the instrument of the emotion, sits in the emotion's chair, embodies the emotion, and expresses its nature musically. The client processes the experience and reflects on it verbally. The therapist makes appropriate interventions to facilitate this process.

Notes: Steps 4-5 may be repeated if the therapist sees the need for further exploration of this "relationship" or if the client proposes continuing the dialogue between themselves and the emotion. This can be done as many times as the therapist deems appropriate.

Step 6: The client comes out of the role of emotion, returns to their seat and reflects on what they have just experienced and learned. The client is then given the opportunity to introduce a third figure: the *mysterious third*. The client chooses an instrument for this figure, places it on an additional chair in the "scene," and positions it where they intuitively feel it belongs. The client should be given sufficient time to relate to the *mysterious third*. The client explains their choice of instrument and the underlying emotions. The therapist makes appropriate interventions to facilitate this process.

Step 7: *Role-play:* The client takes the instrument of the emotion, sits in the emotion's chair, embodies the emotion, establishes a felt connection with the *mysterious third*, and sends a musical message to the *mysterious third* without pre-formulating it. The client processes the experience and reflects on it verbally. The therapist makes appropriate interventions to facilitate this process.

Notes: If, during this step, the origin of the emotion is discovered, Step 8 becomes unnecessary. In this case, the client should be given ample time for reflection, before proceeding to Step 9.

Step 8: *Role-play*: The client takes the instrument representing the *mysterious third*, sits in the *mysterious third's* chair, embodies the *mysterious third*, and expresses its nature musically. The client reflects on the experience verbally. The therapist responds appropriately to facilitate this process.
Notes: Steps 7-8 may be repeated if the therapist sees a need for further exploration of this "relationship" or if the client suggests continuing the dialogue, as many times as the therapist deems appropriate.
It is not advisable to predetermine the course of the therapy process beyond this point. The therapist should base further interventions on the current situation, carefully evaluating which role the client should be guided into to bring them closer to the desired insight. Ideally, the process concludes when the client experiences an "aha" moment and uncovers the root cause of the emotion. To reach this point, the previous steps may be repeated as often as necessary, in the order deemed appropriate by the therapist, and within the time frame available.

Step 9: Moving toward *summary*: If necessary, the therapist offers the client the opportunity to re-enter any of the roles in the triangle and further process any related emotions or relationships.

Step 10: *Summary*: The client returns to their own chair and absorbs the experience gained throughout the process. The client reflects on the experience 1) musically and 2) verbally (the musical part may be omitted if time is limited, but verbal reflection is essential to understanding and integrating the experience).

Case Study Paula

The process and application of the IST method are presented below using the case study of 35-year-old client Paula (not her real name). A summarized description of the application process and the interactions between Paula and the therapist can be found in Table 1.

Paula is an intelligent woman with strong analytical abilities and is highly motivated for therapy. Her primary issue is the frequent, seemingly unfounded feeling of anxiety, arising in various situations. Until this point in the therapy process, the therapist primarily applied supportive interventions including receptive music therapy techniques, which feel comparatively safer to the client than active music-making. Paula has reached a stage in her process where she is ready and willing to confront her inexplicable fear and use musical instruments to do so.

Paula experiences fear particularly in her relationships with men, regardless of the role they play in her life or the level of familiarity she has with them. Paula also feels fear in relation to her partner, including fear of both intimacy and abandonment, as well as fear of her partner's potential displeasure. These fears have led Paula to act according to her partner's expectations or what she assumes he might expect of her. The therapist suggests exploring this specific fear within the relationship, as it is especially perplexing to the client, who believes that, objectively, there is no reason for her fear. Nevertheless, this feeling strongly impacts the quality of the relationship and makes Paula anxious, creating further fear that her partner might leave her.

Table 1

Case study Paula to illustrate the step-by-step implementation of IST

Step	Client's responses, actions und reactions
1	1. Trigger: Her partner responds to her question or remark with reluctance, glaring at her from beneath his brow. 2. Initial perception: He is angry with Paula, although she does not understand why. 3. Body response: Shivers, a twisting sensation in her stomach, and a feeling of being physically small (much smaller than her partner is). 4. Meaning creation: Paula believes she has done something wrong and deserves to be punished. 5. Action tendency: Paula withdraws, possibly leaves the room, and does not dare to initiate conversation with her partner afterward, waiting for him to make the first move.
2	Paula chooses the piano to represent her fear, explaining that the piano is an unfamiliar instrument to her, and the very thought of touching it is intimidating. She experiences chills, similar to the feeling of fear in her relationship.
3	Paula spends a long time searching for a suitable instrument. She listens to the sound of a maraca, touches a thunder tube, and cautiously plays a few timid sounds on a djembe. Eventually, she settles on a frame drum. Paula justifies her choice by saying that the drum has a sound loud enough to confront the fear.
4	Paula does not want to close her eyes while playing music, as the situation feels too frightening for her. She holds the drum in her left hand and plays it with her right hand. Suddenly, she stops

	playing, stands up, and grabs a drumstick. She resumes playing, producing intense, arrhythmic drum sounds with the drumstick. The improvisation lasts approximately two minutes. At the end of the improvisation, Paula closes her eyes, and a few visibly perceptible tremors pass through her body. When she opens her eyes, she says she does not understand whether she was playing to the fear or if she was feeling fear. After consideration, she eventually claims: "I feel fear of fear." This surprising realization confuses her. The therapist suggests that exploring this fear more closely might help bring her clarity.
5	Paula is ready to step into the role of fear. This time, she closes her eyes. Initially, she cautiously taps the piano keys with one finger, as if they might break. Gradually, she begins to use both hands. Her fingers press down on the keys with increasing intensity, producing abrupt staccato clusters that sound quite harsh and painful to the ear. Occasionally, she holds down the keys for a prolonged period, as if frozen, before continuing to play. The music does not form phrases; the sounds and chords seem random and chaotic. Paula suddenly stops playing in the middle of a loud sound stream and says, “I can’t take any more.” She adds that the feeling was strange: the music seemed to open up more and more, and the piano became increasingly familiar, but something inside her seemed to tighten more and more, until it felt like it could not tighten any further. She was not ready to experience this feeling any longer, so she decided to stop playing. She also mentions that while playing, she envisioned a room in her mind, which was quite hazy but gave her the feeling that she had been there before in her life.
6	The therapist considers it appropriate to bring the client out of the role of fear for a moment to provide a pause. Paula expresses the question: "What does this mean now?" The therapist allows the client to search for answers on her own. Paula reflects for a while and finally says: "I feel like I’m very close to something. It scares me a lot... and at the same time excites me, makes me curious. That room in my imagination... it’s familiar, but I can’t remember what room it is, and I couldn’t see it clearly, as if there was a fog in the room." The therapist suggests: "You now have the opportunity to bring another figure into this picture, let’s call it the *mysterious third*. It is someone or something that could help to bring further clarity to this situation. You don't need to figure out who or what it is. Try to rely on your feelings. Take your time, and when you’re ready, choose an instrument for this *mysterious third*." Paula’s first reaction is resistant: "But I don’t see anyone else in that room, or even know if there is anyone." The therapist explains that this is the purpose of the *mysterious third* – to identify someone or something from the fog. Paula remains still for a while. She closes her eyes and sits in silence for some time. Rising from her chair, she walks straight to the thunder tube, takes it, and places it on the third chair. Paula stares at the instrument but says nothing. After a reflective intervention from the therapist, she shrugs and says: "It’s loud, and the wire on the instrument makes a noise that raises the hairs on my arms... I don’t want to touch it."
7	The therapist expresses understanding and inquires whether Paula is ready to step back into the role of fear and, as fear, connect musically with the *mysterious third*. Paula hesitates briefly but then says it is slightly easier than stepping into the role of the *mysterious third*. Paula still wishes to use the piano as the instrument of fear. The client sits at the piano, closes her eyes, and begins to play a slow, minor melody with her right hand in the middle register. Tears start to flow from Paula’s eyes. She plays a continuous, vaguely sorrowful monophonic tune for almost three minutes. After finishing, she sits with her eyes closed for a while longer. When she opens her eyes, she asks, "Can I go into the role of the third?"
8	Paula's expression changes as she steps into the role of the *mysterious third*. She straightens her back and begins to play the thunder tube with determination and force. The performance lasts

only a few seconds, after which she says, "This is my father." It is revealed that her father subjected Paula to both psychological and physical abuse during her childhood. Most of the abuse was verbal, demeaning Paula by implying that she was incompetent and lazy. When Paula dared to express an opinion different from her father's, he saw it as defiance and often punished her by making her stand in a corner or stay in closed room for hours. Occasionally, his anger escalated to the point that he would pull Paula's hair or squeeze her so hard that she was bruised. Her father was inventive in his punishments, and Paula never knew what to expect next.

Conclusion

Through IST, Paula came to understand the roots of her insecure attachment patterns. She also became aware of unconsciously transferring her fear of her father onto her partner, assuming that any sign of facial displeasure might lead to something very unpleasant and frightening. Following IST, Paula experienced ambivalent feelings toward her father, and the process of working through these emotions continued in subsequent therapy sessions.

Additional Observations and Clarifications

The role of the *mysterious third* is generally attributed to a "significant other" (Sullivan, 1938), such as the mother, father, or another caregiver. Frequently, following an occurring insight, this person no longer triggers such emotions in the client. This signals that the client has integrated the role within themselves—and that the related emotions are now experienced in and of themselves. An understanding of why this "significant other" caused such emotions in the client in the past may also emerge. This realization may lead to acceptance and forgiveness. These kinds of insights are often profound and can be life-changing. If the client comes to understand that the emotion or its resulting state originates from within themselves, they may also recognize the potential to manage and change it. Thus, the next step in the therapy process may involve working on implementing this change.

When applying the method, the therapist should remain as open and flexible as possible and not be overly committed to the steps described above. Each client's journey is unique, and it is not always appropriate undergo every step. If the client is ready and highly motivated to understand the origin of the emotion and no longer employs strong defences, the sought-after insight may come as early as Step 4.

The therapist must be prepared for the release of the client's emotions and have sufficient skills to support the client in the process, regulate the pace as needed, or even switch to another method. It is also essential for the therapist to be as self-aware as possible and capable of using countertransference to advance the therapy process toward its goals.

The therapist must be able to assess the appropriateness of applying this method at the current stage of therapy. If the client is experiencing considerable resistance or is too vulnerable, IST may not be the best tool to move forward in therapy, and it may be necessary to employ more supportive techniques to allow the client to gradually open up at their own pace, after which IST can be introduced.

If the desired outcome is not achieved during a single session, the process can be continued in following sessions, using IST if the theme remains relevant. As a BMGIM (The Bonny Method of Guided Imagery and Music) therapist, I also view the application of IST as effective for further working through emotions arising during BMGIM therapy processes and which have not yet led to deeper insights.

Conclusion

IST is a psychodynamic music therapy method that enables immediate insights. It offers the opportunity to process emotions of varying intensity and nature that result from internalized, long-term negative influences, traumatic experiences or current events. The effectiveness of the method depends largely on both the client's readiness to explore the unconscious and reflect deeply on themselves, and the therapist's ability to apply appropriate interventions adequately. The application of the method is designed to enable the origins and dynamics of emotions to be explored and understood in a safe and effective way. Understanding and decoding the psychodynamics of one's own emotions can lead to greater self-awareness, a stronger sense of control, less reactivity, and better overall self-regulation.

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Tegenoverdracht in Austin Vocal Psychotherapy

Countertransference in Austin Vocal Psychotherapy

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Samenvatting

Tegenoverdracht helpt de muziektherapeut te begrijpen wat de cliënt *tussen de regels* communiceert. In de toepassing van Austins Vocal Psychotherapy zijn de tegenoverdrachtsgevoelens die ik ervaar, sterker dan deze bij instrumentale improvisaties in muziektherapie, in het bijzonder bij het gebruik van de *vocal holding* techniek en de *free associative singing* techniek. Vanuit literatuur en via analyse van klinisch werk ga ik in dit artikel op zoek naar een mogelijke verklaring van dit fenomeen. Deze omvat mijns inziens vier elementen: het gebruik van de stem, de fysieke nabijheid tussen cliënt en therapeut, de parallel tussen vocal holding en een moeder-babyrelatie en tenslotte de techniek van free associative singing die een vlotte afwisseling tussen perspectieven faciliteert voor de therapeut.

Trefwoorden: tegenoverdracht – Austin Vocal Psychotherapy – vocal holding – free associative singing

Abstract

Countertransference helps the music therapist understand what the client communicates *between the lines*. In Austin Vocal Psychotherapy I have found countertransference feelings to be stronger than those in instrumental improvisations in music therapy, especially when using the vocal holding technique and the free associative singing technique. Starting from literature on countertransference in music therapy, I describe my understanding of this phenomenon through analysis of examples from clinical case work. In my opinion, a possible explanation includes four elements: the use of the voice, the physical closeness of client and therapist, vocal holding as a parallel to the mother-infant relationship, and free associative singing enabling the therapist to switch swiftly between perspectives.

Keywords: countertransference – Austin Vocal Psychotherapy – vocal holding – free associative singing

♦ Nederlands

Maroda (1991) definieert tegenoverdracht als de bewuste en onbewuste reacties – zowel affectief als cognitief – van de therapeut op de patiënt. Priestley (1994) onderscheidt drie types van tegenoverdracht. *Klassieke tegenoverdracht* is de overdracht van de therapeut naar de cliënt. Deze treedt op wanneer de therapeut onbewust eigen relaties uit het verleden herbeleeft en deze ervaringen op de relaties van de cliënt projecteert. *C-tegenoverdracht*, naar analogie met "complementaire identificatie" beschreven door Racker (1968), beschrijft Priestley als de identificatie door de therapeut met één van de introjecten van de cliënt. Tenslotte is er sprake van *E-tegenoverdracht* (empathische tegenoverdracht), naar analogie met de "concordante identificatie" beschreven door Racker, wanneer de therapeut mee resoneert met de gevoelens van de cliënt, via een emotionele en/of somatische gewaarwording. Priestley stelt dat bepaalde E-tegenoverdracht zich enkel manifesteert tijdens improvisaties.

Austin Vocal Psychotherapy

Bij *Austin Vocal Psychotherapy* (Austin, 1998; 1999; 2008) wordt in de therapeutische relatie gebruik gemaakt van de adem, natuurlijke geluiden, vocale improvisaties, liederen en dialoog, met als doel intrapsychische en interpersoonlijke verandering en groei te faciliteren (Austin, 2022). *Austin Vocal Psychotherapy* heeft twee kenmerkende technieken: de *vocal holding* en de *free associative singing techniek*. Beide worden verder in de tekst kort toegelicht.

Als tegenoverdrachtsgevoelens intenser blijken in *Austin Vocal Psychotherapy*, welke mogelijke factoren dragen hier dan toe bij? Een mogelijke verklaring van dit fenomeen omvat mijns inziens vier elementen: het gebruik van de stem, de fysieke nabijheid tussen cliënt en therapeut, de parallel tussen vocal holding en een moeder-babyrelatie en tenslotte de techniek van *free associative singing* die een vlotte afwisseling tussen perspectieven faciliteert voor de therapeut.

Het gebruik van de stem

Het gebruik van de stem door zowel cliënt als therapeut betekent dat beiden hun meest persoonlijke muziekinstrument inzetten. Muzikale improvisaties vormen een transitionele ruimte zoals beschreven door Winnicott (1971). In het samen zingen is de emotionele en vaak ook fysieke afstand in de therapeutische dyade kleiner. Er is een grotere intimiteit door het gebruik van het lichaam als het primaire muziekinstrument (Austin, 2008).

Fysieke nabijheid tussen client en therapeut

Zowel bij *vocal holding* als bij *free associative singing* zitten cliënt en therapeut naast elkaar aan de piano. Dit brengt de therapeut letterlijk dichter bij het perspectief van de cliënt. Daarnaast deelt men, wanneer men samen zingt, niet enkel geluiden, maar ook trillingen (Austin, 2008). Er is de fysieke sensatie van consonanten en dissonanten; boventonen dragen bij tot de ervaring van onderdompeling in de samenklank. De fysieke nabijheid wordt gecombineerd met emotionele nabijheid, door samen te ademen, zingen en resoneren.

Parallel tussen *vocal holding* en moeder-babyrelatie

De *vocal holding* techniek omvat het gebruik van twee akkoorden in combinatie met de stem van de therapeut, met als doel een consistente en stabiele muzikale omgeving te creëren die improviserend zingen faciliteert.

Vocal holding vertoont veel gelijkenissen met de interactie tussen moeder en baby. Er worden geen woorden gebruikt, enkel de adem en vocale klanken. De therapeut stemt de eigen toonhoogte, volume, pulsering en ritme af op de klanken van cliënt. Door middel van specifieke technieken als *grounding*, *mirroring* en *harmonizing* past de therapeut zich aan de noden van de cliënt aan.

Hierdoor ontstaat een transitionele ruimte waarbinnen overdracht en tegenoverdracht zich gemakkelijker manifesteren. Maar is dit enkel te wijten aan muzikale gelijkenissen met een ouder-kindrelatie? Hoe kunnen we dit begrijpen?

Een mogelijke verklaring vinden we bij Lecourt (1998):

> »In this [mother-infant] relationship, the voice, the melody, and the rhythm can serve as signifiers, and their aesthetic forms can be engraved in the child's memory as therapeutic potentialities. Beauty, then, is linked to the mother's love. […] We can say that a concordant identification in music therapy is an experiment in love wherein a musical characteristic, such as timbre or rhythm, serves as a signifier […] and, as such, provides opportunities for the therapist not only to hear and understand them within the concordant identification but also to respond to them within the complementary identification as the caregiving mother.« (Lecourt, 1998, p.150f.)

Casus: Sofia[1]

Sofia's ouders scheidden toen ze zes was. Ze groeide op met haar moeder; op haar zestiende ging ze voor een jaar naar het buitenland en op haar achttiende trok ze definitief het huis uit. Ze verhuisde meermaals naar een andere stad, land of continent; vaak liet ze alles en iedereen achter om elders opnieuw te beginnen. Sofia spreekt hierover op een luchtige manier, alsof het allemaal gemakkelijk is geweest.

> *Sofia kiest twee akkoorden, C en Em, in een traag tempo, die ik op de piano speel. Ze begint zachtjes te neuriën, twee alternerende noten in een laag register. In unisono neurie ik met haar mee. Sofia klinkt eerder melancholisch; ze lijkt voor zichzelf te zingen. Ze maakt geen oogcontact. Ik voel eenzaamheid en verdriet.*

Hoewel we unisono zingen, ervaar ik Sofia als in zichzelf gekeerd. Het zijn wellicht haar verdriet en eenzaamheid die in mij mee resoneren (E-countertransference).

> *Na enkele minuten unisono breidt Sofia de notenreeks uit, terwijl ik de alternerende noten aanhoud. De klank evolueert naar "ah" en "ooh"; we wiegen allebei zachtjes heen en weer. Sofia verandert naar een nieuwe, herhaalde melodie. Ik blijf enige tijd de twee noten zingen. Dan start ik een herhaalde dalende sequens, waarbij een voorbijgaande dissonant met Sofia's melodie ontstaat. Sofia*

[1] All client names mentioned in this article have been changed to ensure anonymity.

> *neemt mijn melodie over en elimineert op die manier de dissonant. Ik heb het gevoel dat ze mij aanhaalt.*

Wanneer ik de opname achteraf beluister, valt het me op dat de verandering in mijn melodie onverwacht komt; het klinkt alsof ik weg ga van Sofia. Ik hoor een duidelijk verschil met de muzikale interventies die ik gewoonlijk maak. Dit zou kunnen verklaard worden als identificatie met het introject van Sofia's moeder, die niet altijd emotioneel beschikbaar was toen Sofia een klein meisje was (C-tegenoverdracht). Het is belangrijk dat ik Sofia's aanwijzingen volg om naderbij te komen.

> *Onze melodieën komen weer bij elkaar in unisono. We blijven "ooh" en "ah" klanken zingen, die na enkele minuten groeien in een crescendo. Sofia zingt nog steeds in het lage register, haar mond wat meer open, met een klagend geluid. Ik pas grounding toe met een standvastige melodie; ik voel dat ik dicht bij Sofia ben en haar muzikaal vast houd. Sofia lijkt voldoende veiligheid te ervaren om muzikaal op ontdekking te gaan. We doen enige tijd harmonizing; vervolgens worden onze melodieën rustiger en onze klanken zachter. Ik volg Sofia's tempo. In de loop van een langgerekte diminuendo schakelen we weer over op neuriën en beëindigen de improvisatie.*
>
> *In de bespreking zegt Sofia dat ze initieel druk op haar stem voelde, alsof haar keel werd dicht geknepen. Ze kijkt me aan en ziet er erg kwetsbaar uit; dan wendt ze haar blik af met tranen in de ogen.*
>
> *Ze heeft opgemerkt dat ik haar aankeek tijdens de improvisatie, maar zegt dat ze oogcontact te moeilijk vindt en begint te huilen. Ze verwijst naar de blik van haar moeder, zonder verdere uitleg.*

Wanneer ik achteraf de opname beluister, zie ik het beeld van een jonge vrouw die alleen door een woud wandelt, pas na een tijd opmerkt dat ze niet alleen is, en dan mijn aanwezigheid accepteert. Ik ben me bewust van moedergevoelens jegens haar. Vanaf dat moment *wandelen we samen door het woud*: ze laat mijn nabijheid toe en zoekt ze zelfs op, bijvoorbeeld wanneer ze de dissonant oplost – die is op dat moment misschien onverdraaglijk voor haar.

Het beeld van een jonge vrouw alleen in het woud herinnert me aan Sofia die als tiener de wijde wereld in trok; hoe ze haar eigen weg zocht (wandelen door het woud) met enkel zichzelf om op terug te vallen (de aanwezigheid van de ander niet opmerken/accepteren). Dit kunnen we begrijpen als een herhaling van het verleden in de improvisatie. Dit keer, echter, is het script aangepast: Sofia kiest ervoor om niet alleen te blijven.

Free associative singing

Free associative singing beduidt een techniek die gelijkenissen vertoont met vrije associatie in psychoanalyse, maar die ervan verschilt door het feit dat de cliënt zingt in plaats van te spreken, en waarin ook de therapeut zingt. De therapeut draagt via actieve verbale en muzikale interventies bij aan de muzikale stroom van bewustzijn (Austin, 2008).

Bij het gebruik van deze techniek heb ik gemerkt sterk gefocust te zijn bij de start van de sessie (ademhalingsoefeningen, keuze van de akkoorden), maar, eens de improvisatie is gestart, in een *groothoek*-geestestoestand terecht te komen. Deze toestand kunnen we begrijpen in het licht van wat Austin (2008) beschrijft als de keuze om zichzelf open te stellen voor het onderbewuste van

de cliënt. Het is gelijkaardig aan een rêverie: in deze toestand neem ik als therapeut gemakkelijker tekenen van overdracht waar bij de cliënt, en tegenoverdrachtsgevoelens bij mezelf.

Bij free associative singing reageert de therapeut door middel van verbale en muzikale (dit wil zeggen gezongen) interventies op wat de cliënt zingt. Het is daarom belangrijk dat de therapeut de meanderende associaties van de cliënt volgt maar terzelfdertijd de draad van het therapeutisch proces vast houdt. De therapeut staat als het ware met één voet in en één voet buiten het gebeuren.

Het is opnieuw Lecourt (1998) die me helpt hoe dit te begrijpen:

> »The first experience of passivity and receptivity occurs when the infant is rocked by the mother; the first experience of activeness occurs when the baby sings softly in his cradle. These are two parts of the same experience, the first providing the basis for the second. For the infant (and patient), moving from receptivity to activeness requires creativity; for the mother (and therapist), the question is what role should be taken in between.« (Lecourt, 1998, p.155)

Casus: Thomas

Thomas is een jonge man die is vastgelopen op vlak van verschillende ontwikkelingstaken. Hij ervaart hierrond veel frustratie en soms totale inhibitie om tot iets te komen. Er is sprake van algemene depressieve gevoelens.

> *Thomas zingt in een lage tessituur geruime tijd over hoe depressief hij zich voelt. Hij vraagt zich, zingend, af hoe hij zijn situatie kan veranderen. Ik spiegel hem, door zijn woorden (net als hij in de ik-vorm) te herhalen, eveneens in een lage tessituur. Hij bezingt zijn frustraties over het gebrek aan vrienden en over het niet komen tot een studiekeuze. Ik spiegel ("mirroring"). Deze dialoog duurt ruim tien minuten. Ik voel een zwaarte, alsof iets me in een diepe poel naar beneden trekt en ik niet bij machte ben om naar het oppervlak te zwemmen. Ik word een spanning gewaar in mijn nek en armen. Ik voel dat ik niet lang in deze toestand wil blijven. Af en toe voeg ik enkele noten in een hogere tessituur toe. Ik wissel de lage tessituur (die Thomas' depressieve gevoelens symboliseert) en de hogere – voor mijn stem meer comfortabele – tessituur af, en geef ons beiden daarmee wat zuurstof).*

Wanneer ik de indruk heb dat Thomas zich voldoende vastgehouden en ondersteund voelt om wat uitdaging te kunnen verdragen, introduceer ik stilaan kleine variaties wanneer ik zijn woorden herhaal.

> Thomas: *"Ik ben helemaal alleen"*.
> Therapeut, zelfde melodie: *"Ik voel me zo alleen"*.
> Thomas: *"Ik voel me zo alleen"*.
> (…)
> Thomas: *"Er is niemand die me helpt"*.
> Therapeut, zelfde melodie: *"Wie helpt mij?"*.
> Thomas: *"Wie helpt mij?"*.
> Therapeut: *"Ik heb hulp nodig, ik kan dit niet alleen"*.
> Thomas: *"Ik kan dit niet alleen. Help mij"*.
> Therapeut: *"Ik kan dit niet alleen. Help mij"*.

Bij free associative singing kan de cliënt de interventie van de therapeut herhalen wanneer deze als juist aanvoelt. Thomas herhaalt enkele zinnen; hij keert echter steeds terug naar zijn depressieve thema's. Hij is nog niet klaar om op eigen houtje de andere kant te exploreren, maar wanneer deze hem wordt aangereikt (zoals een moeder haar kind kleine hapjes van een nieuw gerecht aanbiedt), *proeft* hij ervan, vertrouwend op de goede bedoelingen van de therapeut.

In de tegenoverdracht voel ik dat ik deze droevige kleine jongen nabijheid wil bieden en vast houden; ik voel echter ook de neerwaartse kracht die uitgaat van de depressie, en het risico erin verstrikt te geraken. Naar mijn inschatting is het belangrijk, en misschien zelfs van levensbelang, dat Thomas de mogelijkheid (her)ontdekt om naar de oppervlakte te komen en frisse lucht te happen. Ik wissel af tussen beide posities.

Besluit

In de toepassing van *Austin Vocal Psychotherapy* ervaar ik sterkere tegenoverdrachtsgevoelens dan bij instrumentale improvisaties in muziektherapie. Een mogelijke verklaring van dit fenomeen omvat m.i. vier elementen – het gebruik van de stem, de fysieke nabijheid van cliënt en therapeut, de parallel tussen vocal holding en een moeder-babyrelatie en de techniek van free associative singing – die een vlotte afwisseling tussen perspectieven faciliteert voor de therapeut. In dit artikel heb ik deze vier elementen toegelicht vanuit reflectie op literatuur en aan de hand van illustraties met casuïstiek.

In de toekomst wil ik verder onderzoeken welke factoren in het gebruik van de stem precies bijdragen aan de sterkere tegenoverdrachtsgevoelens, aan de hand van literatuurstudie, casuïstiek en samenwerking met collega-muziektherapeuten. Daarnaast zou het interessant zijn om deze bevindingen te extrapoleren naar een groepssetting.

♦ English

According to Maroda (1991), countertransference is defined as the conscious and unconscious responses – both affective and cognitive – of the therapist to the patient.

Priestley (1994) identifies three types of countertransference. *Classical countertransference* is the therapist's transference toward the client. It occurs when the therapist unconsciously relives their own past relationships, and projects these experiences onto the client's relationships. *C-countertransference*, in analogy with "complementary identification" as described by Racker (1968), occurs when the therapist identifies with one of the client's introjects. *E-countertransference* (or empathic countertransference), which Priestley links to Racker's "concordant identification", is described as a therapist's sympathetic resonance of some of the client's feelings through their own emotional and/or somatic awareness. Priestley states that some e-countertransference manifestations only appear while the music therapist is improvising.

Austin Vocal Psychotherapy

In *Austin Vocal Psychotherapy* (Austin, 1998; 1999; 2008), breath, natural sounds, vocal improvisation, songs and dialogue are used within a therapeutic relationship to facilitate intrapsychic and interpersonal change and growth (Austin, 2022). *Austin Vocal Psychotherapy* uses

two characteristic techniques: the *vocal holding technique* and the *free associative singing technique*, both of which will be briefly explained below.

If countertransference feelings appear to be more intense in *Austin Vocal Psychotherapy*, then which factors might contribute to this? In my opinion, a possible explanation includes four elements: the use of the voice, the physical nearness of client and therapist, vocal holding as a parallel to the mother-infant relationship, and free associative singing enabling the therapist to alternate swiftly between perspectives.

The use of the voice and the body as primary instruments

Both the client and the therapist, by using their voices, bring in their most personal musical instrument. Musical improvisations form a transitional space as described by Winnicott (1971). By singing together there is less distance between the therapeutic dyad, both emotionally and often physically. There is an increased intimacy because of using the body as the primary instrument (Austin, 2008).

Physical nearness of client and therapist

In both the vocal holding and the free associative singing technique, client and therapist sit next to each other at the piano. This position brings the therapist literally closer to the client's perspective. Moreover, when singing with someone, you are not only sharing sounds but also vibrations (Austin, 2008). The physical nearness of client and therapist intensifies the experience of resonating with one another. Both consonants and dissonants are felt on a very physical level, and overtones contribute to the experience of being immersed in the harmonies. The physical closeness of sitting next to each other is combined with the emotional closeness engendered by breathing, singing and resonating together.

Vocal holding as a parallel to the mother-infant relationship

The *vocal holding technique* in Austin Vocal Psychotherapy involves the intentional use of two chords in combination with the therapist's voice in order to create a consistent and stable musical environment that facilitates improvised singing within the client-therapist relationship. Vocal holding has many similarities to a mother-baby interaction. No words are used, only breathing and vocal sounds. The therapist attunes to the client's music in terms of pitch, volume, pace and rhythm. By using specific techniques (such as *grounding*, *mirroring* and *harmonizing*), the therapist adapts to the client's needs in a musical interplay.

This creates a transitional space where transference and countertransference are likely to occur. But is it only because of these similarities that they often carry aspects of a parent-child relationship? How should this be understood? A possible explanation can be found in Lecourt (1998):

> »In this [mother-infant] relationship, the voice, the melody, and the rhythm can serve as signifiers, and their aesthetic forms can be engraved in the child's memory as therapeutic potentialities. Beauty, then, is linked to the mother's love. […] We can say that a concordant identification in music therapy is an experiment in love wherein a musical characteristic, such as timbre or rhythm, serves as a signifier […] and, as such, provides opportunities for the therapist not only to

hear and understand them within the concordant identification but also to respond to them within the complementary identification as the caregiving mother.« (Lecourt, 1998, p.150 f.)

Case work: Sofia

Sofia's parents divorced when she was a little girl. Sofia grew up with her mother; as a teenager, she left her home to discover the world. She moved to different cities and countries several times, leaving behind places and people, and often starting from anew. Sofia speaks about leaving home and going to live in another continent at a young age in a light-hearted way; as if it were all easy.

> *Sofia picks the C and Em chords and a slow pace. She starts humming, very softly, two alternating notes in a low register. I hum in unison with her. Sofia's sound is rather melancholic, she seems to be singing to herself. She doesn't make eye contact. I get a sense of loneliness that makes me feel sad.*

Although we hum in unison, I feel Sofia as being on her own. The sadness and loneliness I feel, are probably hers, which I resonate with (E-countertransference).

> *We continue humming unison for some time, then Sofia changes to a repeated four-notes-melody while I continue to hum the initial two notes. The sounds evolve to "ah" and "ooh"; Sofia moves to a new, repeated melody. I continue to sing the two notes for some time. Then I start a repeated descending four-notes-melody, which at one point creates a passing-by dissonance to Sofia's melody. Sofia switches to singing unison with me, and in doing so, she eliminates the dissonance. I feel pulled towards her.*

When listening back to the recording afterwards, I notice that the change in my melody comes quite unexpected, and it sounds like stepping back from Sofia's melody. It is different from musical interventions I usually make. It could be explained as identifying with Sofia's introject of the mother who was not always emotionally available for her when she was a little girl (C-transference). It is important that I followed Sofia's indications of wanting me (musically) close to her.

> *Our melodies come together again in unison. We continue "ooh" and "aah" sounds and after some minutes there is a crescendo. Sofia keeps singing in the low register, her mouth more open, with a weeping sound. I do grounding with a steady melody. It feels like a safe space, I feel being near to Sofia and holding her. Sofia seems to have more space to explore musically. We keep on harmonizing for some time, then our melodies become more quiet and we start a long and slow diminuendo. Our sounds become softer, we return to humming. I feel it's important to go slowly. The improvisation ends.*

> *When discussing the improvisation, Sofia says she felt pressure on her voice at the start, her throat feeling pinched. She looks at me and seems very fragile; then she looks away with tears in her eyes.*

> *She reports having noticed my looking at her during the improvisation; she says she finds eye contact too difficult and starts to cry. She refers to the look of her mother without any further explanation.*

When listening back to the recording afterwards, I have an image of a young woman, wandering alone in a wood and, only after some time, noticing she's not alone and accepting my presence. I am aware of motherly feelings towards her. From that moment on, we *walk through the wood together*: she allows me to be near, she even seeks the nearness (e.g. when resolving the dissonant, which maybe is unbearable for her at that moment).

The image of a young woman walking in the wood without noticing the presence of another person (therapist – mother) reminds me of Sofia leaving home for a year at the age of 16, and again, definitely, at 18, searching her own way (walking in the wood), relying only on herself (not noticing/accepting the other). It could be seen as a recreation of the past. However, this time, the script is changed, and Sofia seeks help (from the therapist) to be near her while finding her path.

Free associative singing

Free associative singing describes a technique similar to free association in psychoanalysis, from which it differs in that the client sings instead of speaking, and the therapist sings as well, contributing to the musical stream of consciousness through active verbal and musical interventions.

In using this technique, I have noticed to be much focused when starting the session (breathing exercises, picking the chords), but, once the improvisation has begun, entering a *wide-angle* state of mind. This state can be understood in terms of what Austin (2008) describes as a choice to open oneself to the client's unconscious. It is similar to a *rêverie*, as it facilitates picking up transference signs from the client and accessing the therapist's own countertransference feelings.

During free associative singing, the therapist makes verbal and musical interventions in what the client sings. Therefore, it is important for the therapist to follow the clients' meandering associations while also keeping the therapeutic process on track. The therapist needs to maintain the balance between one foot in and one out. Again, reading Lecourt (1998) helps me grasp some of the meaning:

> »The first experience of passivity and receptivity occurs when the infant is rocked by the mother; the first experience of activeness occurs when the baby sings softly in his cradle. These are two parts of the same experience, the first providing the basis for the second. For the infant (and patient), moving from receptivity to activeness requires creativity; for the mother (and therapist), the question is what role should be taken in between.« (Lecourt, 1998, S. 155)

In the continuous process of deciding what role to take, the therapist may alternate swiftly between holding, containing and supporting the client (receptivity) on the one hand, and inviting, encouraging and challenging them (activeness) on the other.

Case work: Thomas

Thomas is a young man who seems stuck in certain developmental tasks. He feels frustrated and sometimes totally inhibited; overall, he feels depressed.

> *Thomas sings in a low range for quite a long time about feeling depressed and wonders, singing, how to change his situation. I mirror him, repeating his words (using the first-person perspective just as he does), and singing in a low range as well. He sings about his frustration about being unable to make new friends, and about his total inhibition regarding decisions about where and what to study. I continue to mirror him, and we go on like this for more than ten minutes. I feel a heaviness, as if something is pulling me down into a deep pool and I'm unable to swim to the surface. I am aware of a tension in my neck and arms. I have the feeling that I don't want to stay there for a long time. I begin*

> *to sing in a higher range occasionally. I continue to alternate the low range (his range, symbolizing his depressed feelings) with a higher and, to me, more comfortable range (offering both him and myself some 'oxygen').*

When I feel that Thomas has been sufficiently contained and supported to bear some challenge, I start introducing slight variations in repeating his words.

> Thomas: *"I am all alone."*
> Me, same melody: *"I feel so alone."*
> Thomas: *"I feel so alone."*
> (…)
> Thomas: *"There's nobody to help me."*
> Me, same melody: *"Who's there to help me?"*
> Thomas: *"Who's there to help me?"*
> Me: "*I need help, I can't do this by myself."*
> Thomas: *"I can't do this by myself. Help me."*

In free associative singing, the client may decide to repeat the therapist's phrase when they feel the intervention fits. Thomas repeats some phrases; however, he keeps returning to his depressed themes. He isn't ready yet to explore the other side, but when it is offered to him (like a mother offering a bit of new food to an infant), he *tastes* it, trustful of the therapist's intentions.

I notice countertransference feelings of wanting to be near and hold this sad boy's feelings, but also of being pulled down, risking being unable to escape. I estimate it to be important, maybe vital, for Thomas to (re)discover the option of getting up to the surface and inhaling fresh air. I alternate between both positions.

Conclusion

In *Austin Vocal Psychotherapy*, I have found countertransference feelings often to be more intense than in instrumental improvisations in music therapy.

In my opinion, a possible explanation includes four elements—the use of the voice, the physical nearness of client and therapist, vocal holding as a parallel to the mother-infant relationship, and free associative singing—enabling the therapist to alternate swiftly between perspectives. In this article, I have clarified these four elements, reflecting on literature and illustrating with case work.

In the future I'd like to investigate which specific factors in the use of the voice contribute to the phenomenon of more intense countertransference feelings; this investigation will be based upon literature, case work and collaboration with other music therapists. Furthermore, it would be interesting to extrapolate these findings to group settings.

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Behaalde in 1997 een master in muziektherapie aan de LUCA School of Arts te Leuven, België. Ze heeft voornamelijk in de geestelijke gezondheidszorg gewerkt, zowel in residentiële zorg als in dagbehandeling, in België en Italië. Werkte met diverse doelgroepen, waaronder mensen met persoonlijkheidsstoornissen, mensen met een verstandelijke beperking en psychische problemen, en adolescenten. 2022 Austin Vocal Psychotherapy Distance Training af in de UK. Momenteel werkt ze in Leuven, België, in een psychotherapeutisch dagcentrum voor volwassenen met persoonlijkheidsstoornissen.

Graduated with a Master's degree in Music Therapy from LUCA School of Arts in Leuven, Belgium, in 1997. She has primarily worked in mental health care, both in residential settings and day hospitals, in Belgium and Italy, with diverse populations, including people with personality disorders, people with mental disability and mental health problems, as well as adolescents. Completed the Austin Vocal Psychotherapy Distance Training in the UK in 2022. She currently works in a day hospital for adults with personality disorders in Leuven, Belgium.

Reflections on being a multilingual music therapist

Refleksjoner rundt det å være en flerspråklig musikkterapeut

Reflexões sobre ser um musicoterapeuta multilíngue

Reflexionen aus dem Alltag einer mehrsprachigen Musiktherapeutin

Maren Metell

Universitet i Bergen, Griegakademiet, Bergen, Norwegen

Abstract

This series of images shares reflections from a multilingual everyday life. The images depict personal experiences and present multilingualism as a privilege, challenge and opportunity, both personally and politically.

Keywords: multilingualism – translation – power structures – privilege and frustration

Sammendrag

Denne bildeserien deler refleksjoner fra en flerspråklig hverdag. Bildene skildrer personlige erfaringer og presenterer flerspråklighet som et privilegium, en utfordring og en mulighet, både personlig og politisk.

Nøkkelord: flerspråklighet – oversettelse – maktstrukturer – privilegier og frustrasjon

Resumo

Esta série de imagens compartilha reflexões de uma vida cotidiana multilíngue. As imagens retratam experiências pessoais e apresentam o multilinguismo como um privilégio, um desafio e uma oportunidade, tanto pessoal quanto politicamente.

Palavras-chave: multilinguismo – tradução – estruturas de poder – privilégio e frustração

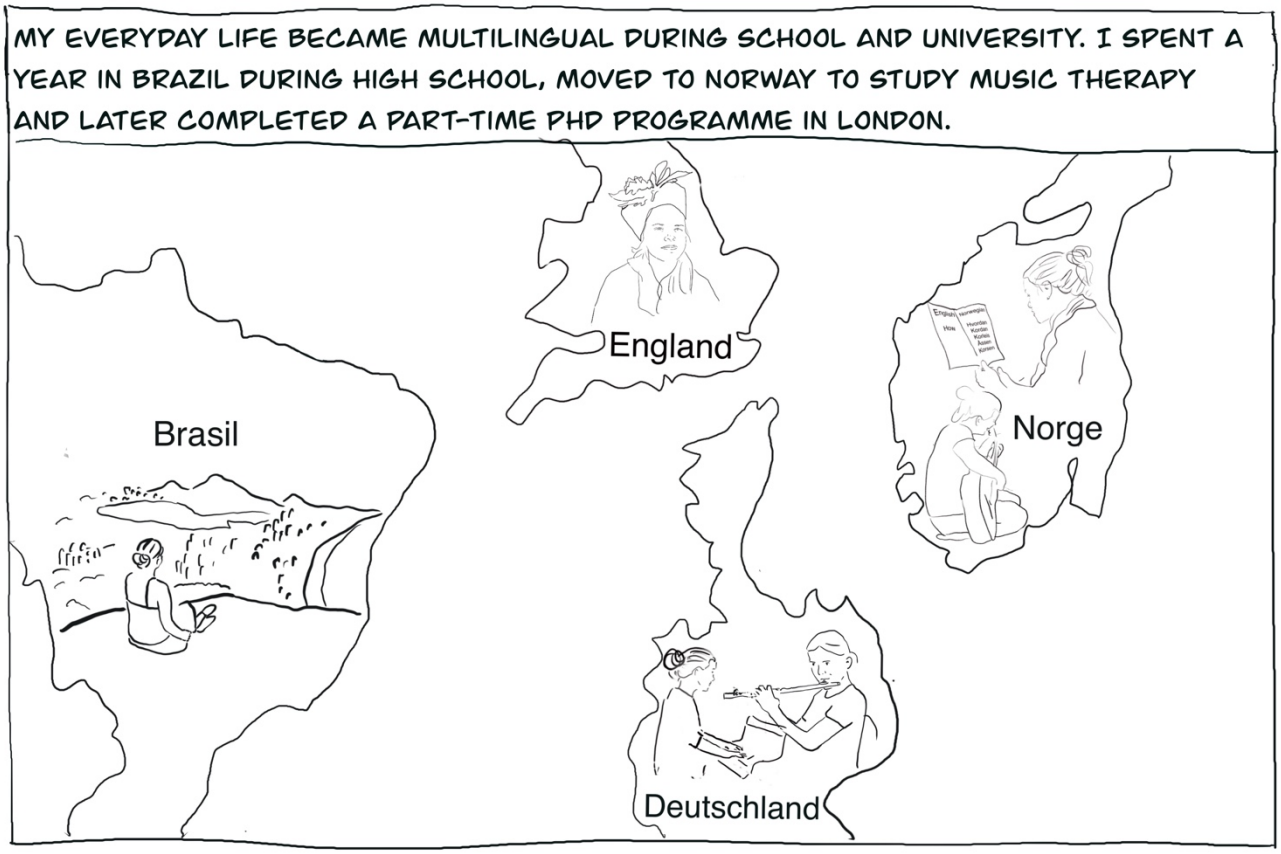
Zusammenfassung

Diese Bilderserie teilt Reflexionen aus einem mehrsprachigen Alltag. Die Bilder schildern persönliche Erfahrungen und präsentieren Mehrsprachigkeit als Privileg, Herausforderung und Chance, sowohl persönlich als auch politisch.

Schlüsselwörter: Mehrsprachigkeit – Übersetzen – Machtstrukturen – Privileg und Frustration

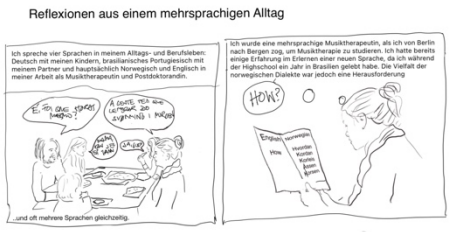
♦ English


I SPEAK FOUR LANGUAGES IN MY EVERYDAY LIFE: GERMAN WITH MY CHILDREN, BRAZILIAN PORTUGUESE WITH MY PARTNER AND MAINLY NORWEGIAN AND ENGLISH IN MY WORK AS A MUSIC THERAPIST IN A SCHOOL AND AS A POSTDOCTORAL RESEARCHER AT THE UNIVERSITY OF BERGEN.
É QUE HORAS MESMO?
A GENTE TEM QUE LEMBRAR DO SVØMMING I MORGEN!
KAN JEG FÅ MER?
JA, GLEICH!
...AND OFTEN SEVERAL LANGUAGES AT THE SAME TIME.


MY EVERYDAY LIFE BECAME MULTILINGUAL DURING SCHOOL AND UNIVERSITY. I SPENT A YEAR IN BRAZIL DURING HIGH SCHOOL, MOVED TO NORWAY TO STUDY MUSIC THERAPY AND LATER COMPLETED A PART-TIME PHD PROGRAMME IN LONDON.
England
Brasil
Norge
Deutschland

TRANSLATING IS A CONSTANT PROCESS IN MY EVERYDAY LIFE.

TRANSLATING FROM ONE LANGUAGE TO ANOTHER,

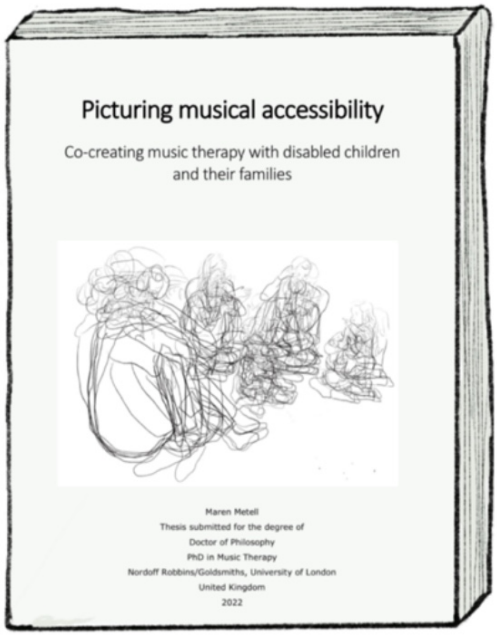


FROM PRACTICE TO RESEARCH AND VICE VERSA,

OF VIDEO RECORDINGS, MUSIC AND WORDS INTO IMAGES.

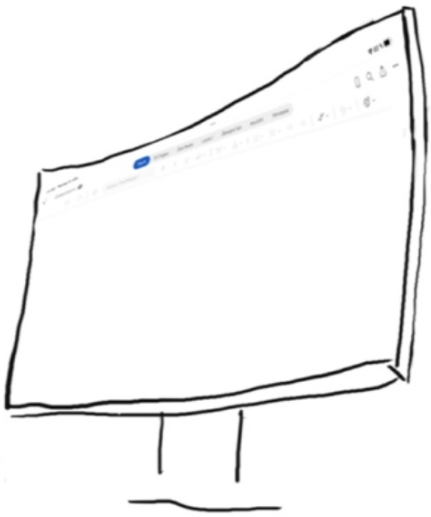
WHEN I AM IN A DIFFERENT CULTURAL CONTEXT OR WORKING WITH PEOPLE WITH A DIFFERENT MOTHER TONGUE, IT DOES SOMETHING TO THE RELATIONSHIP. BOTH BECOME LEARNERS AND TEACHERS AT THE SAME TIME.

ACCESS TO DIFFERENT LANGUAGES ALLOWS ACCESS TO DIFFERENT IDEAS AND CONCEPTS – THIS IS A PRIVILEGE, BUT ALSO A SOURCE OF FRUSTRATION.

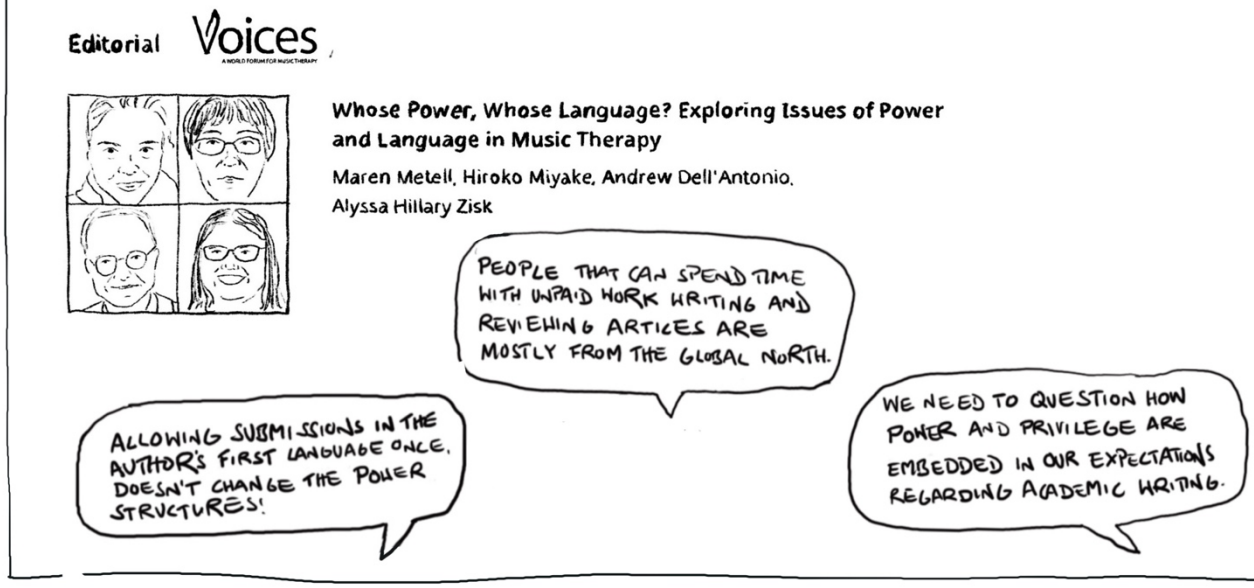


FOR EXAMPLE, 'ACCESSIBILITY' IS A CENTRAL TERM IN MY DOCTORAL THESIS, WHICH TRANSLATES WELL INTO PORTUGUESE, BUT LESS WELL INTO GERMAN AND NORWEGIAN, BECAUSE INDIVIDUAL WORDS ARE EMBEDDED IN A COMPLEX SYSTEM OF CULTURE AND CONTEXT.

FOR ME, SPEAKING AND WRITING DIFFERENT LANGUAGES OFTEN MEANS THAT I DON'T FEEL I CAN ACTUALLY EXPRESS MYSELF WELL IN ANY OF THEM. IN THE FIRST FEW YEARS, I COULDN'T DO IT IN ENGLISH AND NORWEGIAN, AND THEN AT SOME POINT I COULDN'T DO IT IN GERMAN ANYMORE.



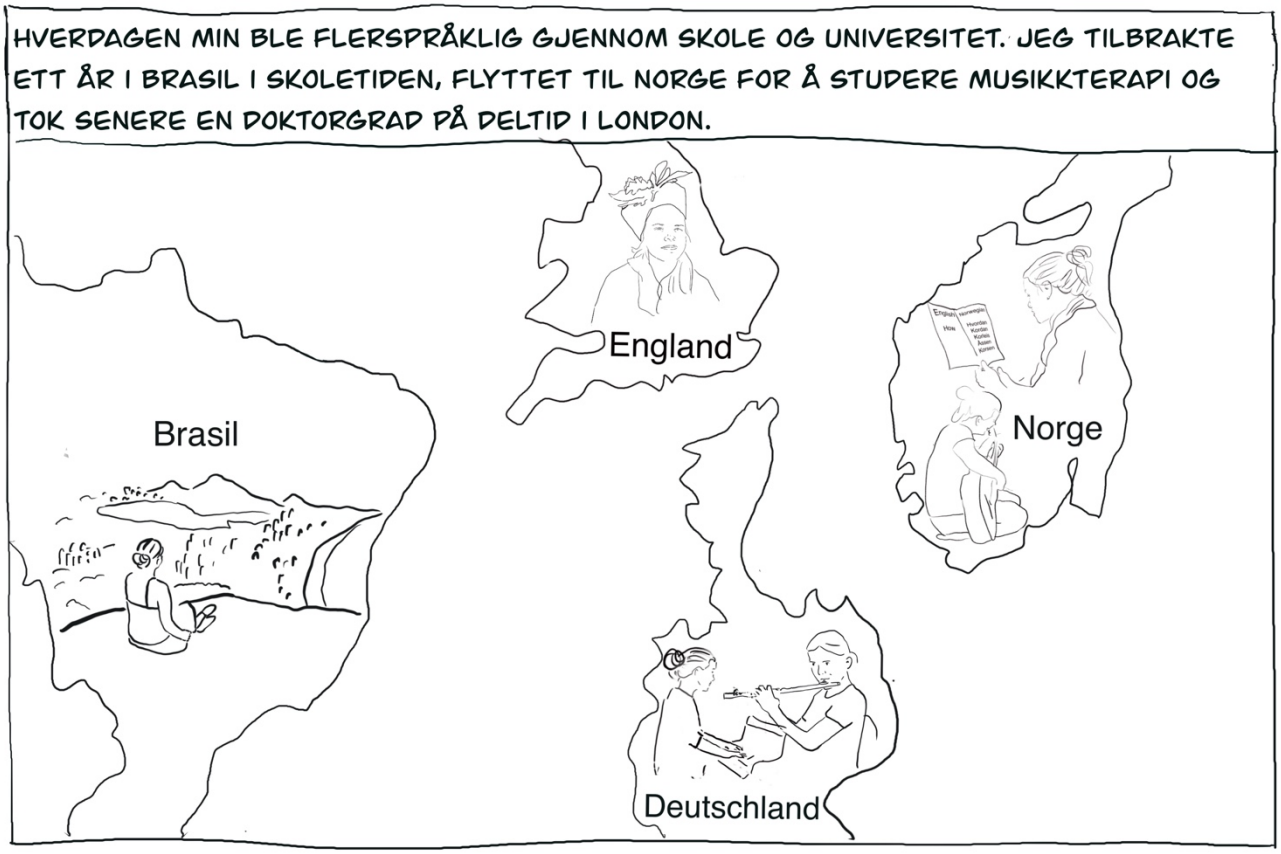
WHILE WORKING ON A SPECIAL ISSUE FOR VOICES ON THE TOPIC OF POWER AND LANGUAGE, I GAINED INSIGHTS INTO THE EXTENT TO WHICH THE MUSIC THERAPY LITERATURE IS EURO-AMERICACENTRIC AND WRITTEN IN THE ENGLISH LANGUAGE. DESPITE OUR EFFORTS TO FACILITATE SUBMISSIONS FROM DIFFERENT COUNTRIES AND IN DIFFERENT LANGUAGES, WE MAINLY RECEIVED CONTRIBUTIONS FROM THE GLOBAL NORTH AND LEARNT ABOUT THE STRUCTURES THAT MAKE MULTILINGUALISM DIFFICULT.



MULTILINGUALISM IS PART OF MY EVERYDAY LIFE AND OFFERS INSIGHT, DEVELOPMENT AND FRUSTRATION, BUT ABOVE ALL IT IS A PRIVILEGE. MULTILINGUALISM IS ALSO A CHALLENGE, BUT EVEN MORE SO AN OPPORTUNITY TO FURTHER DEVELOP MUSIC THERAPY AND MAKE ROOM FOR DIVERSITY.

♦ Norsk


JEG SNAKKER FIRE SPRÅK I HVERDAGEN: TYSK MED BARNA MINE, BRASILIANSK PORTUGISISK MED SAMBOEREN MIN OG HOVEDSAKELIG NORSK OG ENGELSK I MITT ARBEID SOM MUSIKKTERAPEUT PÅ EN SKOLE OG POSTDOKTOR VED UNIVERSITETET I BERGEN.
É QUE HORAS MESMO?
A GENTE TEM QUE LEMBRAR DO SVØMMING I MORGEN!
KAN JEG FÅ MER?
JA, GLEICH!
...OG OFTE FLERE SPRÅK SAMTIDIG.


HVERDAGEN MIN BLE FLERSPRÅKLIG GJENNOM SKOLE OG UNIVERSITET. JEG TILBRAKTE ETT ÅR I BRASIL I SKOLETIDEN, FLYTTET TIL NORGE FOR Å STUDERE MUSIKKTERAPI OG TOK SENERE EN DOKTORGRAD PÅ DELTID I LONDON.
England
Brasil
Norge
Deutschland

Å OVERSETTE ER EN KONSTANT PROSESS I HVERDAGEN MIN.

OVERSETTE FRA ETT SPRÅK TIL ET ANNET,

FRA PRAKSIS TIL FORSKNING OG OMVENDT,

POSITION PAPERS | PEER REVIEWED

How We Talk When We Talk About Disabled Children and Their Families:

An Invitation to Queer the Discourse

Maren Metell[1]*

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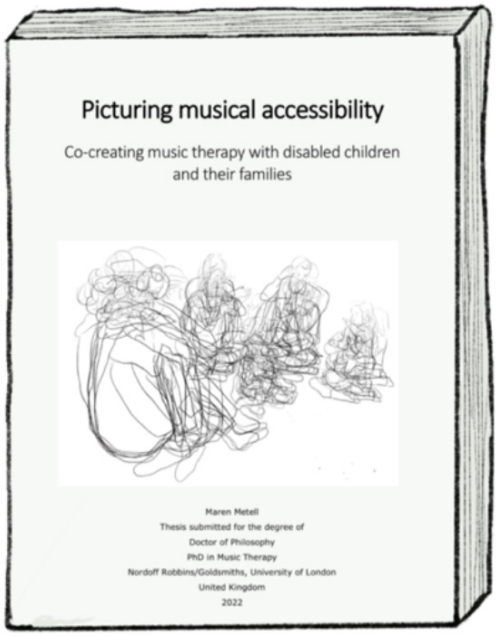
FRA VIDEOOPPTAK, MUSIKK OG ORD TIL BILDER.

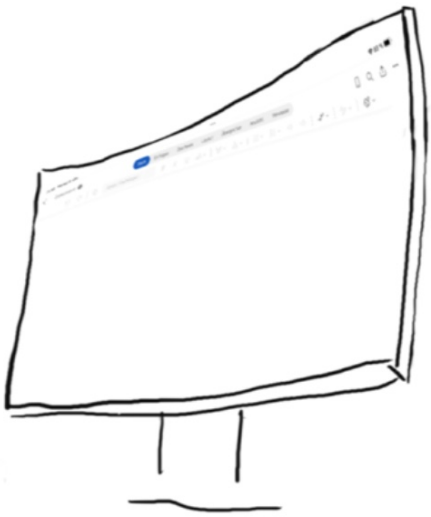
NÅR JEG ER I EN ANNEN KULTURELL KONTEKST ELLER JOBBER MED MENNESKER MED ET ANNET MORSMÅL, GJØR DET NOE MED RELASJONEN. BEGGE BLIR ELEVER OG LÆRERE PÅ SAMME TID.

TILGANG TIL ULIKE SPRÅK GIR TILGANG TIL ULIKE IDEER OG KONSEPTER – DET ER ET PRIVILEGIUM, MEN OGSÅ EN KILDE TIL FRUSTRASJON.



FOR EKSEMPEL ER «TILGJENGELIGHET» ET SENTRALT BEGREP I DOKTORAVHANDLINGEN MIN, SOM OVERSETTES GODT TIL PORTUGISISK, MEN MINDRE GODT TIL TYSK OG NORSK, FORDI DE ENKELTE ORDENE ER INNLEMMET I ET KOMPLEKST SYSTEM AV KULTUR OG KONTEKST.

DET Å SNAKKE OG SKRIVE FORSKJELLIGE SPRÅK BETYR OFTE (FOR MEG) AT JEG IKKE FØLER AT JEG EGENTLIG KAN UTTRYKKE MEG GODT PÅ NOEN AV DEM. DE FØRSTE ÅRENE KLARTE JEG DET IKKE PÅ ENGELSK OG NORSK, OG PÅ ET TIDSPUNKT KLARTE JEG DET HELLER IKKE PÅ TYSK LENGRE.



I ARBEIDET MED ET SPESIALNUMMER AV VOICES OM MAKT OG SPRÅK FIKK JEG INNSIKT I I HVOR STOR GRAD MUSIKKTERAPILITTERATUREN ER ENGELSKSPRÅKLIG OG EURO- OG ANGLOSENTRISK. TIL TROSS FOR AT VI FORSØKTE Å TILRETTELEGGE FOR BIDRAG FRA FLERE LAND OG PÅ FLERE SPRÅK, MOTTOK VI HOVEDSAKELIG BIDRAG FRA DET GLOBALE NORD, OG VI LÆRTE OM STRUKTURENE SOM GJØR FLERSPRÅKLIGHET VANSKELIG.

Editorial Voices

Whose Power, Whose Language? Exploring Issues of Power and Language in Music Therapy

Maren Metell, Hiroko Miyake, Andrew Dell'Antonio, Alyssa Hillary Zisk

PEOPLE THAT CAN SPEND TIME WITH UNPAID WORK WRITING AND REVIEWING ARTICES ARE MOSTLY FROM THE GLOBAL NORTH.

ALLOWING SUBMISSIONS IN THE AUTHOR'S FIRST LANGUAGE ONCE, DOESN'T CHANGE THE POWER STRUCTURES!

WE NEED TO QUESTION HOW POWER AND PRIVILEGE ARE EMBEDDED IN OUR EXPECTATIONS REGARDING ACADEMIC WRITING.

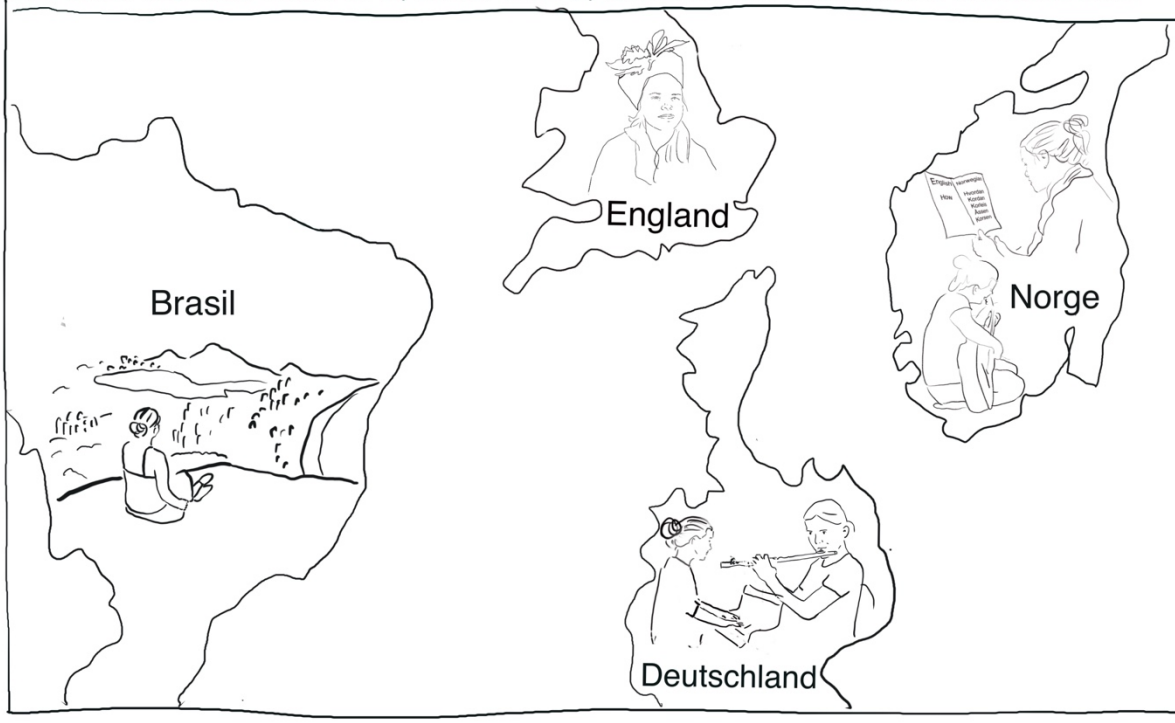
FLERSPRÅKLIGHET ER EN DEL AV MIN HVERDAG OG BYR PÅ INNSIKT, VIDEREUTVIKLING OG FRUSTRASJON, MEN FØRST OG FREMST ER DET ET PRIVILEGIUM. FLERSPRÅKLIGHET ER OGSÅ EN UTFORDRING, MEN I ENDA STØRRE GRAD EN MULIGHET TIL Å VIDEREUTVIKLE MUSIKKTERAPIEN OG GI ROM FOR MANGFOLD.

♦ Português

FALO QUATRO IDIOMAS EM MINHA VIDA COTIDIANA E PROFISSIONAL: ALEMÃO COM MEUS FILHOS, PORTUGUÊS BRASILEIRO COM MEU MARIDO E PRINCIPALMENTE NORUEGUÊS E INGLÊS EM MEU TRABALHO COMO MUSICOTERAPEUTA EM UMA ESCOLA E PESQUISADORA DE PÓS-DOUTORADO NA UNIVERSIDADE DE BERGEN.

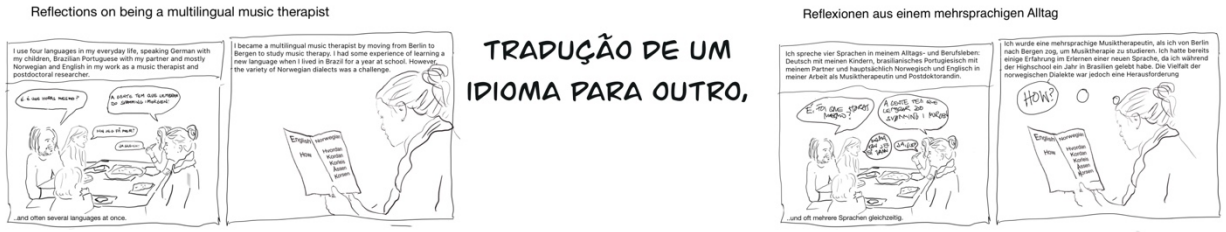
...E MUITAS VEZES EM VÁRIOS IDIOMAS AO MESMO TEMPO.

MINHA VIDA COTIDIANA TORNOU-SE MULTILÍNGUE DURANTE A ESCOLA E A UNIVERSIDADE. PASSEI UM ANO NO BRASIL DURANTE A ESCOLA, MUDEI-ME PARA A NORUEGA PARA ESTUDAR MUSICOTERAPIA E, MAIS TARDE, CONCLUÍ UM DOUTORADO EM LONDRES.



OPEN ACCESS

A TRADUÇÃO É UM PROCESSO CONSTANTE EM MINHA VIDA COTIDIANA.



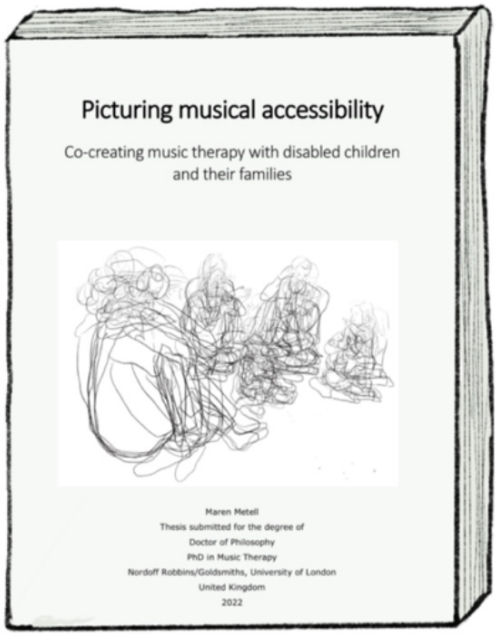
TRADUÇÃO DE UM IDIOMA PARA OUTRO,

DA PRÁTICA PARA A PESQUISA E VICE-VERSA,

DE GRAVAÇÕES DE VÍDEO, MÚSICA E PALAVRAS EM IMAGENS.

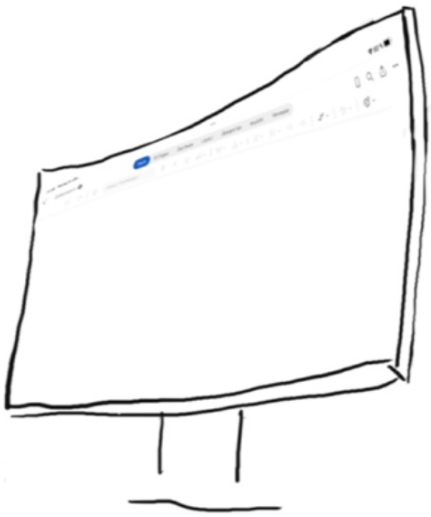
QUANDO ESTOU EM UM CONTEXTO CULTURAL DIFERENTE OU TRABALHO COM PESSOAS COM UMA LÍNGUA MATERNA DIFERENTE, ISSO AFETA O RELACIONAMENTO. AMBOS SE TORNAM APRENDIZES E PROFESSORES AO MESMO TEMPO.

O ACESSO A DIFERENTES IDIOMAS PERMITE O ACESSO A DIFERENTES IDEIAS E CONCEITOS, O QUE É UM PRIVILÉGIO, MAS TAMBÉM UMA FONTE DE FRUSTRAÇÃO.

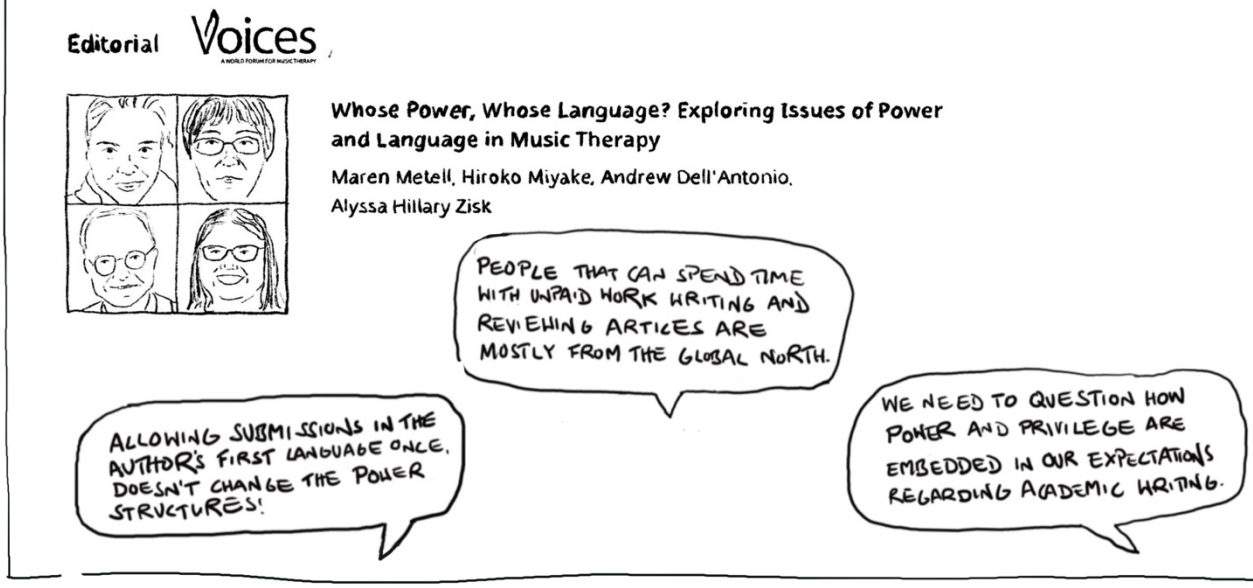


POR EXEMPLO, "ACESSIBILIDADE" É UM TERMO CENTRAL EM MINHA TESE DE DOUTORADO, QUE SE TRADUZ BEM PARA O PORTUGUÊS, MAS NÃO TÃO BEM PARA O ALEMÃO E NORUEGUÊS, PORQUE AS PALAVRAS INDIVIDUAIS ESTÃO INSERIDAS EM UM SISTEMA COMPLEXO DE CULTURA E CONTEXTO.

FALAR E ESCREVER EM IDIOMAS DIFERENTES GERALMENTE SIGNIFICA (PARA MIM) QUE NÃO SINTO QUE CONSIGO ME EXPRESSAR BEM EM NENHUM DELES. NOS PRIMEIROS ANOS, EU NÃO CONSEGUIA FAZER ISSO EM INGLÊS E NORUEGUÊS, E DEPOIS, EM ALGUM MOMENTO, NÃO CONSEGUIA FAZER ISSO EM ALEMÃO.



ENQUANTO TRABALHAVA EM UMA EDIÇÃO ESPECIAL DA VOICES SOBRE O TÓPICO DE PODER E LINGUAGEM, OBTIVE INSIGHTS SOBRE ATÉ QUE PONTO A LITERATURA SOBRE MUSICOTERAPIA É DE LÍNGUA INGLESA OU EURO E ANGLOCÊNTRICA. APESAR DE NOSSOS ESFORÇOS PARA PROMOVER A DIVERSIDADE, RECEBEMOS PRINCIPALMENTE CONTRIBUIÇÕES DO NORTE GLOBAL E APRENDEMOS SOBRE AS ESTRUTURAS QUE DIFICULTAM O MULTILINGUISMO.



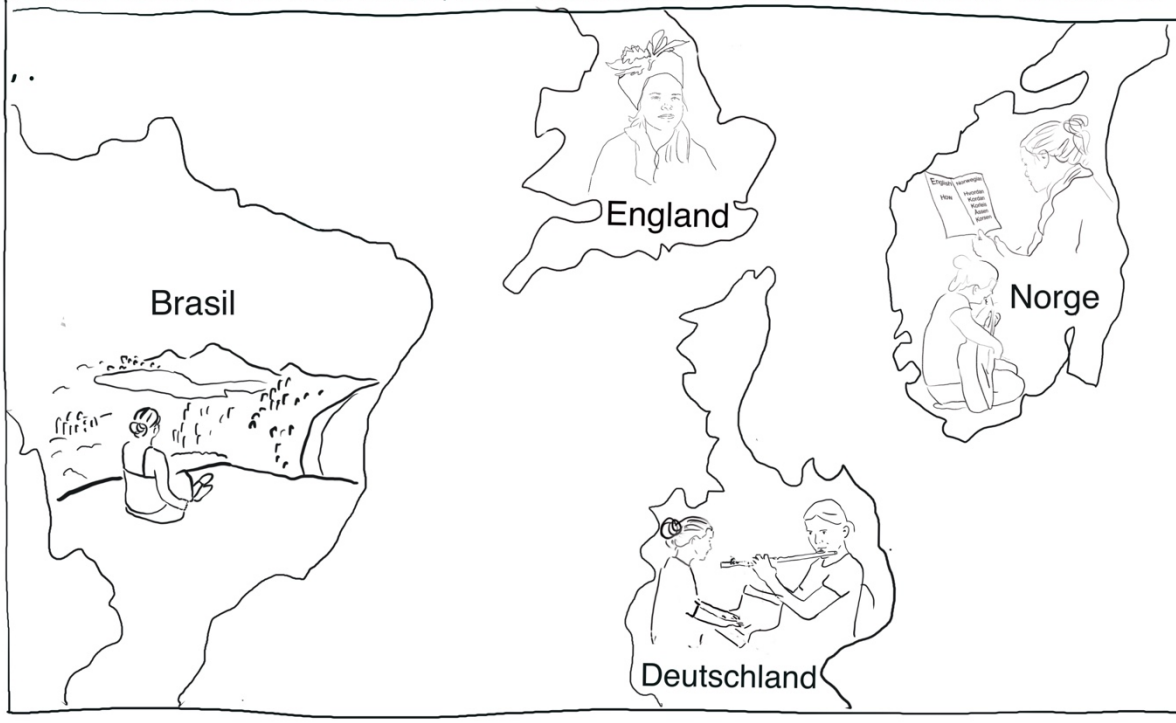
O MULTILINGUISMO FAZ PARTE DA MINHA VIDA COTIDIANA E OFERECE ENTENDIMENTO, DESENVOLVIMENTO ADICIONAL E FRUSTRAÇÃO, MAS, ACIMA DE TUDO, É UM PRIVILÉGIO.
O MULTILINGUISMO TAMBÉM É UM DESAFIO, MAS, MAIS AINDA, UMA OPORTUNIDADE PARA DESENVOLVER AINDA MAIS A MUSICOTERAPIA E ABRIR ESPAÇO PARA A DIVERSIDADE.

♦ Deutsch

ICH SPRECHE VIER SPRACHEN IN MEINEM ALLTAGS- UND BERUFSLEBEN: DEUTSCH MIT MEINEN KINDERN, BRASILIANISCHES PORTUGIESISCH MIT MEINEM PARTNER UND HAUPTSÄCHLICH NORWEGISCH UND ENGLISCH IN MEINER ARBEIT ALS MUSIKTHERAPEUTIN AN EINER SCHULE UND POSTDOKTORANDIN AN DER UNIVERSITÄT IN BERGEN.

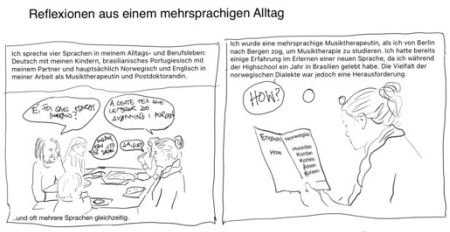
..UND OFT MEHRERE SPRACHEN GLEICHZEITIG.

MEIN ALLTAG WURDE DURCH SCHULE UND STUDIUM MEHRSPRACHIG. ICH VERBRACHTE EIN JAHR IN BRASILIEN WÄHREND DER SCHULZEIT, ZOG NACH NORWEGEN, UM MUSIKTHERAPIE ZU STUDIEREN, UND PROMOVIERTE SPÄTER IN TEILZEIT IN LONDON.



ÜBERSETZEN IST EIN STÄNDIGER PROZESS IN MEINEM ALLTAG.

ÜBERSETZEN VON EINER SPRACHE IN EINE ANDERE,

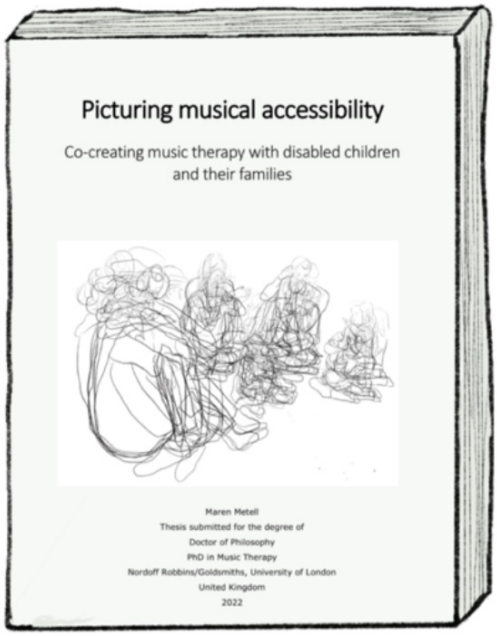


VON DER PRAXIS IN DIE FORSCHUNG UND UMGEKEHRT,

VON VIDEOAUFNAHMEN, MUSIK UND WORTEN IN BILDER.

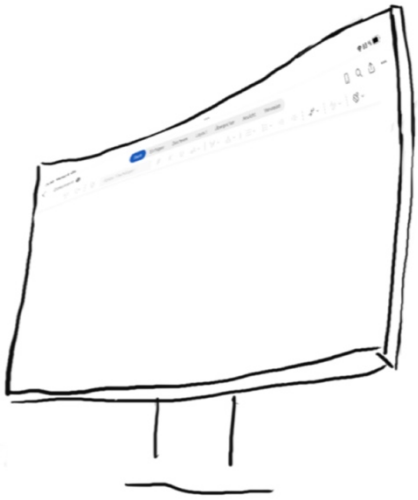
WENN ICH IN EINEM ANDEREN KULTURELLEN KONTEXT BIN ODER MIT MENSCHEN MIT ANDERER MUTTERSPRACHE ZUSAMMENARBEITE, MACHT DAS ETWAS MIT DER BEZIEHUNG. BEIDE WERDEN GLEICHZEITIG ZU LERNENDEN UND LEHRENDEN.

DER ZUGANG ZU VERSCHIEDENEN SPRACHEN ERMÖGLICHT DEN ZUGANG ZU VERSCHIEDENEN IDEEN UND KONZEPTEN – DAS IST EIN PRIVILEG, ABER AUCH EINE QUELLE VON FRUSTRATION.

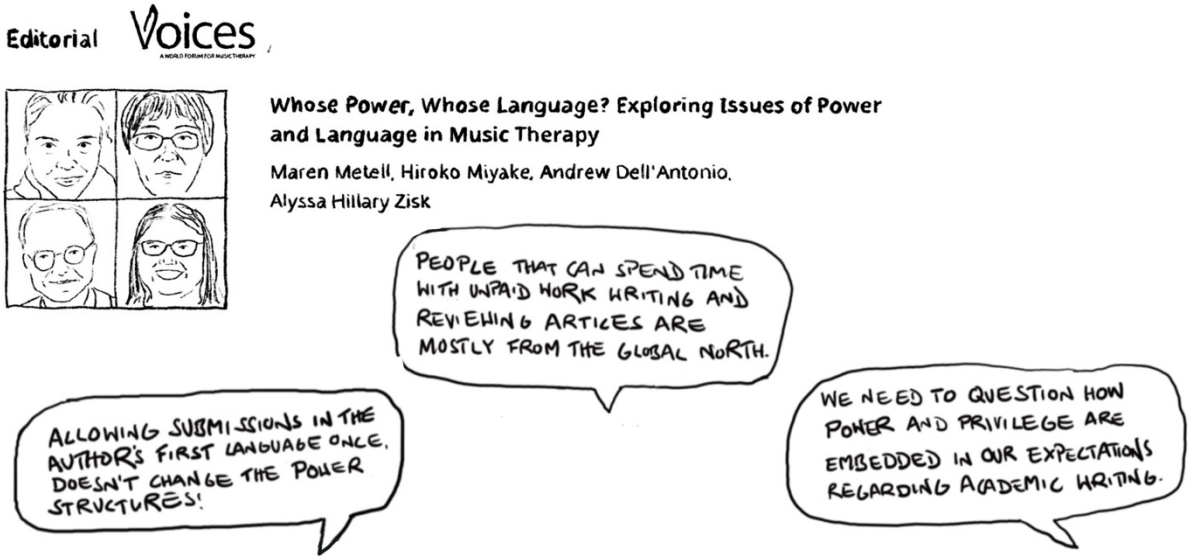


ZUM BEISPIEL IST „ACCESSIBILITY" EIN ZENTRALER BEGRIFF IN MEINER DOKTORARBEIT, DER SICH GUT INS PORTUGIESISCHE, ABER WENIGER GUT INS DEUTSCHE (ZUGÄNGLICHKEIT, BARRIEREFREIHEIT?) UND NORWEGISCHE ÜBERSETZEN LÄSST, WEIL EINZELNE WÖRTER IN EIN KOMPLEXES SYSTEM VON KULTUR UND KONTEXT EINGEBUNDEN SIND.

VERSCHIEDENE SPRACHEN ZU SPRECHEN UND ZU SCHREIBEN BEDEUTET (FÜR MICH) OFT, DASS ICH DAS GEFÜHL HABE, MICH EIGENTLICH IN KEINER DER SPRACHEN GUT AUSDRÜCKEN ZU KÖNNEN. IN DEN ERSTEN JAHREN AUF ENGLISCH UND NORWEGISCH GING ES NOCH NICHT UND IRGENDWANN DANN AUF DEUTSCH NICHT MEHR.



BEI DER ARBEIT AN EINER SONDERAUSGABE FÜR VOICES ZUM THEMA MACHT UND SPRACHE ERHIELT ICH EINBLICKE, WIE SEHR DIE MUSIKTHERAPIELITERATUR ENGLISCHSPRACHIG BEZIEHUNGSWEISE EURO- UND ANGLOZENTRISCH GEPRÄGT IST. TROTZ UNSERER BEMÜHUNGEN FÜR DIVERSITÄT ERHIELTEN WIR HAUPTSÄCHLICH BEITRÄGE AUS DEM GLOBALEN NORDEN UND LERNTEN ÜBER DIE STRUKTUREN, DIE MEHRSPRACHIGKEIT ERSCHWEREN.



MEHRSPRACHIGKEIT IST TEIL MEINES ALLTAGS UND BIETET EINBLICKE, WEITERENTWICKLUNG UND FRUSTRATION, IST ABER VOR ALLEM EIN PRIVILEG. EBENSO IST MEHRSPRACHIGKEIT EINE HERAUSFORDERUNG, ABER NOCH VIEL MEHR EINE CHANCE, MUSIKTHERAPIE WEITERZUENTWICKELN UND DIVERSITÄT RAUM ZU GEBEN.

Author | Forfatter | Autora | Autorin

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From musical fragments to composition

Clinical musical improvisation as a tool for creating meaning

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Abstract

This article explores how clinical musical improvisation transforms undifferentiated affects into accessible musical forms, facilitating deeper psychic processing and self-reflection. It is illustrated by the case of Thorik, a sixteen-year-old who I got to know in a residential treatment program. Throughout the therapeutic process of this energetic adolescent, an interest and intuitive aptitude for music became evident. The character of his musical play was discordant, reflecting his ambivalence between seeking connection and unconsciously seeking rejection. Over time, Thorik experienced growth in sessions where I established a safe space for non-verbal expression and improvisation. This enabled him to develop original compositions from improvisations, which enhanced his self-esteem and identity. This transformation demonstrates the strength of improvisation in promoting emotional regulation and self-discovery.

Keywords: clinical improvisation – emotional regulation – beta and alpha functions – Bion – identity development

♦ English

We encounter Thorik as a sixteen-year-old adolescent in transition (female to male). He had experienced crisis admissions to the urgent child psychiatry unit due to progressively increasing obsessive thoughts and compulsive behaviors, and was admitted to a three-month residential program in child and adolescent psychiatry, with various group therapies, diagnostics, and treatment. He was indicated for weekly individual music therapy, alongside his twice-weekly group sessions.

Longing for safety

The first group session, Thorik adopted a cautious non-verbal posture but showed a natural exploratory attitude. Remarkably, he approached each instrument briefly, engaging for about five seconds before moving on to the next. As a music therapist, I was intrigued by his unconventional attitude and observed while playing along. He seemed indifferent to the other group members, who were less active and staring at him. Eventually, he returned to the instruments he was familiar with, playing melodies he knew. I understood this as if the

musical knowledge provided a sense of safety, allowing him to participate in improvisation while remaining on his own island of familiarity.

After five group sessions, Thorik started with individual music therapy sessions. He was feeling more depressed and refused to speak. Silently, we made our way to the music therapy room, and something comical started to happen: as I was still new to the hospital, I lost my way in the building. We stumbled upon a vacant department. Thorik looked amused and explored the area with a small smirk. He was making eye contact now and there was something playful in the way he interacted non-verbally. After a while we finally found the right therapy room. He walked to the piano and looked at me with big eyes. 'You want me to play?' I asked. He nodded 'yes'. Being aware of my own urge to comfort him, I played. Thorik was listening, focused and quiet. He smiled gratefully and finally spoke: listening to the piano helped him avoid negative thoughts.

Drawn to soothing, vibrant sounds, Thorik chose the metallophone, while I took the xylophone, aiming to bond through these correlated instruments. The improvisation sounded like a flowing connection, though he sometimes fled, resisting me to carry him. The music went on and there was a growth in the therapeutic interplay. At one point, he stopped playing, concentrating on listening. When a xylophone bar fell out, he quickly helped me replace it so I could continue playing. I sensed a contradiction in his longing for safety while struggling to allow it.

Thorik requested the next session to recreate the last improvisation, but I couldn't reproduce the same atmosphere that had given him emotional safety. He dismissed my attempts, indicating for me to stop. Although I tried to meet his needs, I fell short, which frustrated me as I faced my own desire for perfection. I had to accept being a *good enough* caregiver[1], acknowledging it was not possible to meet every need. Thorik, challenged to cope with disappointment, still sensed my effort and care, ultimately accepting my 'good enough' attempt.

Letting go of the anchor

Thorik gradually learned to let go of preconceived knowledge and engage in collaborative, improvisational play. He had a need for self-expression which was connected with his quest for identity, actively searching for who wanted to be. He wanted to distinguish himself from others, which was shown in his playing. Rather than imitating others, he sought originality, emphasizing (verbally) the importance of creating something personal. He could articulate frustration when improvisations were not sounding as he wanted them to.

Thorik's play often sounded disruptive, as he showed little to no consideration for his groupmates and played over their contributions. He was aware of this behavior and could articulate it during reflection. These dynamics mirrored the interactions with his parents, highlighting a parallel. It suggested an unconscious quest for the rejection he had

[1] Aligning the theory of the 'good enough mother' (Winnicott, 1971).

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experienced from them, which deeply affected his sense of self. As a result, he developed a recurring defense mechanism, playing destructively where boundaries were needed to protect the group. Each time the therapist set boundaries, he would shut down and withdraw, reinforcing his negative experiences of not being accepted for who he truly was.

The loud, disruptive play reflects unprocessed beta (β)-elements (Bion, 1970). I aim to explore this theory to clarify its link to developments in music therapy.

Projecting musical fragments as beta-elements

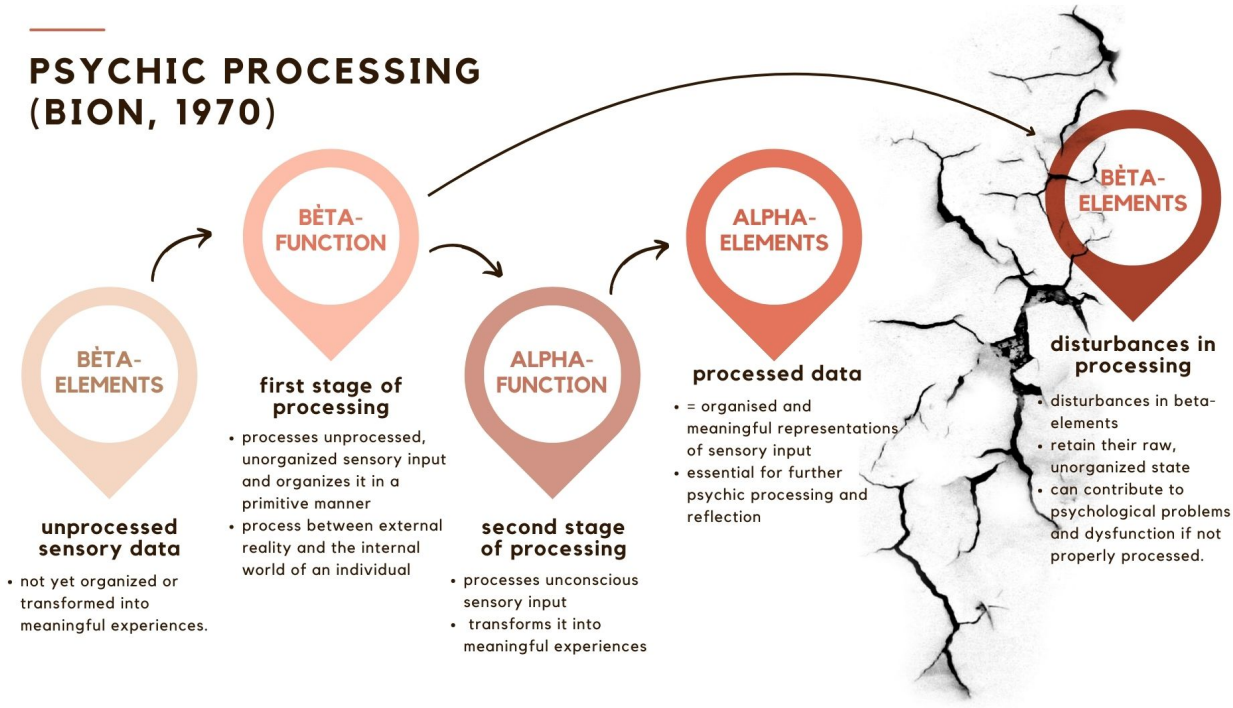

Figure 1. Visual Representation of Psychic Processing.

In psychic processing, unprocessed sensory data (β-elements) must be transformed into organized data (α-elements) occurring two stages: the β function followed by the α function. Disturbances in the first stage leave elements in a raw β-state, behaving like sensory objects[2] (Bion, 1962), contributing to psychological issues. Thorik has faced several disruptions in this transition, resulting in ongoing struggles with internal tension, emotional dysregulation, and difficulties in daily life.

With his overpowering play, Thorik projected disturbed musical data onto me. This discharging character (Freud, 1920) aided in interpreting these musical β-elements. Thorik maintained a paradoxical pattern, breaking next to mending what resonated in the room. I experienced this as a constant game of distance and proximity, seeking connection while simultaneously disconnecting. The improvisation alternated between consonant and dissonant, predictable and unpredictable, coherent and chaotic, soft and aggressive, yet

[2] *Sensory objects* as introduced by Bion refer to mental experiences or thoughts that are not processed symbolically and are instead experienced as if they were concrete, physical objects rather than abstract ideas.

always intense. While destructive, it was also a meaningful part of Thorik's search for healing and connection. This aligns with the theory of abreaction (Breuer & Freud, 1895), as his playing allowed him to relive and express repressed emotions. Engaging with these musical β-elements helped him release emotional load from past experiences, facilitating catharsis (Aristotle, 1996) and fostering emotional healing in the therapeutic environment.

Processing through improvisation

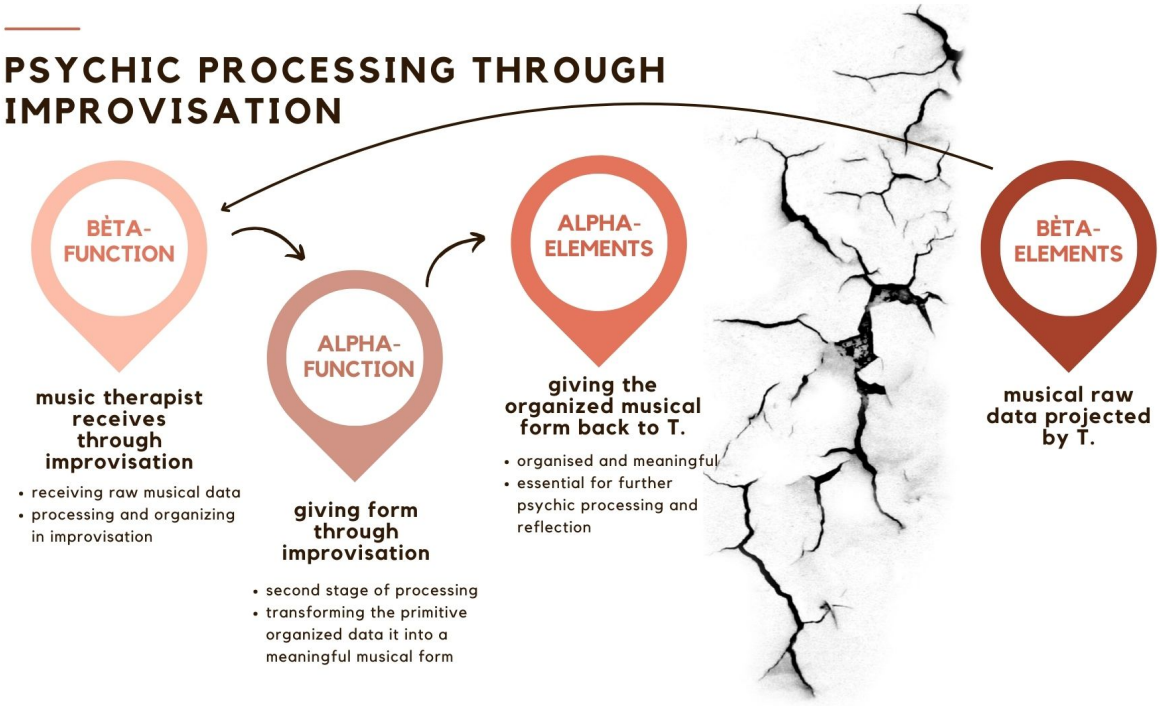

Figure 2. Psychic Processing Through Clinical Improvisation.

Processing raw β data through clinical improvisation is essential for transforming overwhelming emotional experiences into coherent insights, facilitating emotional regulation and psychological integration[3]. The therapist receives Thorik's unprocessed musical projections, organizes them, and returns them in a meaningful form. The attached audio fragments illustrate this process: it was a difficult day for Thorik, and we walked silently to the therapy room. Our contact was one long improvisation. I took a supportive role in the lower piano register while Thorik played in the higher register. The session remained non-verbal.

[3] Brighton and Hove Psychotherapy (2018) discusses integration as a process that "involves the client/patient growing a mind; learning to navigate their feelings and making sense of their thoughts, all whilst accepting reality and being in relationship to others."

Fragment 1: Thorik flees and rhythmically disconnects from me while simultaneously projecting dissonant musical β-elements. It is audible how he is drawn back into connection in a nearly magnetic manner.

Figure 3. QR-Code: Audio fragment 1.

Fragment 2: Later into improvisation, a fragmented part emerged where the rhythm was lost, and the dynamics softened. Dissonant notes formed the basis of a new rhythmic interaction between us. The harmonics and melody evolved into a resolution-themed character. Shortly after, Thorik stopped playing, allowing himself to be guided further into the improvisation by listening. I let the music unfold into a harmonious conclusion as the final chapter of this improvisation. Here he was receiving the organized musical form I was giving him back as the therapist.

Figure 4. QR-Code: Audio fragment 2.

'Je déciderai a demain'

Thorik discovered improvising and playing on the piano is an effective tool to regulate himself. He used his spare time during admission to play alone. A composition emerged from his solo improvisations. Without knowing, the subconscious found a way to do the transformation from β to α independently, without the music therapist. He titled his composition 'Je déciderai a demain'. His choice of words held value. Feeling it should be entirely his work, I suppressed my urge to correct the grammar[4]. Thorik explained he did not know what to call the composition, therefore he did not want to decide today. Each day, he could say, 'I'm deciding that tomorrow'. He was used to a controlling environment with many rules, where decisions were made for him, limiting his freedom as he grew up. Improvising and composing provided a corrective experience, allowing him to feel a sense of freedom and ownership.

Figure 5. QR-Code: 'Je déciderai a demain'.

(Dys)function of (repeating) the composition

Thorik proudly presented his composition to peers and the multidisciplinary team, eager to "give" his music with a big smile, whether they wanted to hear it or not. He had the need to repeat his piece, sometimes appropriately, other times not, each time beaming, 'Isn't it

[4] The author alludes to the fact that Thorik accidentally said "a demain" ("see you tomorrow"). He had meant "Je déciderai demain" ("I will decide tomorrow").

beautiful?' – seeking validation and connection. Though he expressed feeling unintelligent, he discovered a musical talent, realizing he thrived in this area. He enjoyed when others joined in, and how this emotionally affected him. He started spreading this new musical non-verbal regulating medium, as if it was a magical dust he wanted to distribute.

When group improvisations didn't go his way, Thorik stopped improvising and played his piece, non-verbally demanding the group, including me, to follow along. This resulted in a disrupted function of the composition, shifting the organized structure (α-elements) into an aggressive, destructive nature, breaking the improvisation down, returning to a β-like character. Thorik recognized this when I asked what was happening, revealing his recurring unconscious tendency to seek rejection.

Goodbye beyond words

After his residential stay, Thorik returned to the unit multiple times during the post-treatment phase for individual sessions, including music therapy. Initially these went smoothly, with Thorik applying the tools he had learned throughout various therapeutic processes. The music therapy sessions served as a small anchor for him, where he could express himself (non-)verbally, improvise, regulate, and then return to the outside world.

Facing his second-to-last session, Thorik shut down again, making communication difficult. He abruptly decided not to participate just as he reached the entrance and wordlessly walked back to the bus stop. He projected his unprocessed affects onto the caregivers who saw him that day, leaving a sense of helplessness and heaviness that resonated with us after his departure. Leading up to the final music therapy session, Thorik brought the same (non-verbal) heavy weight with him. I felt uncertain and restless at the thought of needing to say goodbye to this valuable therapeutic process. I experienced fear that he would escape this farewell by leaving without contact again. Relief washed over me when we passed through that same door and entered the music therapy room. Thorik did not speak a word. I intuitively adjusted my verbal tone and volume to produce as few verbal sounds as possible, recognizing his significant need for this non-verbal medium.

Thorik chose a chair further from the piano by the window. He listened to my piano improvisation and cried silently. At that moment, I connected with his inner world through music and improvisation, offering him some comfort and understanding, which seemed to have a regulating effect. I invited him to play his composition one last time. He appeared to appreciate the request and engaged without hesitation. After playing his piece, he cautiously glanced in my direction and moved aside, still without words. In this way, he invited me to join him at the piano one last time. This final improvisation had a conclusive character and served as a beautiful and grateful farewell for both Thorik and me. This allowed him to be seen and acknowledged in his pain through music, expressing a lyrical 'goodbye' when words fell short.

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Musiikkipsykoterapia monimutkaisen perhetilanteen hoidossa lastenpsykiatriassa

Music psychotherapy for the treatment of a complex family situation in child psychiatry

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HUS, Lapset ja nuoret, Lastenpsykiatria, Helsinki, Finland

Abstrakti

Artikkeli esittelee integratiivisen psykoterapian lähestymistavan, jossa yhdistyy perhe- ja musiikkiterapian sekä esimerkiksi traumapsykoterapian elementtejä. Menetelmä tarjoaa mahdollisuuden työskennellä lapsiperheiden kanssa, joilla on mielenterveyden häiriöitä, jotka ovat seurausta vakavasta sairaudesta, neuropsykiatrisista häiriöistä, perhe- tai kouluväkivallasta, kuolemasta perheessä tai muista vakavista traumaattisista tapahtumista. Tällä lähestymistavalla psykoterapian tavoitteena on muuttaa traumaattista, raakaa ja jopa somaattista kokemusta siedettäväksi taiteelliseksi ja tarinalliseksi kokemukseksi musiikin avulla. Menetelmä antaa tilaa ja ymmärrystä perheenjäsenten yksilöllisille toipumisrytmeille. Tätä lähestymistapaa on käytetty lasten erikoissairaanhoidon perheiden kanssa tukemaan perheenjäsenten välistä vuoropuhelua musiikin avulla. Tässä perhemusiikkipsykoterapian lähestymistavassa käytetään musiikkiterapian menetelmää nimeltä Tarinasäveltäminen, joka perustuu tarinalliseen musiikilliseen keksintään. Artikkelissa luodaan katsaus esitellyn menetelmän kehittymiseen sekä esitellään menetelmän tekniikkaa ja merkityksiä. Artikkeli on kliinisen kehittämistyön esittelyä.

Avainsanat: perheterapia – musiikkiterapia – psykoterapia – musiikki – trauma – tarinasäveltäminen

Abstract

The article introduces an integrative psychotherapy approach that combines elements of family therapy, music therapy, and, for example, trauma psychotherapy. The method provides an opportunity to work with families with mental health disorders resulting from severe illness, neuropsychiatric disorders, family or school violence, death in the family, or other serious traumatic events. In this approach, the goal of psychotherapy is to transform traumatic, raw, and even somatic experiences into more tolerable, artistic, and narrative experiences through music. The method allows space and understanding for the individual recovery rhythms of family members. This approach has been used with families in

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specialized paediatric care to support dialogue between family members through music. In this family music psychotherapy approach, a music therapy method called *Storycomposing* is used, based on narrative musical invention. The article reviews the development of the presented method and introduces the technique and meanings of the method. The article is a presentation of clinical development work.

Keywords: family therapy – music therapy – psychotherapy – music – trauma – storycomposing

♦ Suomeksi

Esiteltävässä perheterapian ja musiikkiterapian lähestymiskeinoja yhdistävässä psykoterapian työtavassa musiikkia voidaan käyttää prosessin sisällä eri tasoilla riippuen prosessin vaiheiden ja yksittäisten tapaamisten tarpeesta. Musiikki voi toimia täydentävällä tai vahvistavalla tasolla (augmentative level), jolloin pyritään lisäämään toisen hoitomuodon vaikutuksia tai pyritään myötävaikuttamaan hoidollisten päämäärien saavuttamiseksi asiakkaan kokonaisvaltaisessa hoidossa (Bruscia, 1998). Tässä voi olla kysymys esimerkiksi perheterapian edistämisestä. Musiikkipsykoterapiakäsitteillä puhuttaessa kysymys olisi musiikista psykoterapiassa (music in psychotherapy) (Alanne, 2023; Bruscia, 1998).

Erityisesti perheen lapsen näkökulmasta musiikki voi prosessissa toimia sekä intensiivisellä tasolla että ensisijaisella tasolla, jolloin musiikkiterapialla on keskeinen, itsenäinen ja korvaamaton osuus hoitopäämäärien saavuttamisessa ja muutosten aikaansaamisessa (Bruscia, 1998; Wigram ym., 2002). Musiikkipsykoterapian termein silloin on kysymyksessä musiikkikeskeinen psykoterapia (music-centered psychotherapy) tai pienten lasten tai voimakkaasti traumaattisten tapahtumien äärellä musiikki psykoterapiana (music as psychotherapy (Alanne, 2023; Bruscia, 1998).

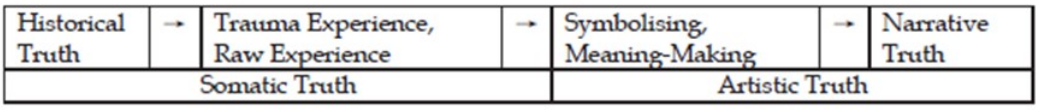
Tarinasäveltämisen esittely

Tarinasäveltäminen on omaan musiikilliseen keksintään perustuva tarinallinen ilmaisukeino, mikä mahdollistaa lapsille tunteiden, ajatusten ja kokemusten ilmaisun, jakamisen ja työstämisen musiikin keinoin. Tarinasäveltäminen on syntynyt 3–6-vuotiaiden lasten parissa heitä kuunnellen ja konsultoiden. Tarinasäveltämisessä on neljä periaatetta, jotka kaikki pitää toteutua, jotta menetelmän hyödyt tulevat esille. Periaatteet ovat: 1. mahdollisuus musiikilliseen ilmaisuun, 2. mahdollisuus luoda teos ilman opettamista ja ohjaamista, 3. teos luodaan toisen kuunnellessa niin tarkasti, että tämä toinen saa kirjattua teoksen muistiin sellaisella tarkkuudella, että tekijän on mahdollista soittaa se uudestaan, 4. kun terapiasuhteessa teosta soitetaan, kuunnellaan, katsotaan nuottikuvaa ja muistellaan teoksen luomisprosessia valmis teos mahdollistaa teoksen merkityssisältöjen pohtimisen ja työstämisen musiikillisesti, keskustellen sekä muilla taiteen keinoilla ja erilaiset tulkinnat teoksesta lisäävät näkökulmia ja tuottavat oivalluksia niin kahdenkeskisessä terapiasuhteessa kuin esimerkiksi perheen ja useamman terapeutin työskentelyssä (Hakomäki, 2005; 2013).

Musiikkiterapian ja perheterapian yhdistäminen

Tässä esiteltävä perhemusiikkipsykoterapian menetelmä on muotoutunut käytännön tarpeesta. Sen ensiaskeleet on otettu koko perheen kuntoutusjaksoilla Suomessa 2000–luvun alussa ja systemaattinen perheterapian ja musiikkiterapian yhdistäminen tarinasäveltämisen keinoin alkoi näiden kokemusten pohjalta lapsiperheiden avokuntoutuskeskuksessa vuonna 2002 (Hakomäki, 2005). Perheterapiaprosessiin yhdistettiin lapsen intensiivinen musiikkiterapiaprosessi ja tarinasäveltämisen keinoin lapsen oli mahdollista työskennellä terapeutin kanssa yhteisellä kahden henkilön muodostamalla työskentelykentällä teoksia tehdessään (the bi-personal field; Ferro, 2006). Teosten avulla vanhemmat ja tarvittaessa myös sisarukset oli mahdollista kutsua tälle samalle kentälle. Teoksia soitettiin, kuunneltiin ja niiden merkityssisältöä sekä esiin nostamia tunteita ja muistoja prosessoitiin keskustellen. Joskus myös vanhemmat tekivät uuden tarinasävellyksen aivan kuin vastalahjana lapsen teokselle. Tarinasäveltäminen on lapsilähtöinen menetelmä, jota on tutkittu väitöskirjatasoisesti yhdessä 14-vuotiaan nuoren kanssa liittyen hänen lapsena kokemaansa traumaattiseen menetykseen ja sitä seuranneeseen terapiaprosessiin tarinasäveltämisen keinoin (Hakomäki, 2013)[1].

Lastenpsykiatrian erikoissairaanhoidossa menetelmän soveltaminen, kehittäminen ja hyödyntäminen alkoi 2020-luvulla tarpeesta löytää joustava ja salliva sekä perheenjäsenten erilaisia tarpeita huomioiva työtapa kompleksisten perhetilanteiden psykoterapian tarpeeseen. Menetelmä tarjoaa mahdollisuuden työskennellä lapsiperheiden kanssa, joilla on mielenterveyden ja perhedynamiikan häiriöitä, jotka ovat seurausta vakavasta sairaudesta, neuropsykiatrisista häiriöistä, perhe- tai kouluväkivallasta, kuolemasta perheessä tai muista vakavista traumaattisista tapahtumista (Hakomäki & Roisko, 2022a). Musiikkiterapia ja tarinasäveltämisen keinot mahdollistavat voimakkaiden, pelottavien, raakojen, kehollisten ja mieltä kuormittavien tapahtumien, sairauksien, ominaisuuksien ja muistojen äärelle asettumisen taiteen ja musiikin keinoin. Tätä todellisten muistojen muuntumisen mahdollisuutta siedettäviksi sekä taiteen keinoin että symbolisten merkitysten avulla on kuvattu seuraavasti (kuva 1).



Kuva 1. Muistojen muuntumisen raamit taiteen keinoin (Hakomäki, 2013, s. 93).

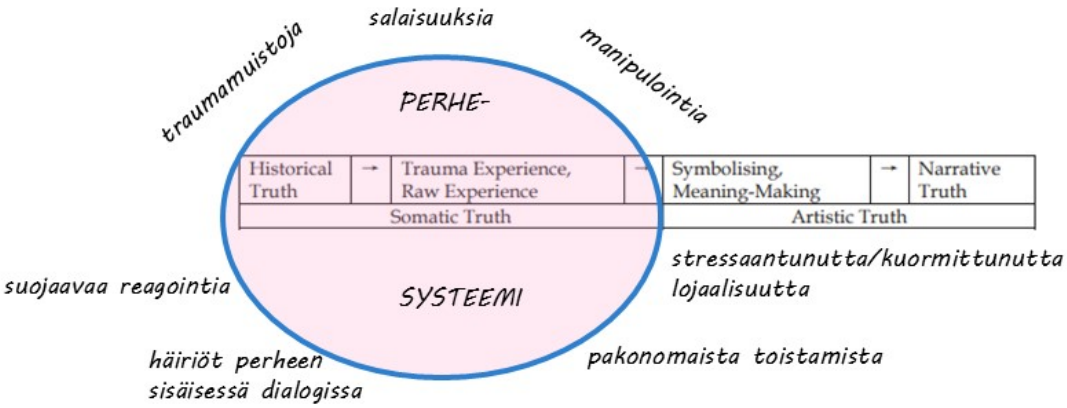
Kuvassa esitetään kuinka kehossa oleva torjuttu muisto, joka sisältää myös tunnemuiston, voi muuntua taiteen ja symbolisten merkitysten avulla terapiasuhteessa työskennellen henkilökohtaisesti riittävän totuuden mukaiseksi ja siedettäväksi tarinalliseksi totuudeksi.

Komplisoitunut perhetilanne

[1] Vuonna 2008 Suomalainen Lääkäriseura Duodecim myönsi kulttuuripalkinnon Hanna Hakomäelle tämän menetelmän kehittämisestä.

Perhemusiikkipsykoterapia tarinasäveltämisen keinoin edellyttää integratiivista lähestymistä psykoterapian eri suuntauksiin. Musiikkiterapia tarjoaa kaikille osapuolille menetelmiä ja tekniikoita itseilmaisuun sekä terapiasuhteessa olemiseen sekä mahdollistaa työskennellä ei-kielellisen musiikillisen ilmaisun ja vuorovaikutuksen keinoin aktivoiden tunteita ja symbolisten merkitysten prosesseja. Musiikin tekeminen ja soittaminen sallii myös kehollista ja motorista toiminnallisuutta, mikä on usein lasten kanssa työskenneltäessä tarpeellista. Lisäksi tarinasävellysten ympärille muodostuva dialogi edistää perheen keskinäistä dialogia myös vaikeista asioista, mutta kuitenkin siedettävästi. Integratiivinen näkökulma palvelee mahdollisuutta löytää kullekin perheelle lapset huomioiden parasta mahdollista hoitoa. (Neimeyer, 2001; Varvin, 2002; Hakomäki, 2012; Valkonen, 2014.)

Kun perhe aloittaa perhemusiikkipsykoterapian komplisoituneessa tilanteessa, joka horjuttaa jonkun tai joidenkin perheenjäsenten mielenterveyttä, perhe on jumiutunut jonkin häiriötä ja epätasapainoa aiheuttavan torjutun tunteen, muiston, kokemuksen tai tosiasian vuoksi (kuva 2).



Kuva 2. Komplisoitunut perhetilanne perhemusiikkipsykoterapian alussa (Hakomäki & Roisko, 2022b).

Tilanne aiheuttaa häiriötä perheen sisäisessä dialogissa, kun traumamuistoilta ja muilta torjutuilta epämiellyttäviltä tunteilta suojaudutaan reagoivasti tai pakonomaisesti toistetaan käyttäytymistä, joka horjuttaa perheen sisäistä tasapainoa. Tällainen käytös voi sisältää manipulointia ja stressaantunutta tai kuormittunutta lojaalisuutta. Perhe ja vanhemmat saattavat olla jumiutuneita esimerkiksi lapsen sairauteen, diagnoosiin tai tietynlaiseen käyttäytymiseen. Perheenjäsenten voi tällöin olla vaikea tai mahdoton tavoittaa toistensa näkökulmaa ja eläytyä toistensa tai lapsen kokemusmaailmaan. Tällöin musiikkiteoksen avulla esiin noussut tunne, ajatus tai muisto voi näyttäytyä tarvittavavan symbolisen etäisyyden päässä, mikä antaa väljyyttä kohdata omia ja toisen tunteita ja ajatuksia turvallisesti ja siedettävästi. Näin musiikki edistää mentalisaatiokyvyn kehittymistä, mikä kyky puolestaan auttaa säätelemään omia tunteita, vakauttaa ihmissuhteita ja edistää perheensisäistä kommunikaatiota (Pajula ym., 2015). Koska musiikki nostaa tunteita pintaan ja terapiatyö etenee koettujen tunteiden kautta kognitiiviseen vuoropuheluun, eikä päinvastoin, perhemusiikkipsykoterapia soveltuu hyvin myös tunnefokusoituneeseen ja lyhytpsykoterapeuttiseen työotteeseen (kts. Preter ym., 2018; Jaakkola ym., 2021). Musiikki

tutkitusti liittyy vahvasti myös kehoon ja musiikki puolestaan herkästi herättää kehon tuntemuksia (Nummenmaa ym., 2018; Putkinen ym., 2024). Näin perhemusiikkipsykoterapia tarinasäveltämisen keinoin edistää mielen ja kehon yhteistyötä kompleksisten tunteiden työstämisessä psykoterapeuttisessa suhteessa.

Perhemusiikkipsykoterapia tarinasäveltämisen keinoin – tekniikasta ja rakenteesta

Hoidon rakenne voi olla esimerkiksi seuraavanlainen:

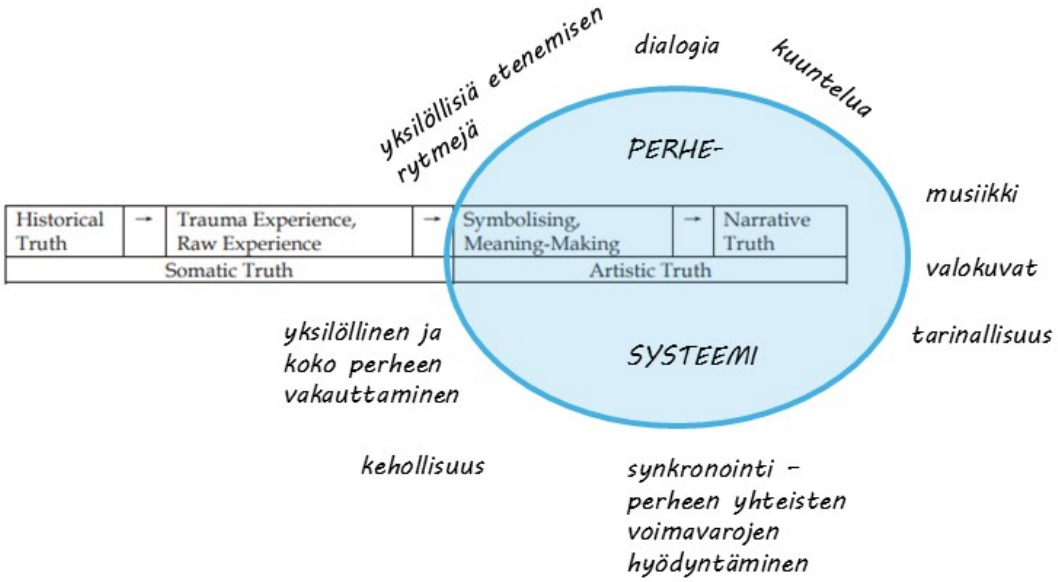
<table>
<tr><th>Toimija</th><th>vko 0</th><th>vko 1</th><th>vko 2</th><th>vko 3</th><th>vko 4</th><th>vko 5</th><th>vko 0</th><th>vko 1...</th></tr>
<tr><td>Vanhemmat</td><td rowspan="5">kaikki yhdessä</td><td colspan="2">PT</td><td rowspan="5">MT</td><td rowspan="5">kaikki yhdessä</td><td rowspan="5">kotiviikko -sisältää perheelle yksilöllisesti räätälöidyn kotitehtävän</td><td rowspan="5">kaikki yhdessä</td><td>PT</td></tr>
<tr><td>Lapsi tai lapset</td><td>MT</td><td>MT</td><td>MT</td></tr>
<tr><td>Sisarukset (tarvittaessa)</td><td></td><td></td><td></td></tr>
<tr><td>Musiikki-terapeutti</td><td>X</td><td>X</td><td></td></tr>
<tr><td>Perhe-terapeutti</td><td>X</td><td></td><td></td></tr>
</table>

Kuva 3. Perhemusiikkipsykoterapian rakenne (Hakomäki & Roisko, 2022b).

Prosessi etenee noin kuuden viikon sykleissä ottaen kuitenkin joustavasti huomioon perheen ajankäytön mahdollisuudet. Tämä on tärkeää perheen terapiamotivaation ylläpitämiseksi. Lapsen tai lapsien viikoittaisilla musiikkiterapiakäynneillä pääasiallisena menetelmänä on tarinasäveltäminen ja uusi teos pyritään tekemään joka viikko. Vanhemmat tapaavat perheterapeuttia hieman harvemmin. Yhteiseen tapaamiseen noin 3 viikon välein voivat tarvittaessa osallistua perheen muutkin lapset. Perheen kokoonpano räätälöidään kulloisenkin perhemuodon tai lapsen/lapsien huoltosuhteiden mukaan ja hoito etenee palautetietoisesti niin, että aiemmat kokemukset ohjaavat prosessin etenemistä. Niin ikään prosessin kotitehtävät laaditaan perheen sen hetkisten tarpeiden mukaisesti. Kotitehtävien tarkoitus on siirtää terapian hyödyt arjen ympäristöön lisäämällä arjen havainnointia perheen toimijuutta psykoterapiaprosessissa. Tässä integratiivisessa menetelmässä psykoterapia, taide (tässä musiikki) ja toiminallisuus kohtaavat (Hakomäki & Roisko, 2022b).

Perhemusiikkipsykoterapian merkityksiä

Artikkelissa esitellyllä menetelmällä on monia mahdollisuuksia tavoitella erilaisia tavoitteita monimutkaisten perhetilanteiden psykoterapeuttisessa työskentelyssä. Musiikki laajentaa ilmaisun keinoja ja antaa lempeää ja sallivaa symbolista etäisyyttä tunteiden ja kokemusten ilmaisuun ja jakamiseen. Taide (tässä musiikki) antaa moniaistillisia mahdollisuuksia olla vuorovaikutuksessa ja dialogissa myös vaikeissa ja riitaisissakin perhetilanteissa (kuva 4).



Kuva 4. Toimiva perhetilanne perhemusiikkipsykoterapiassa (Hakomäki & Roisko, 2022b).

Musiikkiterapia perheterapiassa edistää perheenjäsenten välistä kuuntelua ja kuuntelun avulla myös keskinäistä dialogia. Musiikin lisäksi tarvittaessa myös muut taidemuodot, kuten esimerkiksi valokuvat ja tarinat, edistävät perheen vuorovaikutuksen synkronoitumista, mikä mahdollistaa perheen yhteisten voimavarojen hyödyntämistä. Musiikki tuo psykoterapiaprosessiin mielen työskentelyn lisäksi kehollisuutta ja nämä yhdessä mahdollistavat perheen tilanteen kokonaisvaltaista vakauttamista. Musiikkiterapian avulla toteutettu perheen kanssa työskentely mahdollistaa jokaisen perheenjäsenen aktiivisen osallistumisen terapiaprosessiin. Esimerkiksi vamma tai sairaus ei estä perheenjäsenten psykoterapeuttista työskentelyä. Merkittävää on myös se, että lapset pystyvät osallistumaan prosessiin tasavertaisesti aikuisten kanssa. Lisäksi kaksi terapeuttia tuo prosessiin enemmän peilauspintoja ja transferenssikohteita kuin yksi terapeutti. Terapeuttien näkökulmasta työparityöskentely lisää refleksiivisyyttä, vertaiskeskustelua, dialogia ja työhyvinvointia. Menetelmän tärkeitä elementtejä ovat joustavuus, musiikin tarjoama siedettävä symbolinen etäisyys sekä mahdollisuus monirytmiseen ja moniääniseen dialogiin, joka huomioi terapiaan osallistuvien yksilölliset etenemisen tarpeet. (Hakomäki & Roisko, 2022b.)

Keskustelua

Perhemusiikkipsykoterapia tarinasäveltämisen keinoin on kehittynyt käytännön työn äärellä sekä kuntoutuskeskuksissa että erikoissairaanhoidossa. Taustalla vaikuttavan tarinasäveltämisen työtavan idea on puolestaan löytynyt 3–6-vuotiaiden parissa työskennellessä. Kliinisellä kentällä kehittynyt työtapa on osoittanut erinomaisen toimivuutensa käytännön työssä ja ansaitsisi lisää dokumentointia ja tutkimusta vakuuttavuutensa ja vaikuttavuutensa tueksi. Sekä tarinasäveltäminen että

perhemusiikkipsykoterapia tarinasäveltämisen keinoin ovat kuitenkin jokaviikkoisia lähestymistapoja artikkelin kirjoittajan kliinisessä työssä.

Kiitokset

Kiitän perhepsykoterapeutti, koulutuslastenpsykoterapeutti Liisa Roine-Reinikkaa ja perhepsykoterapeutti Juha Roiskoa työskentelystä kanssani tämän menetelmän keinoin terveydenhuollossa ja erikoissairaanhoidossa. Teidän ammattitaitonne, innostuksenne ja viisaat ajatuksenne ovat vaikuttaneet merkittävästi tämän esitellyn työtavan kehittymiseen.

♦ English

In the psychotherapy approach combining family therapy and music therapy methods, music can be used within the process at different levels, depending on the needs of the process phases and individual sessions. Music can function on an augmentative level, where the aim is to enhance the effects of another form of treatment or contribute to achieving therapeutic goals in the client's overall care (Bruscia, 1998). This could involve, for example, the advancement of family therapy. In the context of music psychotherapy concepts, this would be referred to as "music in psychotherapy" (Alanne, 2023; Bruscia, 1998).

From the perspective of the child in the family, music can function both on an intensive level and on a primary level within the process, where music therapy plays a central, independent, and indispensable role in achieving therapeutic goals and facilitating change (Bruscia, 1998, Wigram et al., 2002). In terms of music psychotherapy, this would be described as "music-centered psychotherapy", or in cases involving very young children or intense traumatic events, "music as psychotherapy" (Alanne, 2023; Bruscia, 1998).

Introducing the Storycomposing method

Storycomposing is a narrative form of expression based on musical invention, which allows children to express, share, and process emotions, thoughts, and experiences through music. Storycomposing was developed by listening to and consulting with children aged 3–6. There are four principles in Storycomposing, all of which must be fulfilled for the benefits of the method to be realized. The principles are: 1. the possibility of musical expression, 2. the opportunity to create a piece without teaching or guidance, 3. the piece is created while someone else listens so attentively that this listener can write down the composition with such accuracy that the creator can play it again, 4. When the piece is played, listened to, and the sheet music is viewed in the therapeutic relationship, and the creation process is recalled, the finished piece allows for the exploration and processing of the meaning of the work musically, through discussion, and by other artistic means. Different interpretations of the piece broaden perspectives and lead to insights in the one-to-one therapeutic

relationship and, for example, in family therapy and with more than one therapist. (Hakomäki, 2005; 2013)[2].

Combining music therapy and family therapy

The family music psychotherapy method presented here has been shaped by practical need. Its first steps were taken during family rehabilitation programs in Finland in the early 2000s, and the systematic integration of family therapy and music therapy through Storycomposing began based on these experiences at an outpatient family rehabilitation center in 2002 (Hakomäki, 2005). An intensive music therapy process for the child was combined with the family therapy process, and through Storycomposing, the child had the opportunity to work with the therapist in a shared, bi-personal field while creating compositions (see Ferro, 2006). Through these compositions, parents and, if necessary, siblings could also be invited into this shared field. The compositions were played, listened to, and their meanings, along with the emotions and memories they evoked, were processed through discussion. Sometimes, parents would create a new composition as if offering a response to the child's piece. Storycomposing is a child-centered method, which has been researched at the doctoral level with a 14-year-old adolescent in connection with a traumatic loss experienced during childhood and the following therapy process through Storycomposing (Hakomäki, 2013).

The application, development, and utilization of the method in specialized child psychiatry began in the 2020s, driven by the need to find a flexible and permissive approach that considers the diverse needs of family members in the psychotherapy of complex family situations. The method offers the opportunity to work with families with mental health and family dynamic disorders resulting from serious illness, neuropsychiatric disorders, family or school violence, death in the family, or other serious traumatic events (Hakomäki & Roisko, 2022a). Music therapy and the means of Storycomposing allow for the processing of intense, frightening, raw, bodily, and mentally heavy events, illnesses, personalities, and memories through art and music. The possibility of transforming real memories into more tolerable ones, both through art and symbolic meanings, has been described as follows (figure 1).

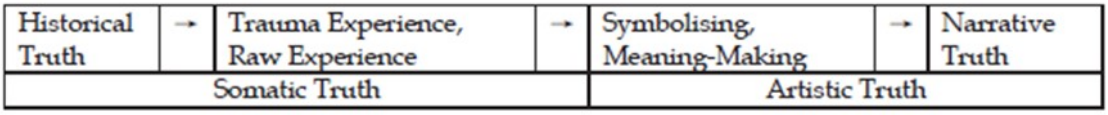


Figure 1. The framework for developing the "narrative truth" (Hakomäki, 2013, p. 93).

The image illustrates how a repressed memory in the body, which also contains an emotional memory, can be transformed through art and symbolic meanings into a personally truthful and tolerable narrative truth while working in the therapeutic relationship.

[2] In 2008, the Finnish Medical Association *Duodecim* granted the Culture Award to Hanna Hakomäki for the development of this method.

Complex Family Situation

Family music psychotherapy through Storycomposing requires an integrative approach to different psychotherapeutic orientations. Music therapy offers all participants methods and techniques for self-expression and engagement in the therapeutic relationship, and it enables non-verbal musical self-expression and interaction, activating emotions and processes of symbolic meanings. Making and playing music also allows for bodily and motor activity, which is often necessary when working with children. Additionally, the dialogue formed around storycompositions promotes dialogue within the family, even about difficult themes, but in a more tolerable way. The integrative perspective helps in finding the best possible treatment for each family, considering the needs of the children (Neimeyer, 2001; Varvin, 2002; Hakomäki, 2012; Valkonen, 2014).

When a family begins family music psychotherapy in a complicated situation that disrupts the mental health of one or more family members, the family is stuck due to some repressed emotion, memory, experience, or fact that is causing disturbance and imbalance (figure 2).

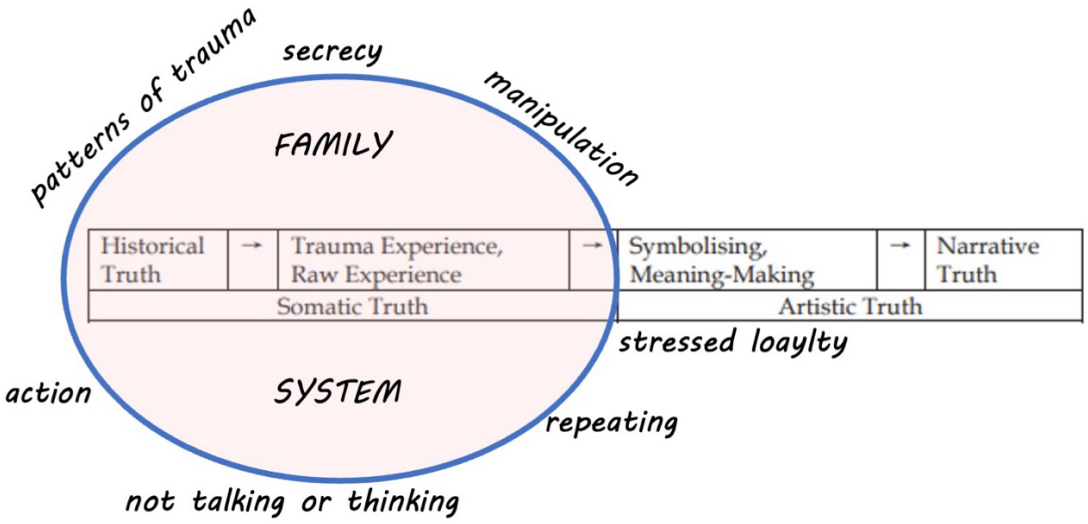


Figure 2. A complex family situation at the start of a family music psychotherapy (Hakomäki & Roisko, 2022b).

The situation disrupts the internal dialogue within the family when traumatic memories and other repressed unpleasant emotions are defended against reactively or when behavior that destabilizes the family's internal balance is compulsively repeated. Such behavior may include manipulation and stressed or burdened loyalty. The family and parents may be stuck, for example, in the child's illness, diagnosis, or certain types of behavior. In such cases, it can be difficult or impossible for family members to understand each other's perspectives or empathize with each other's or the child's experience. At these times, a feeling, thought, or memory that has surfaced through a musical composition can appear at a necessary symbolic distance, allowing space to confront one's own and another's emotions and thoughts in a safe and tolerable manner. In this way, music promotes the

development of mentalization ability, which helps regulate emotions, stabilizes relationships, and enhances communication within the family (Pajula et al., 2015). Since music evokes emotions and the therapeutic work progresses through the emotions experienced into cognitive dialogue, rather than the other way around, family music psychotherapy is well-suited for emotion-focused and short-term psychotherapeutic approaches (see Preter et al., 2018; Jaakkola et al., 2021). Music is also strongly linked to the body, and it easily evokes bodily sensations (Nummenmaa et al., 2018; Putkinen et al., 2024). Thus, family music psychotherapy through Storycomposing fosters the collaboration of mind and body in processing complex emotions within the psychotherapeutic relationship.

Family Music Psychotherapy with Storycomposing – About the Technique and Structure

The structure of the treatment can be, for example, as follows:

Person	week 0	week 1	week 2	week 3	week 4	week 5	week 0	week 1...
Parents	all together	FT		MT	all together	a week at home - includes homework individually tailored for the family	all together	FT
Child or children		MT	MT					MT
Siblings (if needed)								
Music Therapist		X	X					
Family Therapist		X						

Figure 3. The structure of Family Music Psychotherapy (Hakomäki & Roisko, 2022b).

The process progresses in cycles of approximately six weeks, while flexibly considering the family's availability. This is important for maintaining the family's motivation for therapy. During the child or children's weekly music therapy sessions, the primary method used is Storycomposing, and the aim is to create a new composition each week. Parents meet with the family therapist slightly less frequently. Joint family meetings occur approximately every three weeks, and other children in the family can participate if necessary. The composition of the family is tailored based on the current family structure or the custody arrangements of the child/children, and the treatment progresses in a feedback-informed manner, with previous experiences guiding the process. Similarly, homework tasks are designed to meet the family's current needs. The purpose of the homework is to transfer the benefits of therapy to everyday life by increasing the family's observation of daily interactions and their agency in the psychotherapy process. In this integrative method, psychotherapy, art (in this case, music), and functionality come together (Hakomäki & Roisko, 2022b).

Meanings of Family Music Psychotherapy

The method presented in the article offers many possibilities for pursuing different goals in psychotherapeutic work with complex family situations. Music broadens the means of expression and provides a gentle and permissive symbolic distance for expressing and sharing emotions and experiences. Art (in this case, music) provides multi-sensory

opportunities for interaction and dialogue, even in difficult and conflicted family situations (figure 4).

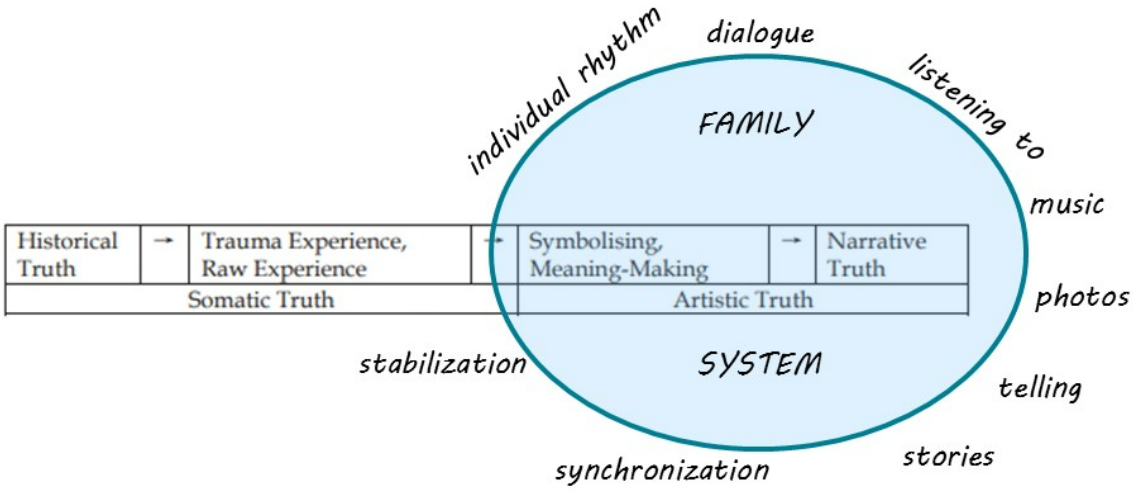


Figure 4. Functioning family situation in family music psychotherapy (Hakomäki & Roisko, 2022b).

Music therapy in family therapy promotes listening between family members, and through listening, also fosters mutual dialogue. In addition to music, other art forms such as photographs and stories can, if needed, support the synchronization of family interaction, enabling the family to utilize their collective strengths. Music adds a bodily aspect to the psychotherapeutic process, alongside mental work, and together these elements help stabilize the family's overall situation. Working with the family through music therapy allows each family member to actively participate in the therapy process. For example, a disability or illness does not prevent family members from engaging in psychotherapeutic work. It is also significant that children can participate equally with adults in the process. Furthermore, having two therapists in the process offers more opportunities for reflection and transference than one therapist alone. From the therapists' perspective, working in pairs enhances reflexivity, peer discussions, dialogue, and well-being at work. Key elements of the method include flexibility, the tolerable symbolic distance provided by music, and the possibility for multi-rhythmic and polyphonic dialogue, which considers the individual progression needs of the therapy participants (Hakomäki & Roisko, 2022b).

Discussion

Family music psychotherapy with the means of Storycomposing has developed through practical work in both rehabilitation centres and specialized medical care, whereas the idea of the Storycomposing method, which has an impact in the background, has been found when working with 3–6-year-olds. The method developed in the clinical field has shown significant functionality in practical work and would deserve more documentation and research with convincing insights and support for effectiveness. However, both Storycomposing and family music psychotherapy using Storycomposing are weekly approaches in the clinical work of the author in the article.

Acknowledgement

I would like to thank Family Psychotherapist, Child Psychotherapist Educator Liisa Roine-Reinikka and Family Psychotherapist Juha Roisko for working with me in health care and special medical care using this method. Your professionalism, enthusiasm and wise thoughts have had a significant impact on the development of this presented way of working.

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Hanna Hakomäki valmistui musiikkiterapeutiksi vuonna 1990, väitteli tohtoriksi 2013 ja valmistui perhe- ja paripsykoterapeutiksi 2017 Jyväskylän yliopistossa ja on nyt työskennellyt kahdeksan vuotta HUSin Helsingin yliopistollisen sairaalan lastenpsykiatriassa vakavista mielenterveyshäiriöistä ja monimutkaisista perhedynamiikasta kärsivien lasten ja heidän perheidensä kanssa. Hänellä on myös pitkä kokemus kehitysvammaisten kanssa työskentelystä.

Hanna Hakomäki graduated as a music therapist in 1990, completed her PhD at 2013 and studies of Family and Couple Psychotherapist at 2017 at the University of Jyväskylä and has now worked for eight years at the HUS Helsinki University Hospital, Child Psychiatry with children and their families suffering from severe mental health disorders and complex family dynamics.

Musicoterapia per le famiglie adottive

Music Therapy for Adoptive Families

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Sommario

L'articolo descrive un intervento d'equipe a supporto delle famiglie adottive in una prospettiva biopsicosociale (Bertini, 1988). La musicoterapia facilita la costruzione delle relazioni, superando le barriere linguistiche promuove il confronto fra culture e diverse identità. L'uso della comunicazione non verbale e degli elementi universali sonoro-musicali, propri del linguaggio musicale, fa emergere e rende significativi i vissuti dei minori e degli adulti, che possono essere così accolti e rielaborati per definire una nuova identità familiare.

Parole chiave: adozione – equipe – famiglia – identità – musicoterapia

Abstract

The paper describes a team intervention to support adoptive families from a biopsychosocial perspective (Bertini, 1988). Music Therapy facilitates building relationships, overcoming linguistic barriers and promotes cultural and identity dialogue. The use of non-verbal communication and universal sound-musical elements, typical of the musical language, brings out and makes meaningful the experiences of minors and adults which can then be welcomed and reworked to define a new family identity.

Keywords: adoption – team – family – identity – music therapy

♦ Italiano

Il progetto di musicoterapia proposto alle famiglie adottive, compreso tra settembre 2015 e giugno 2017, prevedeva un intervento in equipe multidisciplinare che in un'ottica sistemica, mirava a supportare tutti i componenti del nucleo familiare nel periodo che prevedeva l'ingresso e l'inserimento dei figli a scuola. L'esperienza è stata sviluppata all'interno di un progetto realizzato in provincia di Roma nato dall'incontro di diverse figure professionali attive nell'ambito dei disturbi specifici d'apprendimento.

La costruzione della famiglia adottiva è un processo lungo (Chistolini, 2010), spesso ostacolato da imprevisti e accompagnato da poche certezze. Non c'è una nascita a sancire la creazione di una

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nuova famiglia, ma si assiste ad un continuo processo di trasformazione scandito da passaggi burocratici. Per le coppie genitoriali coinvolte nella nostra esperienza, i vissuti emotivi che più frequentemente emergevano erano legati all' elaborazione del lutto (Bowlby, 1999) causato dalla sterilità e dalla perdita di una continuità biologica, connessi al sentimento di estraneità corporea, anche rispetto ai tratti somatici del figlio adottato. A volte l'unica certezza era nel fatto che il bambino aveva radici geografiche e culturali lontane e questo poteva generare fantasie persecutorie verso i genitori biologici e timori di una possibile discriminazione da parte di una società stigmatizzante.

I bambini erano portatori di una storia sospesa fra passato e presente, in cui l'abbandono originario si sommava ai traumi (Verardo & Lauretti, 2020) legati a tradimenti e/o separazioni da figure non sempre relative alla famiglia biologica, come i bambini istituzionalizzati o vissuti in famiglie affidatarie, spesso poco stabili. Nelle famiglie i bambini portavano con sé difficoltà di adattamento a nuovi modelli educativi e culturali e il confronto quotidiano con la diversità del nuovo contesto in cui si inserivano. La complessità delle famiglie adottive ha orientato l'equipe a scegliere il setting di musicoterapia come spazio terapeutico più adeguato.

La musicoterapia, fondandosi sulla relazione e basandosi sulla comunicazione non verbale (Benenzon, Casiglio & D'Ulisse, 2005) avrebbe consentito di aggirare le funzioni cognitive, facilitando le persone ad entrare in contatto con emozioni e sensazioni di cui non sempre erano consapevoli. Inoltre questo setting utilizzando le risorse dei bambini, attraverso l'incontro delle loro identità sonore (ISO) (Benenzon, 1997) con quella del musicoterapeuta, avrebbe consentito di ricostruire la loro storia, ma soprattutto di instaurare una relazione stabile che garantendogli l'esclusività di un tempo e di uno spazio dedicato. Il setting ha rappresenta un luogo dove i bambini si sono sentiti accolti, contenuti, e accompagnati nel mettere insieme i frammenti della propria storia acquisendo un'immagine unitaria di sé (Bruscia, 1995).

La conduzione non direttiva della seduta, che ha privilegiato un approccio accogliente, basato sull'attesa e l'ascolto empatico, ha consentito ai bambini, forse per la prima volta, di fare le proprie scelte in autonomia senza timore di essere abbandonati o traditi: esserci o uscire; stare nella relazione o ritirarsene; mettere in scena o meno, personaggi, paure, aspettative (Bowlby, 1989). La modalità d'intervento attiva e non verbale, l'uso del canale simbolico e metaforico del linguaggio sonoro-musicale, ha permesso a tutti i componenti della famiglia di agire nel qui ed ora della seduta emozioni profonde e situazioni di conflitto (Wigram, Pedersen & Bonde, 2003) interno altrimenti difficili da esprimere a parole (Verardo, 2020). Il progetto multidisciplinare ha tenuto conto dell'unicità dei casi, ha previsto tre fasi, valutazione, trattamento e follow up che possono essere rivolte sia ai soli bambini che all'intero nucleo familiare. La a fase di trattamento ha previsto colloqui mensili con l'intero nucleo familiare e/o di sostegno ai genitori, accompagnando i bambini e la famiglia durante l'anno scolastico, in sinergia con il team docente.

Le sedute sono state a cadenza settimanale; la durata di quella individuale è stata di 40', quella di gruppo è di 75'. Nella parte finale della seduta di gruppo ciascuno ha avuto la possibilità di rielaborare quanto vissuto, attraverso il disegno e il libero uso del colore, individualmente o su un grande foglio condiviso, in questo modo è stata crea una traccia espressiva che poteva essere ripresa come punto di riferimento nell' incontro verbale facilitato dalla psicoterapeuta o come possibile partitura informale da usare nella successiva seduta di musicoterapia.

Nell'adozione è importante facilitare l'incontro fra identità culturali e linguistiche appartenenti ad aree geografiche spesso molto distanti tra loro. Attraverso la musicoterapia in un attento lavoro di equipe, è stato possibile supportare la famiglia nel costruire un suo linguaggio, che superando la rigidità di regole sintattiche e grammaticali, dà valore alla componente non verbale della comunicazione, fatta di contatti, sguardi, sorrisi, intonazioni, come dovrebbe avvenire all'inizio di ogni relazione umana sana, unica e significativa.

♦ English

The music therapy project proposed to adoptive families, which took place between September 2015 and June 2017, involved a multidisciplinary team intervention. From a systemic perspective, such an intervention has the objective of supporting all members of the family unit in the period of their children's admission into the school context. The experience was developed within the framework of a project implemented in Rome, resulting from the meeting of different professional experts working in the field of Specific Learning Disorders (SLD).

The construction of an adoptive family is a long process (Chistolini, 2010), often hindered by unforeseen events and accompanied by few certainties. There is no birth to validate the creation of a new family, Instead, a continuous process of transformation marked by bureaucratic steps occurs. For the parental couple, the emotional experiences that most frequently emerge are related to the mourning process (Bowlby, 1999) caused by sterility and the loss of biological continuity, connected to the feeling of bodily estrangement, and also with respect to the adopted child's somatic features. Sometimes the only certainty lies in the fact that the child has distant geographical and cultural roots which generate persecutory fantasies towards the biological parents and fears of possible discrimination by a stigmatising society.

The children bear a history hanging between the past and the present, in which the original abandonment is added to the traumas (Verardo & Lauretti, 2020) linked to betrayals and/or separations from figures not always related to the biological family. This is the case of children institutionalised or living in foster families, which are often unstable. Currently, children bring with them difficulties in adapting to new educational and cultural models and the daily confrontation with the diversity of the new context in which they must fit. The complexity of adoptive families has guided the team to choose the music therapy setting as the most appropriate therapeutic space.

Music therapy is based on relationships and by relying on non-verbal communication (Benenzon, Casiglio & D'Ulisse, 2005) it bypasses cognitive functions, facilitating people to get in touch with emotions and feelings of which they are not always aware. Moreover, this setting using the children's resources, through the encounter of their sound identities (ISO) (Benenzon, 1997) with that of the music therapist, allows them to reconstruct their history, but above all to establish a stable relationship that guarantees them the exclusivity of a dedicated time and space. The setting represents a place where children can feel welcomed, contained, and accompanied when piecing together the fragments of their own history, acquiring a integrated image of themselves (Bruscia, 1995).

The non-directive manner of the session, which favours a welcoming approach, based on waiting and empathic listening, allows the children, perhaps for the first time, to make their own choices autonomously without fear of being abandoned or betrayed: to be there or to leave; to stay in the relationship or to withdraw from it; to stage or not characters, fears, expectations (Bowlby, 1989). The active and non-verbal mode of intervention, along with the use of the symbolic and metaphorical channel of sound-musical language, allow all members of the family to show deep emotions and internal conflicts (Wigram, Pedersen & Bonde, 2003) otherwise difficult to express in words, within the here and now of the session (Verardo, 2020). The multidisciplinary project, taking into account the uniqueness of the cases, includes three phases: assessment, treatment and follow-up, which can be addressed either to the children alone or to the whole family nucleus. In the treatment phase, monthly interviews with the entire family unit and/or parental support are planned, accompanying the children and family throughout the school year, in synergy with the teaching team.

Sessions are weekly; individual sessions last 40 minutes, while group sessions run for 75 minutes. In the final part of the group session, each person is given the opportunity to re-elaborate what they have experienced, through drawing and free use of colour, individually or on a large, shared sheet of paper. In this way an expressive trace is created which can be used as a point of reference in the verbal meeting arranged by the psychotherapist or as a possible informal score to be used in the following music therapy session.

In adoption, it is important to facilitate the meeting between cultural and linguistic identities belonging to geographical areas that are often very distant from each other. Through music therapy in a careful teamwork, it is possible to support the family in building its own specific language, which, overcoming the rigidity of syntactic and grammatical rules, gives value to non-verbal components of communication (i.e. physical contacts, glances, smiles, intonations), as expected at the beginning of every healthy, unique and meaningful human relationship.

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Waar muziek roepen overbrugt

MIVID: Individuele muziektherapeutische interventie ter vermindering van vocaal storend gedrag bij dementie

Where music bridges shouting

MIVID: An individual music therapeutic intervention to reduce vocal disruptive behavior in people with dementia

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Samenvatting

Deze individuele muziektherapeutische micro-interventie is een gedetailleerde beschrijving van de inzet van muziek door een gecertificeerd muziektherapeut om vocaal storend gedrag bij mensen met dementie in de laatste fase te verminderen. Het artikel beschrijft de werkzame muzikale elementen die invloed hebben op het verminderen van deze vorm van probleemgedrag (ook bekend als BSPD) bij immobiele ouderen met een dementieel beeld. Door zowel een gedegen theoretisch onderbouwing als een gedetailleerde praktijkgerichte beschrijving van de therapeutische attitude en muzikale interventies is het mogelijk deze muziektherapeutische interventie optimaal uit te voeren bij cliënten met deze specifieke problematiek. Dit biedt mogelijkheden voor gericht onderzoek.

Trefwoorden: muziektherapie – micro-interventie – dementie – vocaal storend gedrag

Abstract

This individual music therapeutic micro-intervention provides a detailed description of the use of music by a certified music therapist to reduce vocal disruptive behavior in people with dementia in the final stage. The article describes the effective musical elements that influence the reduction of this form of behavioral problems (also known as BSPD) in immobile elderly people with dementia. Through both solid theoretical support and a detailed practice-oriented description of the therapeutic attitude and musical interventions, it is possible to optimally perform this music therapeutic intervention in clients with this specific problem. This offers opportunities for focused research.

Keywords: music therapy – micro-intervention – dementia – vocal disruptive behavior

♦ **Nederlands**

Wereldwijd lijden 55 miljoen mensen aan dementie. Dat aantal zal naar verwachting ieder jaar met 10 miljoen stijgen (WHO, 2024). In de laatste fase van dementie komen veel van deze mensen in verpleeghuizen te wonen, omdat ze ernstig probleemgedrag vertonen. Behavioural Social Problematic Disorder (BSPD) kan zich bijvoorbeeld uiten als vocaal storend gedrag (VSG) dat naar schatting bij 13% van alle verpleeghuisbewoners minstens eens per week voorkomt (Geelen, 2015).

VSG is gedrag dat zich uit in het voortdurend produceren van geluid dat multi-interpreteerbaar, repeterend of ongericht is en daardoor door de omgeving als storend ervaren kan worden. Het kan gaan om roepen, klanken maken, zingen, brabbelen en praten. VSG is een van de meest impactvolle gedragsstoornissen op de omgeving omdat personen in de nabijheid zoals medebewoners, familie en zorgmedewerkers doorlopend auditief gealarmeerd worden door dit gedrag. Hun stressniveau neemt hierdoor toe wat kan leiden tot BSPD bij andere bewoners of tot stressklachten bij zorgpersoneel. Interventies die het VSG kunnen verminderen in volume, frequentie of intensiteit dragen direct bij aan het welbevinden van desbetreffende cliënt en diens omgeving (Geelen, 2015).

Mensen met dementie in de laatste fase zijn vanwege hun ziektebeeld vaak niet meer in staat om zich via gesproken taal gericht te uiten en gesproken taal te begrijpen (Muthesius, 2019). Er moet een andere manier gevonden worden om contact mogelijk te maken en zo gedrag te kunnen beïnvloeden.

Literatuurstudie

VSG wordt momenteel volgens de Richtlijn Probleemgedrag (Smalbrugge & Zuidema, 2018) behandeld met psychofarmaca. In deze richtlijn wordt als muzikale behandeling het aanbieden van muziek via een koptelefoon gesuggereerd. Ook in de Leitlinie Demenzen (Gebhardt et al., 2024) wordt muziektherapie bij BSPD sterk aangeraden. Veel literatuur beschrijft muziek als een passende interventie om BSPD, waaronder VSG, te beïnvloeden (Sakamoto, 2013; Vink et al., 2013; Steen et al., 2018; Lam, 2020, Dahms, 2021; Hakvoort & Tönjes, 2022; Witte et al., 2024). De auteurs begrijpen VSG als een uiting van onwel bevinden en behoefte aan contact en veiligheid (Huizinga et al., 2023).

Naast voorspelbaarheid lijken een aantal principes bij de behandeling van VSG cruciaal:

a. multisensorische prikkels, in evenwicht tussen voorspelbaarheid en variatie
b. ritmisch entrainment (synchronisatie)
c. vocale voorkeursmuziek

Multisensorisch

Cheng et al. (2019) en Baker (2003) geven aanwijzingen dat multisensorische stimulatie een goede manier zou zijn om BSPD te beïnvloeden. Omdat gehoor en tast de zintuigen zijn die bij dementiële achteruitgang het langst (deels) intact blijven (Thaut et al., 2020), staan deze twee zintuigen in deze interventie centraal. Het evenwicht tussen voorspelbaarheid en variatie beïnvloed de alertheid via de hersenstamreflex (Juslin, 2019).

Ritmisch entrainment

Hoewel Barradas (2021) aantoonde dat de ziekte van Alzheimer wel degelijk effect heeft op het muzikale brein, bleek in ieder geval de werking van de hersenstam reflex gelijk te zijn bij zowel de groep van cliënten met Alzheimer als in de controlegroep van dezelfde leeftijd. Het werkingsmechanisme "ritmisch entrainment" is in deze studie helaas niet onderzocht. Ritmisch entrainment vindt echter plaats in de "oude delen" van de hersenen zoals het cerebellum en de basale ganglia (Juslin, 2019; Thaut, 2021) waardoor we ervan uit kunnen gaan dat ritmisch entrainment ook in de laatste fase van dementie nog deels werkzaam is. Juslin (2019) geeft aan dat door muzikale entrainment tussen twee personen een sterk gevoel van sociale binding en connectie ontstaat. Deze interpersoonlijke synchroniciteit zou ook positief effect op vertrouwen en samenwerken hebben en is daarmee uitermate geschikt om contact te maken met mensen met dementie in de laatste fase (Juslin, 2019; Thaut & Hodges, 2021).

Vocale voorkeursmuziek

Ridder en Gummertsen (2015), Ridder et al. (2023) en Wosch (2011) suggereren dat een contactaanbod door middel van muziek aan mensen met dementie aan de primaire behoefte van contact kan voldoen.

Liederen hebben vanwege hun eenvoudige structuur de voorkeur, omdat het procedurele geheugen wordt aangesproken. Thaut et al. (2020) en Thaut (2014) vonden aanwijzingen dat het geheugen voor muziek lange tijd intact blijft waarbij muziek uit de jeugdjaren het meest betekenisvol zou zijn.Voorkeursmuziek kan ondersteunend zijn bij het creëren van een gevoel van kalmte en diepe ontspanning (Lin et al., 2011; Pedersen, 2017). Salompoor et al. (2011) toonde met hersenscans aan dat het luisteren van muziek van eigen voorkeur dopamine vrij laat komen wat invloed kan hebben op het oproepen of versterken van positieve emoties. Bij een lied met persoonlijke betekenis wordt het limbisch systeem aangesproken wat een gevoel van vertrouwdheid en voorspelbaarheid ten goede komt.

Zingen vraagt om fysiologische inspanning: de adem brengt de stembanden tot klinken. Hoewel de persoon met dementie wellicht zelf geen initiatief meer neemt of niet meer kan zingen, beïnvloedt het zingen van de therapeut toch ook de ademhaling en de spieren rondom de stembanden van de cliënt (Wosch, 2011).

Beck (2006) onderzocht dat zingen stress kan reduceren. Bloedwaardes lieten zien dat het cortisolgehalte verlaagd en de S-IgA-antistoffen verhoogd werden bij koorzangers tijdens het zingen. Ook bij baby's die door hun moeder werden toegezongen, is een verlaging van het cortisolgehalte gemeten (Koshimori, 2021 in Thaut & Hodges, 2021). Hetzelfde effect zou ook tussen muziektherapeut en cliënt van toepassing moeten zijn.

Op basis van dit literatuuronderzoek en jarenlange klinische ervaring hebben de auteurs deze nieuwe micro-interventie (Hakvoort & Tönjes, 2023) ontwikkeld de MIVID: een individuele Muziektherapeutische Interventie middels Vocale -voorkeursmuziek en -Improvisatie ter vermindering van vocaal storend gedrag bij niet-mobiele ouderen met een Dementieel beeld in de laatste fase.

MIVID: muziektherapeutische interventie ter vermindering van vocaal storend gedrag bij dementie

Hieronder volgt een stap-voor-stap beschrijving van deze interventie zodat deze ook door een muziektherapeut uitvoerbaar is of bruikbaar voor onderzoek. In de onderstaande beschrijving van de interventie wordt verwezen naar verschillende *klinische improvisatietechnieken (schuingedrukt geschreven)* van Bruscia (Bruscia, 1987; Carroll & Lefebvre, 2013). De auteurs gaan ervan uit dat gecertificeerde muziektherapeuten geschoold zijn in deze technieken.

Indicatie – doelgroep

MIVID richt zich op mensen met ernstig VSG bij dementie in de laatste fase. De cliënt is niet mobiel of blijft zitten gedurende de interventie. Lichamelijke oorzaken zoals pijn of ziekte zijn na lichamelijk onderzoek niet te verwachten. Cliënten met een zeer slecht gehoor, die ook met gehoortoestel minimaal kunnen horen, zouden minder baat bij het muzikale deel van deze interventie kunnen hebben. Voor cliënten die bekend zijn met traumatische ervaringen door aanraking, moet de MIVID aangepast worden en moet aanraking voorkomen worden. Indien cliënten bekend zijn met heftige traumatische reacties op auditieve prikkels is deze interventie met uiterste voorzichtigheid toe te passen. Het is belangrijk om zich bewust te zijn van spanning verhogende triggers en deze te vermijden.

Rol therapeut

Het contact met de cliënt wordt vanuit jou als therapeut aangegaan vanuit een empathisch directieve benadering (Geelen, 2022) waarbij je ondersteunend, niet-eisend doch sturend handelt. Gebruik een person-centred approach (Muthesius, 2019). Streef naar onvoorwaardelijke acceptatie, waarbij je niet-(voor)oordelend staat tegenover VSG van de cliënt. Zie de vocale uiting als een gebrek aan welbevinden. Je hebt zelf geen emotionele (voor)belasting ten aanzien van deze cliënt of VSG ter voorkoming van tegenoverdracht.

Mechanismes

Juslin (2019) heeft in zijn BRECVEMA theorie een aantal mechanismes beschreven hoe muziek werkt op het brein. In MIVID zijn een drietal mechanismes van belang: hersenstam reflex, ritmisch entrainment en evaluerende conditionering. De hersenstamreflex wordt gebruikt om de aandacht van de cliënt, die ten gevolge van de ziekte erg kort kan zijn, steeds weer naar de muziek te trekken en de aandacht niet te laten verslappen. De steeds beheerst aangeboden nieuwe prikkels zoals variatie in volume, het zingen van de naam of stoppen met de muziek moeten de aandacht van de cliënt beïnvloeden. Ritmisch entrainment wordt in deze interventie vooral gebruikt om synchronisatie te bereiken en zo invloed op vitale kenmerken als ademhaling en hartslag te hebben en gevoel van verbondenheid. Geruststelling en vertrouwdheid worden beoogd door de inzet van bekende muziek, evaluerende conditionering.

De Interventie

Voorbereidingen

a. Doe een zorgvuldige, multidisciplinaire probleemanalyse van het VSG.
b. Zoek de cliënt op het moment dat het VSG zich voordoet op en observeer deze van een afstandje.
c. Maak (met toestemming) een audio- en/of video opname van de vocale uitingen.
d. Analyseer patronen in het VSG.
e. Meet indien mogelijk de frequentie, volume en intensiteit.
f. Analyseer de gedragskenmerken die input geven voor de mogelijk inzetbare muzikale parameters.
g. Zoek favoriete muziek van de cliënt of muziek uit de periode waarin de cliënt tussen de 15 en 25 jaar oud was.
h. Voeg deze muziek toe aan je repertoire en zorg dat je voldoende flexibel bent voor het inzetten van spontane variaties.

Behandeling

a. Neem de cliënt mee naar een rustige omgeving die vertrouwd is voor de cliënt en zorg voor geen verstoring door de omgeving. Tip: indien aanwezig en niet belastend zet je een hartslagmeter op de vinger van de cliënt.
b. Ga recht tegenover de cliënt zitten en spreek deze aan bij naam (hersenstamreflex).
c. Leg jouw handen op de knieën van de cliënt. Mocht de cliënt verbaal of non-verbaal een andere behoefte aan fysiek contact aangeven (bv. knuffelen, de handen vastpakken), pas je de manier aan waarop je tactiele input geeft.
d. Observeer de reacties daarop, kijk of je de ademhaling van de cliënt kan zien en probeer jouw ademhaling daarop aan te passen (synchronisatie, entrainment).
e. Ga mee in eventuele lichamelijke bewegingen van de cliënt. Kijk de cliënt met een open en vriendelijk gezicht aan. Blijf jouw ademhaling synchroniseren. Indien je geen contact krijgt, noem nogmaals de naam van de cliënt. Speel daarbij met je intonatie en houdt rekening met eventuele beperkingen van bepaalde zintuigen.
f. Sluit aan bij de klanken/uitingen van de cliënt terwijl je diens naam zingt. Spiegel de klanken in klankleur, intensiteit, volume, frasering, toonsoort en melodie (reflection, imitating, synchronizing en pacing).
g. Start met het zingen van stukjes van de muziek die je in stap g) en h) van de voorbereiding hebt uitgezocht (evaluerende conditionering) afwisselend met daadwerkelijk spiegelen van de uitingen van de cliënt. Sluit daarbij aan bij de intensiteit van de vocale uitingen van de cliënt (pacing, synchronisatie). Varieer met spiegelen van de uitingen van de cliënt en het introduceren van het lied (hersenstam reflex). Werk toe naar een duidelijke puls in 6/8 of 3/4 maatsoort met een frasering die aansluit bij de ademhaling en hartslag van de cliënt (Loewy, 2015) (entrainment, shaping, tonal centering, holding, rhythmic grounding).
h. Observeer merkbare veranderingen in de uitingen van de cliënt en reageer erop door bij verslappen van de aandacht een interventie te plegen om de aandacht er weer bij te trekken (hersenstamreflex). Zing op zo laag mogelijke toonhoogte binnen de passende toonsoort

(rustgevend). Bepaal het tempo door lichaamssignalen bij voorkeur ademhaling of mogelijke beweging van de cliënt te observeren (ritmische entrainment). Eventueel kan je de maat van het lied ook meetikken met de hand op de knie of meedeinen in beweging.

i. Speel met volgen en leiden en probeer toe te werken naar een leidende rol. Als de aandacht verslapt, pleeg een interventie die de aandacht er weer bijtrekt (hersenstam reflex).

j. Indien synchronisatie is bereikt, begin voorzichtig de intensiteit van het VSG te verminderen (shaping, modelling, calming). Synchronisatie is bereikt als je hetzelfde tempo gebruikt (pacing), de frasering hetzelfde is en de ademhaling gelijkmatig is. Verminder gedoseerd het tempo door net iets langzamer te zingen dan de cliënt roept (let op! het verschil mag niet in één keer te groot zijn; verlies entrainment). Verminder langzaam het volume van de vocale uitingen en de intensiteit van de uitingen. Pas langzaam ook de toonhoogte aan, ga steeds een beetje lager zingen. Stemklank kan steeds iets meer naar sotto voce gaan. Vermijd grote sprongen in de melodie en probeer de frasering steeds op de ademhaling van de cliënt aan te passen en bij voorkeur rustiger te maken (entrainment, shaping, pacing, calming).

k. Herhaal hetzelfde lied of delen ervan maar gebruik ook aanpassingen die de alertheid van de cliënt er weer bij halen (hersenstam reflex), zoals variatie in ritme, volume, andere woorden en logische verandering in toonsoort. Denk hierbij aan kleine improvisaties als het zingen van de naam van de cliënt of geruststellende teksten, toepassen van variatie in melodie of een modulatie. Let op dat de muzikale structuur logisch blijft en geen plotselinge veranderingen kent.

l. Observeer het effect van de interventie op het VSG. Blijf frequentie, volume en intensiteit van het VSG monitoren. Herhaal interventies in stap f) t/m k) van de behandeling tot je een optimaal resultaat bereikt.

m. Het doel is bereikt wanneer frequentie, volume en intensiteit van de vocale uiting dermate zijn verminderd dat zowel cliënt als omgeving hier geen hinder meer van ondervinden of wanneer het niet verder afneemt.

Het is niet mogelijk een precieze tijdindicatie te geven per stap daar dit situatie afhankelijk is. Neem minimaal een kwartier de tijd om deze interventie uit te voeren.

Afronding:

n. Rond het contact af door steeds minder prikkels te geven, steeds zachter te zingen en eventueel de handen weg te nemen om zo bijna ongemerkt het contact te beëindigen. Als het ware is er sprake van een fade-out van alle zintuigelijke prikkels. Idealiter blijft het VSG van de client hierna verminderd. Bij opnieuw toename van frequentie, volume en/of intensiteit in het VSG van de cliënt; herhaal je behandelstappen d) t/m l).

Conclusie

MIVID is in de praktijk ontwikkeld en met literatuur onderbouwd. MIVID maakt via muziek op een basaal niveau contact met mensen met een dementieel beeld in de laatste fase om VSG te helpen verminderen. MIVID kan via improvisatorische technieken (lettend op BRECVEMA principes) doelgericht worden ingezet om contact mogelijk te maken, welbevinden te bevorderen en VSG te verminderen.

De auteurs moedigen andere muziektherapeuten aan gebruik te maken van MIVID. Het zou goed zijn als er onderzoek gedaan wordt naar de effectiviteit ervan.

♦ English

Worldwide, 55 million people suffer from dementia. That number is expected to increase by 10 million each year (WHO, 2024). In the final stage of dementia, many of these people end up living in nursing homes because they exhibit severe behavioral problems. Behavioral Social Problematic Disorder (BSPD) can manifest as vocal disruptive behavior (VDB) which is estimated to occur at least once a week in 13% of all nursing home residents (Geelen, 2015).

VDB is behavior that manifests itself in the continuous production of sounds that are multi-interpretable, repetitive, or undirected and therefore may be perceived as disruptive by the environment. This can include shouting, making sounds, singing, babbling, and talking. VDB is one of the most impactful behavioral disorders on the environment because individuals in the vicinity, such as fellow residents, family, and caregivers, are continuously audibly alarmed by this behavior. This increases their stress level, which can lead to BSPD in other residents or stress complaints in care personnel. Interventions that can reduce VDB in volume, frequency, or intensity directly contribute to the well-being of the affected client and their environment (Geelen, 2015). Due to their dementia, people in the final stage are often no longer able to express themselves or understand spoken language (Muthesius, 2019). An alternative way must be found to enable contact and influence this disturbing behavior.

Literature Review

Currently, VDB is treated with psychopharmaceuticals according to the “Richtlijn Probleemgedrag” (Smalbrugge & Zuidema, 2018). This guideline suggests offering music through headphones as a "musical" treatment. The Leitlinie Demenzen (Gebhardt et al., 2024) also strongly recommends music therapy for BSPD. A significant amount of literature describes music as a suitable intervention to influence BSPD, including VDB (Sakamoto, 2013; Vink et al., 2013; Steen et al., 2018; Lam, 2020, Dahms, 2021; Hakvoort & Tönjes, 2022; Witte et al., 2024). The authors understand VDB as an expression of discomfort and a need for contact and safety (Huizinga et al., 2023).

Besides predictability, several principles seem crucial in the treatment of VDB:

a. Multi-sensory stimuli, balanced between predictability and variation
b. Rhythmic entrainment (synchronization)
c. Vocal preference music

Multi-sensory

Cheng et al. (2019) and Baker (2003) provide evidence that multisensory stimulation is a good way to influence BSPD. Because hearing and touch are the senses that remain partly intact the longest in the progression of dementia (Thaut et al., 2020), these two senses are central to this intervention. The balance between predictability and variation affects alertness via the brainstem reflex (Juslin, 2019).

Rhythmic entrainment

While Barradas (2021) demonstrated that Alzheimer's disease does affect the musical brain, at least the brainstem reflex was found to work the same in both the Alzheimer's group and the age-matched control group. Unfortunately, this study did not investigate the mechanism of "rhythmic entrainment". However, rhythmic entrainment occurs in the "old parts" of the brain, such as the cerebellum and basal ganglia (Juslin, 2019; Thaut, 2021), so we assume that rhythmic entrainment is still partially functional even in the final stage of dementia. Juslin (2019) states that musical entrainment between two people creates a strong sense of social bonding and connection. This interpersonal synchronicity could also positively affect trust and cooperation, making it highly suitable for connecting with people in the final stages of dementia (Juslin, 2019; Thaut & Hodges, 2021).

Vocal preference music

Ridder and Gummertsen (2015), Ridder et al. (2023), and Wosch (2011) suggest that music can fulfill the primary need for contact in people with dementia.

Songs are preferred due to their simple structure, as they engage procedural memory. Thaut et al. (2020) and Thaut (2014) found evidence that music memory remains intact for a long time, with music from the youth years being the most meaningful. Preference music can support creating a sense of calm and deep relaxation (Lin et al., 2011; Pedersen, 2017). Salompoor et al. (2011) showed through brain scans that listening to one's favorite music releases dopamine, which can influence the evocation or enhancement of positive emotions. A song with personal meaning activates the limbic system, benefiting the feeling of familiarity and predictability.

Singing requires physiological effort: one's breath activates the vocal cords. Although the person with dementia may no longer initiate or be able to sing, the therapist's singing also affects the client's breathing and muscles around the vocal cords (Wosch, 2011). Beck (2006) found out that singing can reduce stress. Blood values showed that cortisol levels decreased and S-IgA antibodies increased in choir singers during singing. A similar effect was measured in babies sung to by their mothers (Koshimori, 2021 in Thaut & Hodges, 2021). The same effect should also apply between music therapist and client.

Based on this literature review and years of clinical experience, the authors have developed this new micro-intervention (Hakvoort & Tönjes, 2023), the MIVID: an individual Music therapy Intervention using Vocal preference music and Improvisation to reduce vocal disruptive behavior in immobile elderly people with Dementia in the final stage.

MIVID: Music therapeutic Intervention to reduce Vocal disruptive behavior in Dementia

Below is a step-by-step description of this intervention, so it can be implemented by a music therapist or used for research. In the following intervention description, various clinical improvisation techniques by Bruscia are referenced (Bruscia, 1987; Carroll & Lefebvre, 2013). The authors assume that certified music therapists are trained in these techniques.

Indication – Target Group

MIVID targets people with severe VDB in the final stage of dementia. The client is immobile or remains seated during the intervention. Physical causes such as pain or illness are not expected after a physical examination. Clients with very poor hearing, who can hear minimally even with a hearing aid, may benefit less from the musical part of this intervention. For clients known to have traumatic experiences with touch, MIVID must be adapted, and touch should be avoided. If clients are known to have severe traumatic reactions to auditory stimuli, this intervention should be applied with extreme caution. It is important to be aware of stress-inducing triggers and avoid them.

Therapist's role

Contact with the client is approached from you as a therapist with an empathic directive approach (Geelen, 2022) where you act supportive, non-demanding yet guiding. Use a person-centered approach (Muthesius, 2019). Strive for unconditional acceptance, where you stand non-(pre)judgmentally towards the client's VDB. See the vocal expression as a lack of well-being. You have no emotional (pre)load regarding this client or VDB to prevent negative countertransference.

Mechanisms

Juslin (2019) described several mechanisms in his BRECVEMA theory on how music affects the brain. In MIVID, three mechanisms are important: brainstem reflex, rhythmic entrainment, and evaluative conditioning. The brainstem reflex is used to repeatedly draw the client's attention to the music, preventing their attention from waning. The controlled introduction of new stimuli, such as variations in volume, singing the client's name, or pausing the music, should influence the client's attention. Rhythmic entrainment is mainly used in this intervention to achieve synchronization and thus influence vital characteristics such as breathing and heart rate, and to foster a sense of connectedness. Reassurance and familiarity are intended through the use of familiar music, evaluative conditioning.

The Intervention

Preparations:

a. Conduct a thorough, multidisciplinary problem analysis of the vocal disruptive behavior (VDB).
b. Approach the client at the moment the VDB occurs and observe them from a distance.
c. Make an audio and/or video recording of the vocal expressions (with permission).

d. Analyze patterns in the VDB.
e. Measure the frequency, volume, and intensity, if possible.
f. Analyze the behavioral characteristics that provide input for potentially applicable musical parameters.
g. Find the client's favorite music or music from the period when the client was between 15 and 25 years old.
h. Add this music to your repertoire and ensure that you are flexible enough to incorporate spontaneous variations.

Treatment

a. Bring the client to a calm environment that is familiar to them and ensure no disturbances from the surroundings. Tip: If available and not burdensome, place a heart rate monitor on the client's finger.
b. Sit directly across from the client and address them by their (first) name (brainstem reflex).
c. Place your hands on the client's knees. If the client indicates a different preference for physical contact (e.g., hugging, holding hands) verbally or non-verbally, adjust the way you provide tactile input.
d. Observe the reactions to this; see if you can notice the client's breathing and try to adjust your own breathing accordingly (synchronization, entrainment).
e. Join in any bodily movements of the client. Look at the client with an open and friendly expression. Continue synchronizing your breathing. If you don't establish contact, call the client's name again, playing with your intonation and considering any sensory limitations.
f. Align with the client's sounds/expressions while singing their name. Mirror the sounds in tone color, intensity, volume, phrasing, key, and melody (reflection, imitating, synchronizing, and pacing).
g. Start singing parts of the music you identified in steps g) and h) of the preparation (evaluative conditioning), alternating with directly mirroring the client's expressions. Match the intensity of the client's vocal expressions (pacing, synchronization). Vary between mirroring the client's expressions and introducing the song (brainstem reflex). Aim for a clear pulse in a 6/8 or 3/4 time signature, with phrasing that matches the client's breathing and heart rate (Loewy, 2015) (entrainment, shaping, tonal centering, holding, rhythmic grounding).
h. Observe noticeable changes in the client's expressions and respond by intervening to recapture attention if it wanes (brainstem reflex). Sing in the lowest possible pitch within the appropriate key (soothing). Determine the tempo by observing body signals, preferably breathing or possible movements of the client (rhythmic entrainment). Optionally, you can tap the beat of the song with your hand on the knee or sway along with the movement.
i. Play with following and leading, and try to work towards a leading role. If attention diminishes, intervene to recapture it again (brainstem reflex).
j. If synchronization is achieved, start gently reducing the intensity of the VDB (shaping, modeling, calming). Do this while maintaining the same tempo (pacing), consistent phrasing, and even breathing. Gradually decrease the tempo by singing slightly slower than the client calls out (note: the difference must not be too large at once; to avoid losing entrainment). Gradually lower the volume and intensity of the vocal expressions. Slowly adjust the pitch as

well, singing progressively lower. The vocal tone can shift increasingly towards sotto voce. Avoid large jumps in the melody and try to adapt the phrasing consistently to the client's breathing, ideally making it calmer (entrainment, shaping, pacing, calming).

k. Repeat the same song or parts of it, but also incorporate adjustments that help regain the client's alertness (brainstem reflex), such as variations in rhythm, volume, different words, and logical changes in key. Think of small improvisations like singing the client's name or reassuring texts, applying variations in melody, or a modulation. Ensure that the musical structure remains logical without sudden changes.

l. Observe the effect of the intervention on the VDB. Continuously monitor the frequency, volume, and intensity of the VDB. Repeat interventions from steps f) to k) of the treatment until optimal results are achieved.

m. The goal is achieved when the frequency, volume, and intensity of the vocal expression have decreased sufficiently that neither the client nor their surroundings are disturbed, or when it no longer decreases.

It is not possible to provide a precise time estimate for each step as this depends on the situation. Take at least fifteen minutes to carry out this intervention.

Ending

n. Conclude the contact by gradually reducing stimuli, singing softer, and possibly removing your hands to subtly end the contact. This is akin to a fade-out of all sensory stimuli. Ideally, the client's VDB remains reduced afterward. If there is a renewed increase in the frequency, volume, and/or intensity of the client's VDB, repeat treatment steps d) to l).

Conclusion

MIVID was developed in practice and is supported by literature. MIVID uses music at a basic level to establish contact with individuals with dementia in the final stage to help reduce vocal stereotypy (VDB). MIVID can be purposefully applied through improvisational techniques (focusing on BRECVEMA principles) to facilitate contact, promote well-being, and reduce VDB. The authors encourage other music therapists to use MIVID. The authors stimulate further research into the effecitveness of the intervention.

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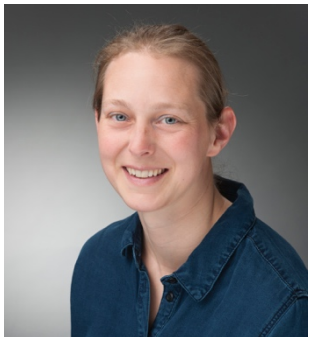

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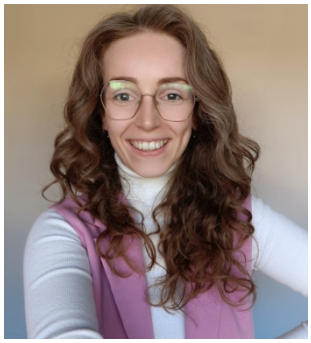

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Exploring Community Singing for Mothers of Fallen Soldiers — a Music Therapy Intervention to Enhance Well-Being

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Abstract

Ongoing wars around the world have left populations with severe mental illnesses including post-traumatic stress disorder (PTSD). The present study examines music therapy, particularly community singing, as a potential intervention to support the well-being of mothers of fallen soldiers. A community singing program (six group sessions, each lasting 90 minutes) was offered to Armenian mothers who lost their sons in the war, and feedback was gathered through a questionnaire. Analysis was conducted using thematic analysis to identify themes relating to their experiences and perceptions of the music therapy program. Results show that community singing delivered substantial benefits, including enhanced self-confidence and improved mood. This study contributes to the growing body of evidence supporting the effectiveness of community singing as a valuable intervention in aiding individuals coping with profound grief and loss.

Keywords: music therapy – community singing – trauma – mothers – fallen soldiers

♦ English

The traumas of war have a significant impact on the mental health and well-being of the affected communities and their future generations (Carta et al., 2015). Trauma can manifest in various forms, such as post-traumatic stress disorder (PTSD), and it can affect a person's mental and emotional well-being. The prevalence rates of mental disorders, including anxiety and mood disorders, range up to 47 % (Priebe et al., 2010), and it is evident that these issues persist even after the war. In several countries, a wide range of health care and community-based services are provided to support and aid these populations (Al-Tamimi& Leavey, 2022; Franciskovi ć et al., 2008). Studies show that Community Music Therapy (CMT) emphasizes the communal aspects of music, acknowledging the social and cultural contexts that shape individuals 'health and well-being (Ansdell, 2002). CMT promotes social connectedness and inclusion, which is crucial in supporting war-affected populations who often face isolation and marginalization. Community singing, in particular, plays a significant role in promoting mental health and well-being. Singing

together enhances social connectedness, a sense of belonging, and emotional resilience (Bailey & Davidson, 2005; Clift & Hancox, 2001). The collective experience of singing helps bridge gaps between individuals, creating a supportive environment that celebrates diversity and shared resilience (Gridley et al., 2011). Research has also shown that community singing improves psychological outcomes by meeting essential individual needs such as autonomy, connectedness, and self-esteem (Hendry et al., 2022). These benefits are crucial for populations affected by war and trauma, as music is able to provide a safe, communal space for expression and healing.

Since 1988, Armenia has faced a series of wars, resulting in war casualties being one of the main contributors to its demographic crisis (Avetisyan, 2021). With a relatively young median age of fallen soldiers, families and mothers are left in the aftermath. While there are efforts to support the psychological well-being of those who were left behind, it is more often targeted at children in group settings, with few projects addressing adults (Heidenreich, 2005). Currently, there are no music therapy services provided in Armenia and few mental health services which exclusively target soldiers and veterans. In addition, there is also limited literature and research done on mothers who have lost their sons in the line of duty. The present study is an initiated project in collaboration with the mental health center in Village Proshyan, Armenia. The study aims to explore the use of community singing with mothers of fallen soldiers and to gain insights about their experiences and perceptions of the music therapy program.

Methods

The following describes the implementation of the music therapy program and the evaluation of the open questionnaire at the end of the program using reflexive thematic analysis. The study participants were recruited with the help of the Proshyan Center for Mental Health, a center that offers support programs specifically for family members of fallen soldiers. The initial request was to recruit eight to twelve mothers from different regions, who were interested in taking part in a music therapy program. With the help of the center, eight mothers were invited to the program. The participating mothers (mean age = 41.5 years, range = 38-51 years) had no previous experience with therapy and had different levels of musical knowledge. Written informed consent was obtained from all participants at the beginning of the program.

Participants attended six group music therapy sessions over one month. The sessions were facilitated by a music therapist (Author 1), and they were conducted in Armenian which is the first language of both therapist and participants. Each group session lasted 90 minutes and followed a similar structure of warm-up activity, main intervention and closing activity. The content and materials of the sessions were planned in the spirit of CMT. Warm-up activities include introductions, body percussion, dancing to folk music, and clapping games. The main intervention is community singing of folk songs, popular songs, and songs specifically requested by the participants. The session concludes with a closing activity consisting of music listening, guided breathing exercises, and mantra chanting.

After the last group music therapy session, the participants received a questionnaire. All eight participating mothers took part in the survey. Open-ended questions were asked to capture general information about the participants' experiences and perceptions of music therapy, including what impressed or disturbed them, what qualities of the therapist were important to them, and what they

would like to change in the sessions. The questions and answers were then translated into English and the data organized into tables.

The authors systematically subjected the data obtained to a reflexive thematic analysis based on the guidelines of Braun and Clarke (2006). Independently of each other, the authors systematically analyzed the data in the following steps: (1) The authors thoroughly read the data to familiarize themselves with it. (2) They coded the data independently and grouped them according to patterns of meaning. (3) Author 2 created a preliminary list of possible topics based on the groups of patterns of meaning. (4) Both authors discussed the codes and topics, and the list of topics was further refined. Author 1 paid careful attention to possible biases, as she also led the music therapy sessions. Author 2 was not involved in the sessions and was able to analyze the data from a more unbiased position.

Results

Using reflexive thematic analysis of the data obtained, five topics were identified:

Theme 1: Positive effect on mood

Overall, participants found the music therapy program to be a pleasant experience. They spoke about experiencing calmness and peace from the sessions, and reacted very positively. One participant felt »relief from their current state of mind« after attending the sessions.

- »This format of group music therapy transferred a lot of positive energy.«

Theme 2: Enhanced self-confidence and self-awareness

Through singing, participants made new discoveries about themselves in the process. They acknowledged and appreciated the changes within themselves. The concept of *overcoming* was mentioned frequently in the responses:

- »I overcame my inhibitions and sang.«
- »It was a depressive period in my life, but I overcame it during this program.«
- »I was just bothered because I was closed, but I tried to overcome.«
- »In the beginning, it was difficult for me when the therapist asked us to sing or dance. I felt discomfort inside, but I overcame it.«

Participants shared about what they could not do before and they reflected on how they have changed through the sessions. Some welcomed singing back into their lives, while others experienced physical changes such as *improving attention* and better sleep:

- »I did not think that I could sing and listen to music freely and easily. With music therapy, new feelings appeared for me.«
- »I felt opened up somehow as if you have not smiled and felt happy for a while. Then you try to sing and even dance, and I tried – and I did it! Before that, I was thinking I would never do these things.«

- »I had convinced myself that I could not sing or dance after my son's loss. But I overcame my stereotypes and an interesting change happened. My sleep has recovered from its disturbed state since 2018, and now I started sleeping without pills. Besides the improved sleep, with the help of breathing exercises, I can control and get rid of my negative thoughts.«

Theme 3: Therapeutic alliance between therapist and client

Participants appreciated the therapist's presence and facilitation in the sessions. Some participants commented positively about their professional expertise, while others expressed love and gratitude for the therapist:

- »I love the therapist, she is a very good and sincere person. Our communication is very positive, simple, and frank.«
- »I am very grateful to the therapist for her professional attitude towards us.«

Theme 4: Encouraged group dynamics

Participants valued the presence of the group and enjoyed group activities such as group dancing. Being part of a group also helped them to form new relationships, allowing them to observe new insights about themselves and others.

- »It was impressive to me that I noticed changes in the other participants of the group.«

Theme 5: Increased motivation

Several participants shared that they gained a positive impression of music therapy and community singing because of the progress they had made through the sessions. They expressed enthusiasm to participate and are motivated to take part in similar therapy sessions in the future.

- »I would like to participate frequently [referring to music therapy] and to have the same feelings again.«
- »In the beginning, I was hesitant and was not sure if I should come. But I joined and I didn't regret it. I was looking forward to our meetings.«

Discussion

The present study aimed to explore the use of community singing with mothers of fallen soldiers. Data on the experiences and perceptions of the mothers participating in the study regarding the music therapy program offered were collected using a questionnaire with open-ended questions.

Overall, the responses from the participants were positive. Participating in the music therapy program has provided them with several benefits to their well-being including improved mood (Theme 1), calmness, and relief. Singing in particular, helped them to grow in self-confidence and self-awareness (Theme 2), allowing them to overcome personal challenges and struggles. The therapeutic alliance between the therapist and the participants (Theme 3) had a supportive impact on communication, fostering a positive atmosphere and a sense of ease among the group. The community group setting of the program enhanced interpersonal connection and encouraged

group dynamics (Theme 4), which alleviates loneliness and creates a supportive environment at the same time. In general, participants had a positive impression of music therapy and expressed increased motivation (Theme 5) to participate in similar programs in the future.

While the present study provides important insights about music therapy and community singing for this specific population, several limitations must be acknowledged. The sample size was small and limited to a specific geographic area, which limits the generalisability of the findings to broader populations. Instead, a larger and more diverse participant pool could be used in the future to enhance the applicability of the results. The reliance on only one form of self-reported data can be mitigated by incorporating objective measures, such as assessments of emotional well-being and self-confidence, which would strengthen the study's validity. It is also recommended that having more sessions or a longer program duration in the future can provide more insights and a better understanding of working with this population.

In conclusion, the present study suggests that music therapy can positively impact the self-confidence and well-being of mothers of fallen soldiers. The participants' acceptance and willingness to continue participating in community singing, highlight its potential as a therapeutic intervention that support them in their mental health journey. Future research should continue to refine music therapy programs for this population and explore its transformative potential in supporting healing and recovery.

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Creating Family Spaces Through Music: Fostering Connection and Development

Створення сімейного простору через музику: сприяння зв'язку та розвитку

Crearea unui spațiu familial prin muzică: promovarea conexiunii și dezvoltării

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Abstract

In 2022, a Ukrainian-Romanian project was initiated to introduce music therapy at the Brain Up therapy center in Piatra-Neamț, Romania: Led by a Ukrainian-speaking music therapist, music therapy was integrated into sessions with dyads and families of children with special needs. Preliminary results show positive changes in clients' verbal and nonverbal communication. Key goals of music therapy include enhancing socialisation, language skills, and emotional regulation. The results emphasize the unique role of nonverbal musical interactions in music therapy, which led to improved family communication and positive changes in children's emotional and verbal development. Significant progress was observed in socialisation, self-regulation, and speech – even when there were language barriers – underscoring the importance of non-verbal interactions. The results offer promising opportunities for further research and application in similar contexts.

Keywords: music therapy – communication – socialisation – speech development – self-regulation – systemic family psychotherapy

Анотація

У 2022 році був реалізований україно-румунський проєкт, спрямований на інтеграцію музичної терапії в Центрі терапії Brain Up у П'ятра-Нямц, Румунія. Проєкт здійснювався під керівництвом україномовного музичного терапевта, та був спрямований на роботу з діадами та сім'ями дітей з інвалідністю. Музична терапія була впроваджена для покращення комунікаційних процесів, соціалізації, мовного розвитку та емоційної

регуляції. Попередні результати свідчать про позитивні зміни в вербальній та невербальній комунікації учасників. Окремо було відзначено важливість невербальних музичних взаємодій, які сприяли поліпшенню взаємодії в сім'ях та розвитку емоційних і вербальних навичок у дітей. Прогрес у соціалізації, саморегуляції та мовленні був помітним, навіть при наявності мовних бар'єрів, що підкреслює значення невербальної комунікації. Результати проєкту відкривають нові можливості для подальших досліджень і застосування музичної терапії у схожих контекстах.

Ключові слова: музична терапія – комунікація – соціалізація – мовний розвиток – саморегуляція – сімейна психотерапія.

Rezumat

În 2022, a fost implementat un proiect ucraineano-român care a vizat integrarea terapiei prin muzică în cadrul Centrului de Terapie Brain Up din Piatra-Neamț, România. Proiectul a fost realizat sub îndrumarea unui terapeut muzical vorbitor de limba ucraineană, care a lucrat cu diade și familii ale copiilor cu nevoi speciale. Terapia prin muzică a fost introdusă pentru a îmbunătăți procesele de comunicare, socializare, dezvoltare a limbajului și autoreglare emoțională. Rezultatele preliminare arată schimbări pozitive în comunicarea verbală și nonverbală a participanților. Un aspect important a fost rolul interacțiunilor muzicale nonverbale, care au contribuit la îmbunătățirea interacțiunii familiale și la dezvoltarea abilităților emoționale și verbale ale copiilor. Progrese semnificative au fost observate în socializare, autoreglare și vorbire, chiar și în prezența barierelor lingvistice, subliniind importanța comunicării nonverbale. Rezultatele proiectului deschid noi oportunități pentru cercetări viitoare și aplicarea terapiei prin muzică în contexte similare.

Cuvinte cheie: terapie prin muzică – comunicare – socializare – dezvoltare a limbajului – autoreglare – psihoterapie de familie.

♦ English

According to Frohne-Hagemann (2001), understanding a child's worldview and providing them with the space to develop based on their unique needs is gaining increasing attention among researchers and practitioners working with entire families. While it is expected to focus on correcting symptoms or treating disorders, the subject-oriented model (Prokopiv, 2019) emphasises psychotherapeutic intervention towards optimising neurodevelopmental processes. Therapeutic relationships and musical experiences created through joint music-making and interactive musical games foster favourable conditions for experiencing new, positive relationships. This, in turn, enables the possibility of re-patterning family dynamics, allowing families to learn new and more effective forms of communication that support the child's developmental process.

Research on families raising children with disabilities suggests that communication within these families is often affected by the child's self-regulation and socialisation challenges. Khmyzova and Ostapenko (2011) highlight that such families frequently experience a lack of emotional support. In this context, family-based music therapy has been shown to improve self-regulation and

enhance the quality of social interactions, resulting in positive developmental and behavioural changes, particularly in interactions with adults (Malloch, 2012).

When working with families of children with multiple and profound psychomotor disorders, our music therapy approach to communication development was primarily based on the concept of neuroplasticity (Baker & Roth, 2009). According to data from Groß, Linden & Ostermann (2010), the effectiveness of music therapy lies in its holistic impact on the brain, simultaneously engaging rhythmic and melodic elements, as rhythm, meter, and phrasing activate the left hemisphere, while melody, harmony, and timbre stimulate the right hemisphere.

Materials and Methods of Research

The project's goals were based on a developed model, with the primary aim of establishing communication through music therapy. The main objectives included fostering interaction, enhancing emotional regulation, and promoting speech development. The model identified three critical communication components: regulatory, affective, and informational, focusing on emotional expression, regulation, and cognitive activation.

The study involved 20 families with children (aged 2.5 to 13 years) with neurodevelopmental disabilities and communication difficulties. Twelve children (65%) were assigned to Group 1 as Gestalt Language Processors (GLP), characterised by holistic language processing (Blanc, 2012), while the remaining eight (35%) were in Group 2 with an analytical approach. Diagnoses included profound disabilities, autism spectrum disorder (ASD), and sensorimotor alalia.

Music therapy sessions (5 to 10 per family) were conducted in a family format with no additional interventions. The effectiveness was evaluated based on changes in social, emotional, and language skills, using the *Music in Everyday Life* (MEL) questionnaire (Gottfried, 2012) and the Natural Language Acquisition (NLA) framework (Blanc, 2012). Despite the language barrier, each child showed unique and significant improvements in both verbal and nonverbal abilities, highlighting the individualised nature of the music therapy intervention.

Therapists observed significant improvements in children from the GLP group, showing enhanced creative and spontaneous communication. The NLA framework guided the intervention, addressing six stages of language development, as outlined by Peters, Prizant and Blanc (Blanc, 2012). Interventions included communicative improvisation, free improvisation, songwriting, and other media like dance and drawing. These approaches were aligned with Irvin Yalom's (1995) principles, focusing on establishing cohesion and catharsis within the family.

The primary goal was to create a positive experience of interaction that addressed communication needs and encouraged self-regulation. The therapeutic environment supported participants in expressing themselves creatively, with the therapist playing a key role in building relationships and guiding musical interactions. This approach helped families explore and develop new, constructive ways of engaging in joint creative activities.

The primary goal was to create a positive experience of interaction that addressed communication needs and encouraged self-regulation. The therapeutic environment supported participants in expressing themselves creatively, with the therapist playing a key role in building relationships and

guiding musical interactions. This approach helped families explore and develop new, constructive ways of engaging in joint creative activities.

Results

Communication diagnostics, focusing on social, emotional, and language changes, were conducted using the NLA framework, the MEL questionnaire, and the *Dynamic Characteristics of Change due to Music Therapy Intervention* (DCC) questionnaire created explicitly for this project by T. Chernous. For the verbal criterion, various scales of the DCC self-questionnaire were analysed and evaluated according to the NLA approach. Mathematical and statistical data processing using the IBM® *SPSS* Statistics software program (version 27) was conducted using Spearman correlation analyses, and the significance of the data was evaluated using Pearson's Chi-square (X^2) distribution.

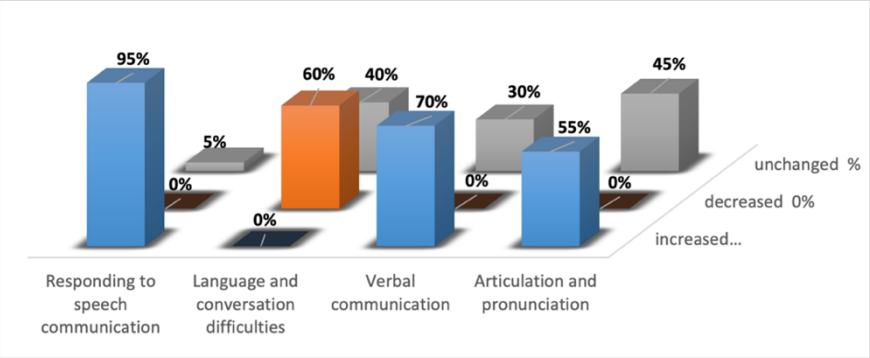

Figure 1. Analysis of indicators of the DCC regarding the verbal criterion (*N*=20).

According to the DCC results (Figure 1), positive changes were observed in all respondents in terms of understanding and perceiving sound. Additionally, 95% showed improvement in responding to speech communication, 60% experienced a reduction in language difficulties, 70% reported overall enhancement in verbal communication, and 55% noted improvements in articulation and pronunciation. The NLA approach used to diagnose language shifts (Figure 2) revealed overall improvement in Group 1, while no improvement was observed in Group 2.

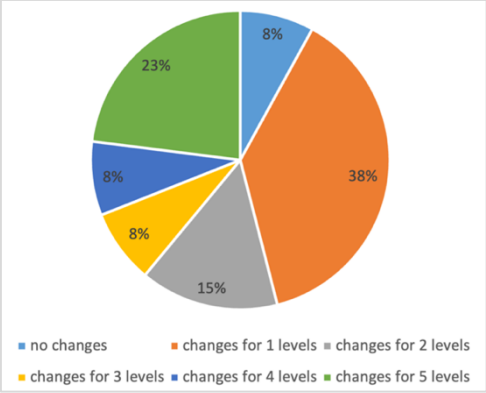

Figure 2. Analysis of testing indicators based on the NLA framework (N=20)

The highest growth percentage (38%) was observed in respondents who advanced by one level, and a significant percentage (23%) showed growth by 5 levels. This highlights the potential benefits of using music therapy with GLP learners.

Regarding the social criterion, analysis of the scales related to social topics from the DCC revealed that 100% of respondents reported improved interaction within the family; 90% noted improved interaction within familiar social environments, 65% experienced better interaction with unfamiliar social environments, and 55% observed a decrease in problematic behaviour.

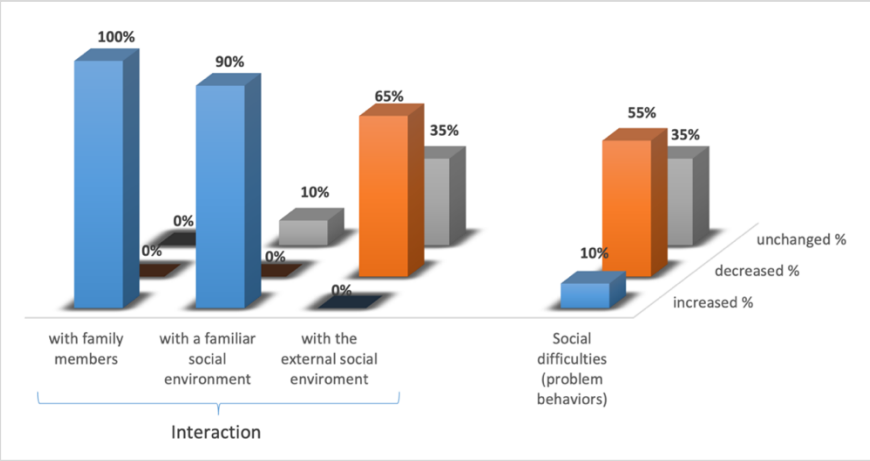

Figure 3. Analysis of indicators (DCC) according to the social criterion (*N*=20).

Based on the MEL test results (Figure 3), another parameter was identified: the impact of musical interaction, which was related to the social criterion. Analysis of the results before (M1) and after (M2) the course of MT showed a significant increase in the use of musical interaction in everyday communication (Figure 4).

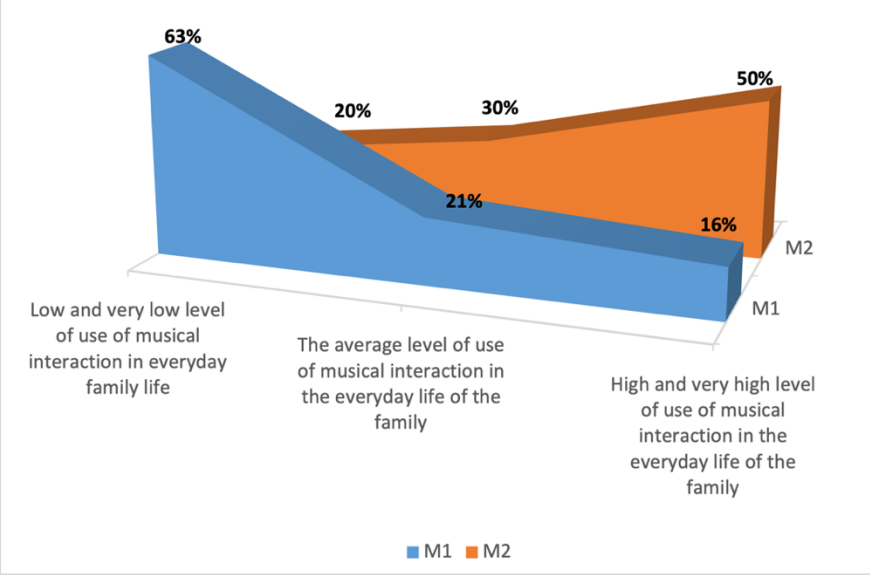

Figure 4. Application of musical interaction in everyday communication (N=20).

The development of self-regulation skills was assessed using the emotional indicators from the DCC questionnaire. The results showed a general improvement in overall emotionality in 80% of respondents, an increase in emotional expression in 90%, a better understanding of emotions in 75%, and improved emotion regulation in 70% of respondents. The positive psycho-emotional influence of the musical environment was further supported by the increase in the *high and very high level of use of musical interaction*, rising from 16% to 50% among families, while the *low and very low level of use of musical interaction* dropped from 63% to 20%.

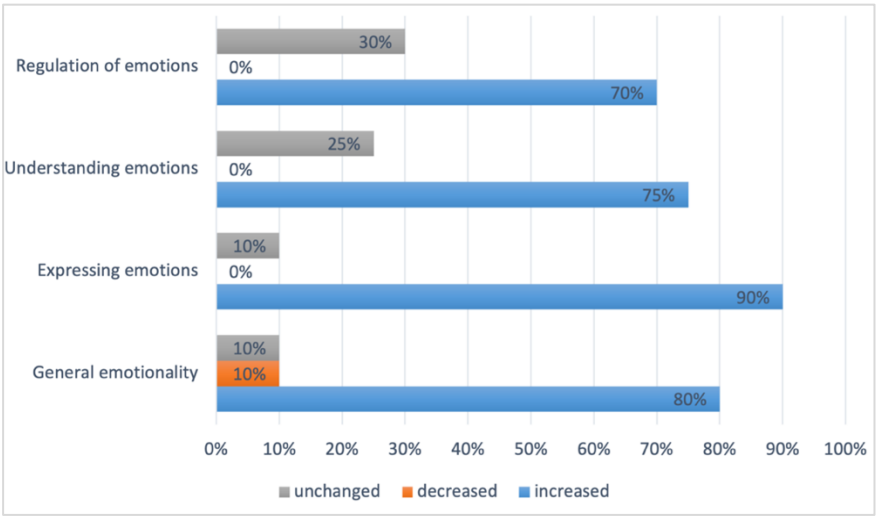

Figure 5. Analysis of indicators (DCC) according to the emotional criterion (*N* =20).

The application of Spearman's correlation coefficient revealed a significant two-way correlation between the indicators of the MEL and DCC questionnaires, highlighting essential aspects of MT's impact on self-regulation in sensory and social development.

Self-regulation Development: Positive correlations between the presence or absence of family members playing musical instruments and increased sensitivity to sounds (r=.460; p≤0.01) as well as general auditory perception (r=.449; p≤0.01) suggest that enriching auditory experiences is beneficial. Additionally, negative correlations found between increased sensitivity to sounds and the overall MEL score (r=.513; p≤0.01) indicate a decrease in auditory sensitivity as musical interaction experiences increased. Furthermore, negative correlations between interaction while playing musical instruments and increased sound sensitivity (r=-.626; p≤0.05), highlight the importance of positive joint musical activities in enhancing auditory sensory processing. Significant correlations were identified between joint family playing of musical instruments and an increase in the child's motivation and preference to play musical instruments (r=-.600; p≤0.05). Notably, the significant quantitative indicators show a correlation with the desire and interest to play a greater variety of musical instruments (r=.548; p≤0.01). This underscores the crucial role of joint family music-making in the positive development of motivational and cognitive processes.

Social Development: There were correlations between decreased interaction with familiar social environments and increased joint musical activities within the family (r=-.467; p≤0.01). The most substantial negative correlations were observed between the quantitative indicator (r=-.525; p≤ 0.01) of joint musical activities using apps (r=-.508; p≤0.01). This implies that the child becomes deeply engrossed in the musical activity, reducing their need for interaction with their social environment.

Speech Development: Positive results in increased speech production were observed within the group of GLP learners (Figure 4). According to the parents' observations, while there was a decrease in verbal experience during listening, there was also an increase of speech production during joint singing. Negative correlations between qualitative indicators of the experience of observing family members playing musical instruments (r=-.489; p≤ 0.01) indicate a link between a lack of such experiences and increased articulation and conversational difficulties. An interesting observation

was the correlation between increased language and conversational difficulties and the frequency of joint music listening ($r=.474$; $p\leq0.01$).

Discussion

Research on the influence of MT on communication often emphasises aspects of speech self-regulation and the development of functional social skills which include experiencing effective musical interaction (Pasiali, 2012), cognitive development, and the subtle psycho-emotional influence of a music-enriched environment (Williams, 2015). This concept formed the project's foundation, which aimed to integrate MT into the comprehensive rehabilitation process at the *Brain Up Therapy Centre* in Piatra-Neamț, Romania.

Given that the music therapy sessions were conducted by a foreign therapist, music and joint musical interaction served as the primary mode of communication.

The study revealed positive shifts in comprehension and perception, evidenced by a 95% improvement in respondents' speech/sound communication. These findings are consistent with scientific data on the positive impact of music therapy on speech development, including increased vocalisation, enhanced verbalisation quality, better vocabulary understanding, and a general rise in the desire to communicate, which often manifests as echolalia. Additionally, the effectiveness of music therapy in speech development is associated with providing a positive psycho-emotional experience while processing complex rhythmic and intonation patterns, which contribute to producing more extended, more complex speech phrases. This is confirmed by our project results, where 70% of respondents showed improved verbal communication, 60% experienced a reduction in language difficulties, and 55% demonstrated improved articulation.

There is potential for future research, as our study recorded cognitive shifts that showed improved memory, enhanced attention, and better comprehension.

According to Lonsdale (2011), using music as an alternative means of communication aligns with fundamental skills for engaging with the external world. This is particularly significant when working with families of children with profound and multiple mental disorders who are often in vegetative states or have minimal levels of awareness. For such families, music therapy proved crucial in creating a space for musical interaction, facilitating non-verbal communication, enabling psycho-emotional exchange, and balancing the communication levels between family members and the child despite their limited abilities.

Limitations and Future Directions

The project had some limitations, including a small number of respondents, and diagnostic constraints, particularly concerning patients with multiple and profound mental and physical disorders. Despite these challenges, the study's results validate MT as a valuable method in the rehabilitation of children with disabilities.

Conclusions

The project led to positive changes in the dynamics of verbal and non-verbal communication within families, providing a developmental space for disabled children and mental-physiological disorders. Music therapy at the Brain Up Therapy Center indicated beneficial effects on developing socialisation processes, manifested in enhanced language skills and improved emotional regulation in children. Particularly notable were the improvements in language development among children identified as GLPs. The results also showed a significant increase in musical interaction within families, improved communication within the family system, and overall positive changes in the child's development.

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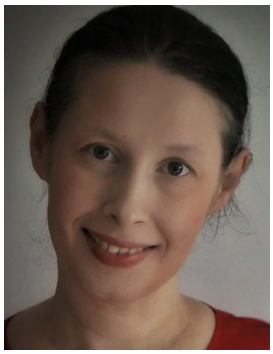

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Reconocimiento de la Musicoterapia como Profesión en España

Perspectiva Historica y Acciones Futuras

Music Therapy as a Profession in Spain

A Historical Perspective and Future Directions

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Resumen

Este artículo describe las acciones realizadas para el reconocimiento profesional de la musicoterapia en España entre 2000-2024, que se inician en 2007 con la primera reunión de los representantes de las cinco Asociaciones Españolas de Musicoterapia afiliadas a la Confederación Europea de Musicoterapia (AEMTA-EMTC). En esta reunión se acuerda iniciar diferentes acciones para trabajar a favor del reconocimiento profesional, mejorar la práctica clínica y promover directrices comunes para la educación y supervisión de los musicoterapeutas. En 2010, siguiendo las directrices dadas por la EMTC se comenzó a trabajar en el Registro Español de Musicoterapeutas Acreditados (REMTA). El proceso de acreditación de musicoterapeutas y de supervisores de musicoterapia se inició en 2012 y continúa vigente. Al día de hoy, 164 musicoterapeutas y 40 supervisores de musicoterapia están inscritos en el Registro Español de Musicoterapia (REMTA). El trabajo realizado desde las AEMTA-EMTC ha sido y continúa siendo una estrategia eficaz para la organización de la profesión de musicoterapia en España y mejorar su reconocimiento profesional y social.

Palabras claves: regulación, acreditación, práctica profesional, musicoterapia, España.

Abstract

This article provides an overview of the activities for professional recognition of music therapy in Spain from 2000-2024. Beginning with the first meeting of representatives from five Spanish Music Therapy Associations affiliated with the European Music Therapy Confederation (AEMTA- EMTC) in 2007, diverse efforts were established to address professional recognition, improve clinical practice and promote common guidelines for education and clinical training supervision. Following advice from EMTC, in 2010 work began on the Spanish Music Therapy Register (REMTA) which has remained in operation from 2012 until today. In 2024, a total of 164 music therapists and 40 music therapy supervisors are registered with REMTA. The outcomes of the working group (AEMTA-EMTC) indicate that this effort is effective in increasing awareness of the profession with both the public sector and policymakers, and improving professional and social recognition.

Keywords: music therapy recognition, music therapy regulation, music therapy accreditation, professional practice, Spain.

♦ Español

Desde el establecimiento de la profesión de musicoterapeuta en 1950, los musicoterapeutas se han preocupado por definir normas de formación, reconocimiento profesional y social de su actividad profesional en las distintas regiones del mundo (Register, 2013). Diferentes organizaciones profesionales como la Federación Mundial de Musicoterapia (WFMT), la Confederación Europea de Musicoterapia (EMTC), la Asociación Americana de Musicoterapia (AMTA), la Asociación Canadiense de Musicoterapia (CAMT), la Asociación Australiana de Musicoterapia (AMTA), entre otras, han trabajado para establecer sistemas de reconocimiento y acreditación profesional de los musicoterapeutas que hayan finalizado estudios universitarios de musicoterapia y un proceso de certificación professional, por ejemplo: Certification Board for Music Therapists (CBMT), EE.UU; Certified Music Therapist (MTA), Cánada; Registered Music Therapists (RMTs), Australia; New Zealand Music Therapy Registration Board, European Music Therapy Register (EMTR).

Desde su creación en 1991, la Confederación Europea de Musicoterapia (EMTC) ha desempeñado un papel activo en el desarrollo y el reconocimiento de la profesión de musicoterapia en Europa (Ridder et al., 2015). Con el objetivo de establecer criterios de registro profesional a nivel europeo, la EMTC creó la Comisión de Registro del EMTR, bajo la dirección de Jos De Backer y Julie Sutton, que se encargó de identificar estándares de formación académica y práctica profesional, y aspectos comunes y diferenciales en el desarrollo de la profesión de la musicoterapia en los países europeos miembros de la EMTC. Como consecuencia de este trabajo, se diseñó el Registro Europeo de Musicoterapeutas (EMTR), que fue aprobado en la Asamblea General de la EMTC durante el 8º Congreso Europeo de Musicoterapia en el año 2010 (Nöcker-Ribaupierre, 2011). El Registro Europeo de Musicoterapeutas (EMTR) estuvo activo entre 2010 y 2017, registrándose los primeros musicoterapeutas profesionales en el año 2012.

Con el fin de promover el desarrollo profesional y el reconocimiento profesional en cada país miembro, la EMTC recomendó la puesta en marcha de un registro de musicoterapeutas. Siguiendo

este consejo, en 2010 las Asociaciones Españolas de Musicoterapia afiliadas a la EMTC (AEMTA-EMTC) comenzaron a trabajar en el Registro Español de Musicoterapeutas (EMTR) (Sabbatella, 2011).

La Musicoterapia en España: Ideas principales

Perspectiva Histórica (1960-2024)

A principios de los años 60, la Dra. Serafina Poch introdujo la musicoterapia y trabajó como musicoterapeuta en España. En los años 70, varias figuras pioneras impulsaron la disciplina como Aittor Loroño, Patxi del Campo y el Dr. Rolando Benenzon. En 1975, la sección española de la Sociedad Internacional para la Educación Musical (ISME-España) creó un «Grupo de Estudio dedicado a la Musicoterapia». En esa misma década se fundaron la Asociación Española de Musicoterapia (1977) y la Asociación Catalana de Musicoterapia (1983). En la década de los 90 se celebró el VII Congreso Mundial de Musicoterapia (1993) en la ciudad de Vitoria. Este evento contribuyó a dar a conocer la profesión a los profesionales españoles de la educación y la sanidad.

Con el cambio de siglo (2000) se fundaron varias Asociaciones de Musicoterapia en distintas regiones del país: Asociación Aragonesa de Musicoterapia (AAMT); Asociación Castellano-Leonesa para el Estudio, Desarrollo e Investigación de la Musicoterapia y la Arteterapia (ACLEDIMA); Asociación Gaditana de Musicoterapia (AGAMUT); a nivel nacional (Asociación para el Desarrollo y la Investigación de la Musicoterapia (ADIMTE); y Asociación Española de Musicoterapeutas Profesionales (AEMP) en el año 2007, asociación aprobada por el Ministerio de Trabajo, lo que indicaba que el reconocimiento de la profesión podría estar próximo (Mercadal-Brotons et al., 2017). En 2014 se fundó la Federación Española de Musicoterapia (FEAMT) creando así una entidad que podría ofrecer cierta unidad ante el aumento de asociaciones de musicoterapia que, en la actualidad llegan a ser 59 las inscriptas en el registro nacional (Sabbatella et al., 2018).

La formación en musicoterapia comenzó en 1992 con un máster en la Universidad de Barcelona coordinado por la Dra. Serafina Poch, al tiempo que se desarrollaban programas de formación privados en el norte de España (Vitoria y Bilbao). A partir del año 2000 se crearon otros másteres en la capital, Madrid, y en todo el país (Barcelona, Cádiz, Salamanca y Valencia). En la actualidad existen 6 másteres universitarios, un máster en línea y otro en el Conservatorio y 2 másteres de formación privada.

Pasos Hacia La Organización De La Profesión

En el año 2007 se celebró el primer encuentro de representantes de las cinco Asociaciones Españolas de Musicoterapia afiliadas a la Confederación Europea de Musicoterapia (AEMTA-EMTC). Las asociaciones ACLEDIMA, ACMT, AGAMUT, MAP y APM trabajaron conjuntamente, y fruto de intensas y frecuentes reuniones fueron una serie de «documentos de trabajo» (Sabbatella et al., 2018):

- 2007 Funcionamiento, funciones y responsabilidades de las asociaciones miembros de la EMTC
- 2007 Funciones del Delegado español de la EMTC (revisión 2017)
- 2008 Directrices para evaluar los planes de estudios de los Másteres de Musicoterapia en España

- 2009 Criterios para ser Musicoterapeuta Profesional en España
- 2010 Registro Español de Musicoterapeutas (revisiones 2017; 2021)
- 2010 Reglamento de la Comisión Española de Acreditación de Musicoterapeutas Profesionales (CAEMT).
- 2014 Código Deontológico del Musicoterapeuta Profesional en España, (revisión 2019)
- 2016 Criterios para la Organización de Congresos Nacionales de Musicoterapia (revisión, 2018)

En la primera década del siglo XXI fue necesario comenzar a organizar la profesión, especialmente ante la proliferación de asociaciones y cursos no universitarios (Del Moral et al., 2015a). Hoy, 15 años después, sigue siendo necesario impulsar la unificación, el desarrollo profesional y el reconocimiento para establecer estándares de formación, certificación, regulación y acreditación de la musicoterapia en España que garanticen su futuro profesional (Sabbatella et al., 2023).

Sistema Español de Acreditación de Musicoterapeutas (REMTA)

La Comisión Española de Acreditación de Musicoterapeutas Profesionales (CAEMT) se creó en 2010 para poner en funcionamiento el Sistema Español de Acreditación en Musicoterapia (REMTA). En 2014 se creó el Registro Español de Musicoterapeutas Acreditados (MTAE) y Supervisores (SMTAE). El proceso de acreditación sigue las directrices de la EMTC, aunque la profesión aún no está reconocida oficialmente. En 2022 se revisó el proceso de acreditación para permitir el registro inmediato de musicoterapeutas recién formados, al tiempo que se acredita a aquellos profesionales que cuentan con 2 años completos de experiencia (MTAE), y se reconoce la capacidad de los profesionales con experiencia (más de 5 años de labor clínica profesional) para supervisar musicoterapia (SMTAE) (tabla 1) (Sabbatella et al., 2023).

Tabla 1

Sistema Español de Acreditación en Musicoterapia (REMTA) (CAEMT, 2024)

Categorias	**Criterios**
Musicoterapeutas recién egresados	• Título de grado o máster en musicoterapia, según se define en el documento «Criterios para ser musicoterapeuta en España»
Musicoterapeuta Acreditado en España (MTAE)	• Título de grado o máster en musicoterapia, según se define en el documento «Criterios para ser musicoterapeuta en España» • Dos años de experiencia profesional a tiempo completo o equivalente (mínimo de 430 horas de trabajo clínico) • 30 horas de práctica clínica supervisada individual o en grupo) Se pueden incluir las horas de supervisión realizadas durante la formación (20%) • 30 horas de self-experience (por ejemplo, psicoterapia continuada, psicoanálisis, terapia sistémica, musicoterapia) • 30 horas de formación continua (cursos, talleres, asistencia a congresos y conferencias, etc.) relacionado con el campo de la musicoterapia, en los dos últimos años.
Supervisor Acreditado de Musicoterapia en España (SMTAE)	• Cinco años, a tiempo completo de experiencia como musicoterapeuta, o equivalente (mínimo de 1075 horas de trabajo clínico) • 75 horas de práctica clínica supervisada (individual o en grupo, máximo 8

	participantes) • 75 horas de formación continua (cursos, talleres, asistencia a congresos y conferencias, etc.) relacionado con el campo de la musicoterapia, en los últimos cinco años

El REMTA entró en funcionamiento en 2012. Los periodos de registro abarcan:

- 2012: 1ª convocatoria abierta para la acreditación MTAE
- 2014: 2ª convocatoria MTAE – 1ª convocatoria SMTAE
- 2016: 3ª convocatoria MTAE – 2ª convocatoria SMTAE
- 2018: 4ª convocatoria MTAE – 3ª convocatoria SMTAE
- 2022: 5ª convocatoria MTAE
- 2023: 6ª convocatoria MTAE – 4ª convocatoria SMTAE

En 2024 hay un total de 164 musicoterapeutas (MTAE) inscritos en el Registro Español de Musicoterapia (REMTA), de los cuales 40 son supervisores acreditados de musicoterapia (SMTAE) (tabla 2), (figura 1) (CAEMT, 2024).

Tabla 2

Número total de musicoterapeutas acreditados 2024 en España por Comunidad Autónoma

Comunidad Autónoma	**Musicoterapeuta Acreditado en España (MTAE)**	**Supervisor de Musicoterapia Acreditado en España (SMTAE)**
Andalucía	11	5
Aragón	19	4
Islas Baleares	2	1
Canarias	1	-
Cantabria	-	-
Castilla-La Mancha	2	-
Castilla y León	11	5
Cataluña	46	10
Comunidad de Madrid	28	7
Comunidad Foral de Navarra	5	-
Comunidad Valenciana	9	7
Extremadura	3	-
Galicia	6	-
La Rioja	1	-
País Vasco	13	1
Principado de Asturias	3	-
Región de Murcia	4	-
Ceuta y Melilla	-	-
TOTAL	**164**	**40**

Figura 1. Número total de musicoterapeutas acreditados en España (2024).

Conclusiones

La EMTC definió cuatro términos clave para identificar el estatus de reconocimiento y regulación de la musicoterapia como profesión en los países miembros de la EMTC (EMTC, 2024):

- Reconocimiento legal: La ley reconoce la actividad profesional (por ejemplo, la musicoterapia aparece en la codificación estadística, y podría figurar como profesión médica alternativa, etc.);
- Regulación: La ley define claramente lo que hay que cumplir para poder trabajar como musicoterapeuta (por ejemplo, realización de un máster en musicoterapia, finalización de un proceso de acreditación, proceso de certificación, supervisión regular y horas de desarrollo profesional continuo);
- Certificación/registro legal: Certificación/registro que puede exigirse legalmente (por ejemplo, un musicoterapeuta sólo puede ejercer profesionalmente si está registrado);
- Certificación/Registro por parte de una asociación: Una certificación realizada por una asociación de musicoterapia o arteterapia sin consecuencias legales.

En 2021, el Grupo de Trabajo para el Reconocimiento Profesional de la EMTC llevó a cabo una encuesta entre los países miembros de la EMTC para determinar la situación de cada país en relación con el reconocimiento y la acreditación de la profesión de musicoterapeuta (EMTC, 2024). A día de hoy, la situación de España no ha cambiado, sin reconocimiento legal, regulación ni certificación.

a. La legislación nacional no reconoce la musicoterapia. No hay requisitos definidos que se deban cumplir para ejercer la profesión de musicoterapeuta.

b. No existe un proceso de certificación o registro que se aplique por ley.
c. Existe un proceso de certificación o registro que no se aplica por ley, sino que lo lleva a cabo una entidad formada por representantes de las principales asociaciones de musicoterapia, la Comisión de Acreditación Española de Musicoterapeutas Profesionales (CAEMT). Esta entidad, REMTA-CAEMT administra el proceso de acreditación sin repercusiones legales.

En estas dos primeras décadas del siglo XXI se ha emprendido un largo camino y se sigue trabajando, resaltando algunas prioridades.

a. Es necesario que un organismo regulador gubernamental compruebe los planes de estudios y las credenciales y experiencia del personal, a fin de garantizar que se cumplen las normas de formación (Del Moral & Sabbatella, 2018).
b. En cuanto a la práctica clínica, si bien la creación de la REMTA es un hito que promueve la regulación de la práctica, se necesitan más esfuerzos para promover la formación continua y la supervisión (Sabbatella et al.2018; Sabbatella et al., 2023).
c. La profesión necesita más musicoterapeutas en activo. Es notable el número de estudiantes que han completado programas de formación en musicoterapia que han optado por trabajar en el campo de la docencia en lugar de trabajar como musicoterapeutas clínicos (Del Moral et al., 2011; Del Moral et al., 2015a).
d. La investigación en musicoterapia debe mejorar en términos de cantidad, calidad y fiabilidad, mientras que la tutoría de las tesis doctorales debe estar mejor organizada e informada (Del Moral et al., 2014; Del Moral et al., 2023).
e. Como profesión, la musicoterapia necesita adquirir una identidad unificada, lo que contribuiría a la celebración periódica de congresos nacionales (Del Moral et al., 2015b; Mercadal-Brotons et al., 2017).

En los últimos 25 años, el esfuerzo por lograr una identidad profesional unificada ha incluido pasos hacia la organización de la Formación en Musicoterapia; la redacción de directrices para la Acreditación en Musicoterapia; la promoción de la acreditación entre los profesionales, y la publicación de Directrices Éticas para la Práctica Clínica y la Investigación (Del Moral et al., 2023; Sabbatella et al., 2023). Sin embargo, la Musicoterapia en España sigue teniendo dificultades para lograr el reconocimiento oficial por parte de las autoridades gubernamentales. Los resultados del grupo de trabajo AEMTA-EMTC indican que este esfuerzo es eficaz para aumentar el conocimiento de la profesión tanto por parte del público como de los responsables políticos, y mejorar el reconocimiento profesional y social. El proceso de reconocimiento legal sigue su curso y aún deben darse nuevos pasos.

♦ English

Since the creation of the profession of music therapist in 1950, music therapists have ought to establish standards for the training and professional and social recognition of their professional activity in regions throughout the world. Professional organisations such as the World Federation for Music Therapy (WFMT), the European Music Therapy Confederation (EMTC), the American Music Therapy Association (AMTA), the Canadian Association for Music Therapy (CAMT), the Australian Music Therapy Association (AMTA), among others, have worked to establish

professional recognition and accreditation systems to identify music therapists who have successfully completed the certification process. These include the Certification Board for Music Therapists (CBMT), USA; Certified Music Therapist (MTA), Canada; Registered music therapists (RMTs), Australia; New Zealand Music Therapy Registration Board; and European Music Therapy Register (EMTR), among others.

From its establishment in 1991, EMTC has played an active role in the development and recognition of the profession of music therapy in Europe (Ridder et al., 2015). To establish criteria for professional registration at a European level, the EMTC identified standards of academic training and professional practice, and common areas of development in relation to the profession of music therapy in all affiliated European countries. To do this, the EMTR Registration Commission was established under the leadership of Jos De Backer and Julie Sutton. Initially approved in 2010 at the EMTC General Assembly during the 8th European Congress of Music Therapy (Nöcker-Ribaupierre, 2011), this register was active from 2010 to 2017, with the first professional music therapists registered in 2012.

To encourage professional development and professional recognition in each affiliated country, the EMTC recommended the implementation of a register of music therapists by adapting the EMTR to each country. Following this advice, in 2010 the Spanish Associations of Music Therapy, in affiliation with EMTC (AEMTA-EMTC) began working on the Spanish Music Therapy Register (REMTA) (Sabbatella, 2011).

Music Therapy in Spain: A Brief Overview

Historical Perspective (1960-2024)

In the early 1960s, Dr Serafina Poch was the first person to work as a music therapist in Spain. There were several important figures involved in music therapy in the 70's, including Aittor Loroño, Patxi del Campo, and Dr. Rolando Benenzon. A significant interest was shown in 1975 by the Spanish section of the International Society for Music Education (ISME-Spain) which established a *Study Group dedicated to Music Therapy*. Within a decade, two music therapy associations were founded, namely the Spanish Association of Music Therapy (1977); the Catalan Association of Music Therapy (1983).

The VII World Congress of Music Therapy (1993) in Vitoria, Spain, cast a spotlight on music therapy early on in this country. This event helped bring the profession to the attention of Spanish education and health-allied professionals during the late 1990s.

Enthusiasm grew at the turn of the century (2000) as several music therapy associations were being founded in different regions of the country: Asociación Aragonesa de Musicoterapia (AAMT); Asociación Castellano-Leonesa para el Estudio, Desarrollo e Investigación de la Musicoterapia y la Arteterapia (ACLEDIMA); Asociación Gaditana de Musicoterapia (AGAMUT), and at the national level (Asociación para el Desarrollo y la Investigación de la Musicoterapia (ADIMTE); and Asociación Española de Musicoterapeutas Profesionales (AEMP). What appeared to be an important achievement, in 2007 was the approval of the latter association, AEMP, by the Spanish Ministry of Employment, indicating that recognition of the profession might be forthcoming.

Meanwhile, in 2014 the Spanish Music Therapy Federation (FEAMT) was founded, thus creating an entity which could offer some unity to the exponential growth of music therapy associations, today numbering 59 in the national registry.

Training in music therapy began in 1992 with a Master course at the University of Barcelona, coordinated by Dr Serafina Poch, while private training programmes were developed in the north of Spain (Vitoria and Bilbao). Further master programmes were established after 2000 in Madrid, Barcelona, Cádiz, Salamanca and Valencia. Today there are 6 university masters programmes, one online master, one at the Conservatoire, and two privately run master training programmes.

Steps Towards the Organisation of the Profession

In 2007 the first meeting of representatives from the five Spanish Music Therapy Associations affiliated with EMTC (AEMTA- EMTC) was celebrated. The associations ACLEDIMA, ACMT, AGAMUT, MAP and APM worked in collaboration, and a series of *working documents* was the result of intense and frequent meetings:

- 2007 Operation, duties and responsibilities of the EMTC member associations
- 2007 Functions of the EMTC Spanish Delegate (review 2017)
- 2008 Guidelines to assess the curriculum of Music Therapy Masters in Spain
- 2009 Standards for being a Professional Music Therapist in Spain
- 2010 Spanish Music Therapy Register (review 2017; 2021)
- 2010 Spanish Commission for Accreditation of Professional Music Therapists (CAEMT).
- 2014 Code of Ethics for Professional Music Therapists in Spain, (review, 2019)
- 2016 Criteria for the Organization of National Music Therapy Congresses (review, 2018)

In the first decade of the 21st century, it became crucial to begin organising the profession, especially in light of the proliferation of associations and non-university courses. Today, 15 years later, it is still necessary to encourage unification, professional development and recognition to establish standards of training, certification, regulation and accreditation of music therapy in Spain to guarantee its futureas a profession Sabbatella et al., 2023).

Overview Of The Spanish Music Therapy Accreditation System (REMTA)

The Spanish Commission on Accreditation of Professional Music Therapists (CAEMT) was created in 2010 to make the Spanish Music Therapy Accreditation System (REMTA) operational. In 2014 the Spanish Register of Accredited Music Therapists (MTAE) and Supervisors (SMTAE) was set up. The accreditation process follows the EMTC guidelines, although the profession is still not officially recognised. In 2022, the accreditation process was revised to allow recently trained music therapists to register immediately, while accrediting those professionals who have 2 full years of experience (MTAE), and recognising the capacity of mature professionals (over 5 years of professional clinical work) to supervise music therapy (SMTAE) (table 1) (Sabbatella et al., 2023).

Table 1

Spanish Music Therapy Accreditation System (REMTA) (CAEMT, 2024)

Categories	Criteria
Recently-Trained Music Therapists	• Music therapy degree or master, as defined in the document 'Standards for being a music therapist in Spain'
Accredited Music Therapist in Spain (MTAE)	• Music therapy degree as defined in the document 'Standards for being a music therapist in Spain' • Two years of full-time professional experience, or equivalent (minimum 430 hours of clinical work) • 30 hours of supervised clinical practice (individual or group supervision) This can include the supervision hours undertaken during training (20%) • 30 hours of self-experience (e.g. ongoing psychotherapy, psychoanalysis, systemic therapy, music therapy) • 30 hours of continuing professional development (courses, workshops, congresses and conferences attendance, etc.) connected with the field of music therapy, in the last two years
Accredited Supervisor of Music Therapy in Spain (SMTAE)	• Five years, full-time of professional experience as music therapist, or equivalent (minimum 1075 hours of clinical work) • 75 hours of supervised clinical practice (individual or in group, maximum 8 participants) • 75 hours of continuing professional development (courses, workshops, congresses and conferences attendance, etc.) connected with the field of music therapy, in the last five years

The REMTA was operational in 2012. The registration periods cover:

- 2012: 1st registration open for accreditation MTAE
- 2014: 2nd registration MTAE – 1st registration SMTAE
- 2016: 3rd registration MTAE – 2nd registration SMTAE
- 2018: 4th registration MTAE – 3rd registration SMTAE
- 2022: 5th registration MTAE
- 2023: 6th registration MTAE – 4th registration SMTAE

In 2024, a total of 164 music therapists (MTAE) are listed in the Spanish Music Therapy Register (REMTA), of which 40 are accredited music therapy supervisors (SMTAE) (table 2), (figure 1).

Table 2

Total number of accredited music therapist in Spain by region

Autonomous Community	Spanish Music Therapist Register (MTAE)	Spanish Music Therapy Supervisor (SMTAE)
Andalucía	11	5
Aragón	19	4
Islas Baleares	2	1
Canarias	1	-

Cantabria	-	-
Castilla-La Mancha	2	-
Castilla y León	11	5
Cataluña	46	10
Comunidad de Madrid	28	7
Comunidad Foral de Navarra	5	-
Comunidad Valenciana	9	7
Extremadura	3	-
Galicia	6	-
La Rioja	1	-
País Vasco	13	1
Principado de Asturias	3	-
Región de Murcia	4	-
Ceuta y Melilla	-	-
TOTAL	**164**	**40**

Figure 1. Total number of accredited music therapists in Spain (2024)

Conclusions

The EMTC defined four key terms to identify the Recognition and Regulation Status of Music Therapy as a profession in EMTC Member Countries (EMTC, 2024):

- Legal recognition: The law recognises the professional activity (e.g., music therapy appears in statistical coding and might be listed as an alternative medical profession etc.).

- Regulation: The law clearly defines requirements to work as a music therapist (e.g. completion of a master degree in music therapy, completion of the accreditation process, certification process, regular supervision, and hours of continuing professional development).
- Legal Certification/Registration: A certification/registration that may be legally enforced (e.g., A music therapist may only work professionally if registered.)
- Association Certification/Registration: A certification/registration carried out by a Music Therapy or Arts Therapy Association without legal consequences.

In 2021, the EMTC Recognition Action Team conducted a survey of EMTC member countries to determine the status of each country regarding recognition and accreditation of the music therapy profession (EMTC, 2024). Today, Spain's situation remains unchanged, with no legal recognition, regulation or certification.

a. The national law does not recognise music therapy. There are no clearly defined requirements that must be met to practice music therapy professionally.
b. There is no certification or registration process that is enforced by law.
c. There is a certification or registration process that is not law enforced but is carried out by an entity comprised of representatives of leading music therapy associations, the Spanish Commission on Accreditation of Professional Music Therapists (CAEMT). This entity, the REMTA- CAEMT administers the accreditation process without legal repercussions.

In these first two decades of the 21st century, a long journey has been undertaken and work is still in progress, with some pressing priorities.

a. There is a strong need for a governmental regulatory body to check curriculum, as well as staff credentials and experience, in order to ensure that training standards are met.
b. Regarding clinical practice, while the establishment of the REMTA is a landmark that promotes practice regulation, more efforts are needed to promote continuous education training and supervision.
c. The profession needs more active clinicians. A notable number of alumni who have completed music therapy training programmes have chosen to work in the teaching field rather than work as clinical music therapists.
d. Research in music therapy must be improved in terms of quantity, quality and reliability, while mentoring of Doctoral dissertations needs to be better organised and informed.
e. As a profession, music therapy needs to acquire a unified identity, aided by holding regular national conferences.

In the last 25 years, the endeavour to achieve a unified professional identity has included steps towards the organisation of music therapy training; the writing of guidelines for music therapy accreditation; the promotion of accreditation among professionals, and the publication of ethical guidelines for clinical practice & research. Achieving official recognition of music therapy by governmental authorities in Spain remains challenging. The outcomes of the working group (AEMTA-EMTC) indicate that this effort is effective in increasing both public and policymaker awareness of the profession and improving professional and social recognition. The process of legal recognition is still on-going, and new steps are yet to be taken.

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«Music was my first love…»[1], … but it won't be enough.

Réflexions sur l'identité professionnelle

Reflections on professional identity

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Résumé

Dans cette contribution succincte, j'examine certains aspects de mon identité professionnelle. Celle-ci est constituée à la fois d'éléments verbaux, issus de la psychologie, et d'éléments non verbaux, davantage axés sur la musicothérapie. Je perçois cette dualité comme un enrichissement de ma pratique thérapeutique, car elle me permet de proposer aux client.es une approche variée et sur mesure, en fonction de leurs besoins.

Mots clés: psychologie – musicothérapie – verbal – non-verbal – identité thérapeutique

Abstract

In this brief contribution, I reflect on various aspects of my professional identity. It consists of both verbal elements derived from psychology and non-verbal elements, which are more music therapy oriented. I see this dyad as an enrichment of my therapeutic practice, as it allows me to offer clients a tailored and wide-ranging therapeutic approach.

Keywords: psychology – music therapy – verbal – non-verbal – therapeutic identity

[1] Title of a song by John Miles (https://youtube.com/@johnmilesofficial).
Lyrics: *Music was my first love, and it will be my last. Music of the future and of the past. To live without my music would be impossible to do. In this world of troubles, my music pulls me through.*

♦ Français

La musique a toujours été un élément fondamental de ma vie, bien avant que je puisse en comprendre toute la portée. Dès mon enfance, chanter en famille faisait partie de mon quotidien. À l'âge de six ans, j'ai entamé une formation musicale dans le rigoureux système musical du Luxembourg et j'ai passé de nombreuses heures au conservatoire local. Il ne m'a pas fallu longtemps pour réaliser que la musique ne quitterait jamais ma vie et qu'elle pourrait peut-être même devenir ma profession.

L'impact profond de la musique, qui unit les individus, ainsi que son effet thérapeutique, qui m'a probablement soutenu lors de certaines crises durant mon adolescence, m'ont intrigué dès mon plus jeune âge. C'est ainsi que l'idée de devenir musicothérapeute a commencé à germer en moi.

J'ai rapidement pris conscience que la profession de musicothérapeute, bien que fascinante et pleine de sens, n'est pas reconnue politiquement dans mon pays d'origine, le Luxembourg, ni dans beaucoup d'autres pays. Cela signifiait un chemin professionnel paré d´obstacles et pourvu d´une sécurité limitée. Cependant, ne souhaitant pas abandonner mon objectif, je choisis de faire preuve de persévérance et de me tourner vers la psychologie, cette « sœur aînée » de la musicothérapie. En plus de m'offrir une base théorique solide et une approche large et intégrative, j'espérais que cette étape me garantirait également une sécurité professionnelle et financière. Une étude récente montre par ailleurs que l'absence de reconnaissance officielle de la musicothérapie et l'insécurité financière qui en découle peuvent avoir un impact négatif sur la satisfaction professionnelle et les perspectives de carrière des musicothérapeutes (Eyre, Meadows & Gollenberg, 2023).

«Le terme psychologie provient de la combinaison du grec *psychē* ('souffle, principe vital, vie, âme') et de *-logia* (du grec logos, signifiant 'discours, parole, raison')»[2] (Merriam Webster Dictionary, 2024). Il s'agit donc de l´enseignement de l'âme et de la raison, que j'ai étudiée et que j´applique dans ma pratique depuis des années. Cette discipline m'a ouvert les portes de connaissances théoriques essentielles à mon travail et m'a aidé à développer une approche professionnelle axée sur l'ouverture et l'individualité. Durant mes études de psychologie, j'ai pris conscience de l'importance des processus neurologiques dans notre fonctionnement humain. Ces connaissances continuent d'influencer mon travail au quotidien, y compris en tant que musicothérapeute. Comprendre et expliquer l'impact de la musique non seulement d'un point de vue émotionnel, mais aussi biologique et neurologique, est devenu pour moi un enjeu central (Bowling, 2023). L'entretien psychologique fait également partie intégrante de mes séances de musicothérapie.

Je perçois ma pratique à la croisée entre musicothérapie et psychologie comme une réelle opportunité et une source d'enrichissement, tant pour moi-même que pour mes client.es. En intégrant des éléments verbaux et non verbaux au cours de mes séances thérapeutiques, je suis en mesure de mieux répondre aux besoins spécifiques de chaque client.e et de les accompagner précisément là où iels se trouvent dans leur processus. Cette double approche oriente et définit mon identité professionnelle, qui me parait être, selon Karkou (2016, p. 8), un « holding » – un cadre sûr et clair dans lequel je peux évoluer et agir.

[2] Original: "The word psychology was formed by combining the Greek *psychē* (meaning 'breath, principle of life, life, soul') with –logia (which comes from the Greek *logos*, meaning 'speech, word, reason').

La musicothérapie, tout comme d'autres thérapies à médiation artistique, peut s'avérer particulièrement bénéfique pour les client.es qui, pour diverses raisons, n'ont pas accès au langage, ne l´ont pas encore développé ou l'ont perdu. Cependant, il s´avère que la majorité des musicothérapeutes n´exercent pas exclusivement sans éléments verbaux (Nelligan & McCaffrey, 2020). Les praticien.nes formé.es à la thérapie non verbale benenzonienne constituent ici une exception (Classier & Lociuro, 2019). Un entretien ciblé, une question pertinente ou une introduction verbale permettent souvent d´initier un processus musical et musicothérapeutique.

Dans ma pratique, j'ai constaté que mon identité thérapeutique est nourrie par l'utilisation combinée des approches verbale et non verbale. C´est ainsi que je tisse des liens thérapeutiques et m'engager dans des processus avec les client.es qui sont prêt.es à s'ouvrir à cette combinaison de méthodes. Après tout, la thérapie est d'autant plus fructueuse lorsque la relation thérapeutique est authentique et que le client et le thérapeute peuvent se rencontrer sur un pied d'égalité.

« …Music of the future... ». J'espère qu'à l'avenir, davantage de collègues choisiront la voie d'une double qualification, élargissant ainsi leur identité professionnelle afin de pouvoir proposer aux client.es une prise en charge aussi variée et adaptée que possible.

♦ English

Music has always been an integral part of my life, long before I could truly grasp its significance. Singing together in the family was part of my daily childhood routine. At the age of six, I began formal music education in the strict Luxembourgish music system and spent many hours at the local conservatory. It didn't take long for me to realize that music would accompany me throughout my life and might even become my profession.

The profound, connective, yet also therapeutic power of music, which undoubtedly helped me through one or another crisis during my youth, intrigued me relatively early on. Thus, the thought of becoming a music therapist began to grow within me.

I quickly realized that this fascinating and meaningful profession of music therapy is not politically recognized in my home country of Luxembourg, as is also the case in many other countries. This means that a professional path is associated with many hurdles and little security. However, I did not want to give up my goal. Instead, I decided to show perseverance and initially turn to psychology – essentially the *older sister* of music therapy. In addition to a solid professional foundation and a broad, integrative approach, I hoped that this step could also offer me professional and financial security. A recent study shows that the lack of official recognition of music therapy practice, as well as financial uncertainties, can negatively impact job satisfaction and future prospects for music therapists (Eyre, Meadows & Gollenberg, 2023).

»The word psychology was formed by combining the Greek psychē (meaning 'breath, principle of life, life, soul') with -logia (which comes from the Greek logos, meaning 'speech, word, reason')« (Merriam Webster Dictionary, 2024). I have studied and applied this doctrine of soul and reason in my practice for years. It opened doors to theoretical knowledge that is indispensable for my work and helps me establish an approach based on openness and individuality in my professional practice. During my studies in psychology, I became aware of the importance of neurological processes for our human functioning. These insights still influence my daily practice today – also

as a music therapist. It is important to me to understand and explain the effects of music not only from an emotional perspective but also from a biological and neurological one (Bowling, 2023). Psychological conversation techniques also flow into my music therapy sessions.

The fact that I work as a cross-trained music therapist and psychologist is a valuable opportunity and enrichment – both for myself and for the clients with whom I have been privileged to work. By offering both verbal and non-verbal elements in a therapeutic session, I am able to better meet the individual needs of my clients and meet them exactly where they are in the process. This dual approach shapes my professional identity, which, according to Karkou (2016, p. 8), appears to me as a holding – a secure and clear framework within which I can move and act.

Music therapy – like other artistic therapies – is particularly helpful for clients who lack language for various reasons, have not yet developed it, or have lost speech and language skills. However, it turns out, that most music therapists do not work entirely without verbal components (Nelligan & McCaffrey, 2020). The exceptions are mainly those colleagues trained in and practicing the non-verbal therapy after Benenzon (Classier & Lociuro, 2019). A targeted conversation, a well-placed question, or a verbal introduction often creates potential for initiating subsequent musical- and music therapy processes. In my own practice, it has been shown that my therapeutic identity is shaped by these two approaches – both verbal and non-verbal. Thus, I build therapeutic relationships and engage in processes with clients who can engage with this combination of methods. Ultimately, therapy is most successful when an authentic therapeutic relationship is created, and the client and therapist can meet on equal terms.

»…Music of the future…«. I hope that in the future, more colleagues will pursue dual qualifications, thereby expanding their professional identity to offer clients a therapeutic approach that is as diverse and tailored as possible.

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Perspectivas transculturales en una residencia de ancianos

Reflexiones sobre el lenguaje, la cultura y la relación terapéutica

Transcultural perspectives in a nursing home

Reflections on language, culture, and therapeutic relationship

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Resúmen

Este trabajo ofrece una perspectiva sobre la intersección entre la diversidad cultural y lingüística en la práctica de la musicoterapia dentro del contexto de una residencia de ancianos en Alemania. A partir de mi experiencia personal como ciudadano mexicano enfrentando los desafíos de la comunicación en un idioma extranjero, reflexiono sobre las sutilezas prácticas, los obstáculos y los beneficios inesperados que he encontrado. Además, este manuscrito introduce una vision transcultural para comprender mejor cómo la fluidez entre culturas e identidades juega un papel clave en la formación de las relaciones terapéuticas.

Palabras clave: cultura – transcultural – lengua – relaciones terapéuticas

Abstract

This paper offers perspectives on the intersection of cultural and linguistic diversity in music therapy practice within the context of a German nursing home. Drawing from personal experience as a Mexican national navigating communication challenge in a foreign language, the author delves into reflections on the practical nuances, obstacles, and unexpected benefits encountered. Moreover, this manuscript introduces a transcultural lens to better understand how fluidity between cultures and identities plays a vital role in shaping therapeutic relationships.

Keywords: culture – transcultural – language – therapeutic relationships

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♦ **Español**

Soy originario de México, pero he vivido fuera del país desde que tenía 16 años. Comencé a aprender alemán en 2016 y empecé a trabajar en una residencia de ancianos en Alemania en 2021. Aunque mi formación en musicoterapia fue en inglés, logré alcanzar un nivel C1 en alemán cuando comencé a ejercer en este idioma.

El concepto de transculturalidad de Afef Benessaieh ofrece un marco útil para entender mi experiencia en este contexto. La transculturalidad, según Benessaieh, no es simplemente la coexistencia de múltiples culturas, sino un proceso de fluidez cultural donde las identidades y experiencias se entrelazan a través de fronteras culturales (2010). Este concepto nos permite superar las nociones fijas de diferencia cultural y reconocer la naturaleza dinámica e híbrida de nuestras identidades culturales. En mi trabajo como musicoterapeuta, habito un espacio transcultural donde mi herencia mexicana y el contexto cultural y lingüístico alemán se entrelazan. Esta fusión de identidades culturales enriquece el proceso terapéutico, permitiendo conexiones más complejas y multidimensionales con los pacientes.

El lenguaje, en este sentido, se convierte en algo más que un medio de comunicación; actúa como un mediador cultural. El diálogo terapéutico se ve moldeado por la capacidad del terapeuta para navegar tanto la fluidez lingüística como los matices culturales. La teoría de Benessaieh nos invita a ver el lenguaje no solo como una posible barrera, sino como un espacio de cohabitacion donde constantemente se crean nuevos significados culturales.

Obstáculos y Adaptaciones

Trabajar en una residencia de ancianos en Alemania ha presentado una serie de obstáculos lingüísticos y culturales. A pesar de mi dominio del alemán, las sutilezas de trabajar con pacientes mayores —muchos de los cuales tienen problemas auditivos o deterioro cognitivo— añaden capas de complejidad a la comunicación. Aquí es donde la competencia transcultural se vuelve esencial. Implica no solo hablar el idioma, sino también entender las señales culturales no verbales, las historias y las emociones que están incrustadas en el lenguaje.

A veces he sentido que mis limitaciones lingüísticas obstaculizan mi capacidad de atender plenamente a mis pacientes. Sin embargo, la transculturalidad nos enseña que estas limitaciones pueden replantearse como oportunidades para el crecimiento. Ser un musicoterapeuta mexicano en Alemania a menudo despierta la curiosidad de los pacientes, quienes desean saber más sobre mi origen. Esta curiosidad abre espacio para la auto-revelación, un aspecto delicado pero importante de la relación terapéutica. ¿Cuánto debe uno revelar sobre sí mismo en terapia y cómo moldea esta auto-revelación la dinámica terapéutica? Al compartir aspectos de mi trasfondo cultural, no solo conecto con mis pacientes, sino que también modelo apertura y adaptabilidad, cualidades clave en el proceso terapéutico.

La Relación Terapéutica

La relación terapéutica es un componente crucial de casi cualquier intervención terapéutica. Como destaca el trabajo de Benessaieh sobre la transculturalidad, es precisamente la fluidez entre culturas lo que permite el desarrollo de relaciones más ricas y multifacéticas. En el trabajo de

cuidados a largo plazo, esta relación es quizás aún más crítica, ya que el terapeuta a menudo se convierte en una figura central en la vida emocional y psicológica del paciente. La transculturalidad en la musicoterapia subraya la necesidad de flexibilidad y apertura. Como musicoterapeutas, debemos estar sintonizados no solo con la música, sino también con los idiomas y culturas de nuestros pacientes, reconociendo que estos son componentes integrales de su identidad y bienestar.

Conclusión

La musicoterapia, particularmente en un contexto transcultural, nos invita a repensar las nociones convencionales de identidad, lenguaje y cultura. Basado en las teorías de Afef Benessaieh sobre la transculturalidad, este manuscrito ha explorado cómo la diversidad cultural y lingüística puede enriquecer, en lugar de obstaculizar, el proceso terapéutico. Al abrazar la fluidez de las identidades y reconocer el rico potencial del intercambio cultural, los musicoterapeutas que trabajan en entornos culturalmente diversos pueden fomentar relaciones terapéuticas más profundas y auténticas. El enfoque transcultural no solo amplía las herramientas del terapeuta, sino que también enriquece el viaje terapéutico tanto para el terapeuta como para el paciente.

♦ English

I am originally from Mexico but have lived outside of Mexico since I was 16 years old. I began learning German in 2016 and started working in a German nursing home in 2021. Although my music therapy training was conducted in English, I attained at least a C1 level in German by the time I started practicing in this language.

Afef Benessaieh's notion of transculturality offers a compelling framework to understand my experience in this context. Transculturality, as Benessaieh posits, is not merely the coexistence of multiple cultures but a process of cultural fluidity where identities and experiences are interwoven across cultural boundaries (2010). This concept allows us to move beyond fixed notions of cultural difference and instead recognize the dynamic, hybrid nature of our cultural identities. In my work as a music therapist, I inhabit a transcultural space where my Mexican heritage and the German cultural and linguistic context intersect. This blending of cultural identities enriches the therapeutic process, allowing for more complex and multidimensional connections with patients.

Language, in this sense, becomes more than just a means of communication; it becomes a cultural mediator. The therapeutic dialogue is shaped by the therapist's ability to navigate both linguistic fluency and cultural nuance. Benessaieh's theory invites us to view language not only as a potential barrier but as a space of negotiation where new cultural meanings are constantly created.

Obstacles and Adaptations

Working in a German nursing home has presented a series of linguistic and cultural obstacles. Despite my proficiency in German, the nuances of working with elderly patients—many of whom have hearing issues or cognitive impairments—add layers of complexity to communication. This is where transcultural competence becomes essential. It requires more than just speaking the

language; it involves understanding the unspoken cultural cues, histories, and emotions embedded in the language.

At times, I have felt that my linguistic limitations hindered my ability to fully serve my patients. Yet, transculturality teaches us that these limitations can also be reframed as opportunities for growth. Being a Mexican music therapist in Germany often sparks curiosity among patients, who are eager to learn more about my background. This curiosity opens up space for self-disclosure, a delicate but important aspect of the therapeutic relationship. How much does one reveal about oneself in therapy, and how does this self-disclosure shape the therapeutic dynamic? By sharing aspects of my cultural background, I not only connect with my patients but also model openness and adaptability—key qualities in a therapeutic process.

The Therapeutic Relationship

The therapeutic relationship is a crucial component of almost any therapeutic intervention. As Benessaieh's work on transculturality highlights, it is the very fluidity between cultures that allows for richer, more multifaceted relationships to develop. In long-term care work, this relationship is perhaps even more critical, as the therapist often becomes a central figure in the patient's emotional and psychological life. Transculturality in music therapy underscores the need for flexibility and openness. As music therapists, we must be attuned not only to the music but also to the languages and cultures of our patients, recognizing that these are integral components of their identity and well-being.

Conclusion

Music therapy, particularly in a transcultural context, invites us to rethink conventional notions of identity, language, and culture. Drawing on Afef Benessaieh's theories of transculturality, this manuscript has explored how cultural and linguistic diversity can enhance, rather than hinder, the therapeutic process. By embracing the fluidity of identities and recognizing the rich potential of cultural exchange, music therapists working in richly cultural settings can foster deeper, more authentic therapeutic relationships. The transcultural approach not only expands the therapist's toolkit but also enriches the therapeutic journey for both therapist and patient alike.

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Final Chord

Bridging Languages

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