Music Therapy New Zealand

TE RŌPŪ PUORO WHAKAORA O AOTEAROA

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The New Zealand Journal of Music Therapy (NZJMT) is a peer-reviewed, open access and print journal, published annually by Music Therapy New Zealand (MThNZ) for music therapists, students, allied professionals, and others interested in music therapy. Our purpose is to raise awareness of music therapy and related approaches in the wider community, and to extend the knowledge and understanding of music therapists.

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Authors and reviewers are asked to consider the relevance of their work to contemporary music therapy practice in Aotearoa New Zealand and to read past issues of the journal and to download the submission guidelines from https://www.musictherapy.org.nz/journal. First person writing is preferred, where appropriate. Note our use of EPICURE and IMRaD checklists for evaluation of articles, and requirements for formatting and referencing.

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Editorial: Looking Back, Reflecting, Moving Forward

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Citation

Hunt, E. L. & Cho, H. (2024). Looking back, reflecting, moving forward [Editorial]. *New Zealand Journal of Music Therapy, 22,* 1-6.

With great excitement and gratitude, we warmly welcome you to the 2024 edition of the *New Zealand Journal of Music Therapy*. As first-time Co-Editors, we (Hyunah and Emily) have navigated the challenges and joys of compiling this volume and our journey has been one of learning and growth. We extend our heartfelt thanks to our contributors for entrusting us with their words, and to our reviewers and advisors for supporting our work. In particular, we would like to sincerely acknowledge previous Editor Alison Talmage for her advice and her meticulous preparation of handover documentation and Assistant Editor May Bee Choo Clulee for her invaluable support through the year.

The 2024 issue of the journal includes a case study by Ajay Castelino, based on his PhD research, which explores how therapist composed song recordings can resource families of preschool children with complex needs. TJ Hernandez shares insights into intersectional identity and the complexities of navigating oppression, power and privilege from his experiences as a music therapy student. We also share book reviews by Renata Kuswanto and Alison Talmage to inspire you, as well as a Theses and Publications Alert to keep you up to date with work published by New Zealand Registered Music Therapists beyond the scope of this journal.

When contemplating our first editorial, I (Emily) wondered what saying or proverb from my own culture[1] might be appropriate to acknowledge those

[1] I am Tangata Tiriti and have lived in Aotearoa New Zealand for 17 years, but most of my ancestry lies in Guernsey, a small island off the coast of France which became part of England in 1066 when William the Conqueror of Normandy seized the English throne from Edward the

who have gone before. This saying attributed to polymath and "natural philosopher" Sir Isaac Newton was what sprang to mind:

> [We are] standing on the shoulders of giants. (Chen, 2003, p. 135).

The quote comes from a letter Newton wrote to his rival Hooke in 1675 and is often used to acknowledge how progress in science and knowledge is built on the foundation of the work of previous scholars (Chen, 2003). This year we have celebrated the 50th Anniversary of Music Therapy New Zealand and the 20th Anniversary of Aotearoa New Zealand's only Master of Music Therapy programme with a very successful conference titled *Looking Back Moving Forward*. Both New Zealand and international presenters spoke on a diverse range of subjects and shared inspiring insights into their work and the music therapy field (MThNZ, 2024). Keynote speaker Denise Grocke (2024) reflected on her involvement with New Zealand's fledgling music therapy community and the work done by some remarkable people to establish the profession, the New Zealand Society for Music Therapy (later to become Music Therapy New Zealand) and the training programme which is now offered at Victoria University of Wellington - Te Herenga Waka, New Zealand School of Music - Te Kōkī. Conference celebrations also included the launch of *A History of Music Therapy New Zealand (1974-2023): Passionate People* (MThNZ & Rickson, 2024).

So, it does indeed feel as though Hyunah and I are "standing on the shoulders of giants" when we consider the significant work that established the music therapy profession in Aotearoa, and has brought Music Therapy New Zealand and the *New Zealand Journal of Music Therapy* to this point. The innovative and creative direction in which Ali and May have steered the journal in recent years offers a particularly rich and exciting foundation.

However, when I explored a little deeper, I discovered that the roots of Newton's saying go back to the Middle Ages; a similar sentiment is attributed to Bernard of Chartres by John of Salisbury in 1159 (Merton, 1985). In this case the translation adds another element; "Bernard of Chartres used to compare us to dwarfs perched on the shoulders of giants" (MacGarry, 1955, p 167).

As a music therapist on her own personal Post-Ableist Music Therapy (PAMT) (Shaw, 2022) and social justice journey, the word 'dwarf' made me pause. Whilst it is true that this metaphor reflects the humility of the

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Confessor at the Battle of Hastings, famously portrayed in the Bayeux Tapestry (Bayeux Museum, 2024).

current knowledge seeker (the dwarf) and the huge respect and appreciation of the foundation provided by previous masters (giants) this metaphor is inherently ableist. The obvious and uncomfortable implication in this metaphor is that dwarfism makes a person less significant, and that physical height is an indicator of superiority and professional standing.

This led me to reflect on Adjunct Professor Daphne Rickson's comments at the book launch of *A History of Music Therapy New Zealand (1974-2023): Passionate People* (MThNZ & Rickson, 2024):

> This presentation, and the published history, contains language that was appropriate at the time that would not be included in modern writing. So let's just contextualise what you are reading. (Rickson, 2024.)

Carolyn Shaw's keynote speech at this year's conference, a letter to her younger music therapist self, also highlighted how our understanding of music therapy theory and practice, as well as our sense of how we belong, changes over time (Shaw, 2024).

When "Looking Back" there is much value in pausing to reflect on the knowledge and work that brings us to the current moment. When "Moving Forward" we can then do so reflexively and in a way that grows our knowledge and practice further. That act of reflection and reflexivity also marks the moment where researchers push the "research bubble" just a little to discover something new, adding to the bubble of what was previously known.

With this in mind, our editorial is titled; "Looking back, *reflecting,* moving forward." The journal is a pivot point for reflection. It is your opportunity to contribute to the growing body of knowledge as well as your potential to guide what comes next. For those who presented at the conference, you have already started this task and we would urge you to consider writing up your paper and submitting it to the journal.

Should another incentive be required to share your work, we would highlight the importance of research and writing about music therapy practice in securing sustainable and equitable funding for your participants. As we navigate a post-pandemic world and an economy in recession, funding challenges look likely to persist. In New Zealand, sudden changes to Individualised Funding (IF) have caused significant problems and although at the time of writing music therapy is still considered within scope of flexible funding (MSD, 2024), there is still much uncertainty about future funding changes.

In Australia, policy changes to the National Disability Insurance Scheme (NDIS) included an initial cut to all art and music therapy services. This was swiftly reversed but the current restrictions place a financial limit, which is not in line with comparable therapy services, on how much can be claimed for music therapy. It also states that "while art and music therapy remain permissible, they do not meet the evidentiary standards required to be classified as a 'therapy' under the definition of NDIS supports" (NDIS, 2024).

As an editorial team, this prompts us to reflect on the concept of "evidence" and challenges us to explore and demonstrate what constitutes evidence across diverse individuals and contexts. We aim to share the stories of individuals that illustrate the evidence of music therapy's effects. We believe it is essential to acknowledge the diverse experiences of others and emphasise that focusing solely on visible, measurable evidence is both a regression and a misstep. Through this journal, we hope to shed light on these important perspectives, but we need your help to do so by sharing your stories.

To encourage more submissions, the editorial team are delighted to announce that Music Therapy New Zealand will be offering writing workshop(s) to support New Zealand Registered Music Therapists who are new to writing or who would like to improve their writing skills. Details about this will be announced in early 2025. To inspire your writing journey, included in this journal is Alison Talmage's review (2024) of Mertler's book *Disseminating your Action Research: A Practical Guide to Sharing the Results of Practitioner Research* (2024). You may like to take this as an invitation to explore how you might translate practice into research.

Journal guidelines can be found on the MThNZ website.[2] We consider a wide variety of submissions, including (but not limited to): Practice-based, research, theoretical or case study articles about music therapy; less formal, practice-based or autobiographical articles for the Community Voices section; interviews, arts-based elements; student contributions; relevant articles about related fields or allied professions, if clearly relevant to music therapy practice; book and resource reviews; and other items at the discretion of the editorial team. Please note, however, that we are a scholarly journal, and all submissions require some engagement with existing music therapy literature – after all, to grow knowledge we are "standing on the shoulders" of those who went before.

We hope that this issue inspires you to think critically, engage deeply and contribute your own ideas to future editions. Thank you for joining us on

[2] https://www.musictherapy.org.nz/journal/

this exciting adventure. Together, let's make the *New Zealand Journal of Music Therapy* a beacon of insight and discovery.

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The Role of Music Therapist Composed Song Recordings in Supporting Families to Independently Use Music with Preschool Children with Complex Needs: A Case Study

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Keywords

Pre-school; families; complex needs; music therapy; song recordings

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Review

This article was independently reviewed by two anonymous peer reviewers.

Abstract

This case study presents the journey of a family in using pre-composed song recordings to support their independent therapeutic use of music with their preschool child with complex needs. Nine music therapy sessions were offered at the family's home over eight months. A seven song album of songs composed and recorded by the music therapist was offered to the family to support their engagement with their child. These recordings supported the family's therapeutic use of music with the song lyrics offering a prompt to guide the caregiver in engaging with their child; providing a structured framework for the family to engage in joint fun activities through music; serving as a resource for passively engaging the child when the caregiver was busy; acting as a benchmark to assess the child's current level of engagement and providing 'building blocks' to enable the family to begin improvising songs to suit their child's needs. It

is suggested that the provision of song recordings be included as part of music therapy sessions to help the independent therapeutic use of music by families outside the music therapy sessions.

This case study is an extract from my PhD research completed through Te Herenga Waka, Victoria University, Wellington, New Zealand in 2022. The research focussed on how a music therapist can support families of preschool children with complex needs to use music therapeutically at home. I worked with four families over eight months and during the sessions, I collaborated with families to explore how they might utilise their strengths and resources to use music therapeutically with their child. My PhD research employed an interpretivist multiple-case study design. One of the findings was that the collaboration between the family and music therapist was supported by therapist-supplied resources. One of these resources was song recordings.

The case study presented here relates to nine music-making sessions with one of these families. A key component of those sessions was the use of pre-composed songs. This case study demonstrates how the family used music therapist composed songs to enrich interactions with their child with Complex Needs.

Literature Review

Children with complex needs present with severe cognitive, neuromotor and/or sensory challenges. This can affect their conceptual, social and practical skills (Schalock, 2021). These challenges across multiple areas mean that children with complex needs have a high level of dependence on their personal and professional caregivers (Kruithof et al., 2020).

Music therapists often explore collaborative partnerships to support staff to utilise music to support children with disabilities in settings such as early learning centres and schools. They empower staff to use music to meet individual and academic goals (Rickson, 2010), enhance students' progress (Tomlinson, 2020), engage students through spontaneous musical play (Pethybridge, 2013) and promote independence in daily routines (Kern et al., 2007).

However, over one third of parents and whānau (family) of children with complex needs have been discouraged from enrolling their child at one or more early childhood education (ECE) services in New Zealand since kaiako (teachers) are not confident teaching disabled children, and the kaiako feel they struggle to access support to help them develop (ERO, 2022). This factor, in addition to the high level of care required to support

the child, has resulted in preschool children with complex needs often staying primarily in home settings rather than early learning centres.

Music therapists acknowledge that they want to support families to use music therapy strategies and activities beyond music therapy sessions, including at home (Gottfried, 2016; Jacobsen & Thompson, 2016). An important outcome of music therapy sessions is to resource whānau, both by modelling activities and also offering suggestions for new ways to connect with their tamariki (children) (Loth, 2008).

One medium frequently used to engage children in the home setting is through songs. Songs provide a structured and predictable framework for musical interactions (Johnels et al., 2022). Singing songs is a commonly used and highly valued component of the musical interaction between children and their caregivers (Johnels et al., 2022). Music therapists use pre-existing songs, live original songs and lyric replacement in music therapy sessions (Schwartzberg & Silverman, 2014). They also facilitate therapeutic songwriting with clients (Baker, 2015; Baker & Wigram, 2005).

Music therapists pre-compose songs for use in music therapy as part of standard practice (MThNZ, 2020). However, the literature on this topic is sparse. Pre-composed songs appear to be primarily used with children and adolescents in schools or adults with developmental disabilities to individualise therapy (Jones, 2006) and meet the unique needs of each person (Farnan, 1987). It is recommended that the lyrics of these pre-composed songs are simple, concise, repetitive and set to accenting words with a focus on enabling task orientation (Farnan, 1987). The melody can have a stepwise motion, natural phrasing and a limited pitch range to allow a wide range of people to join in singing the songs (Brunk, 1990; Farnan, 1987). Songs are preferably tested in music therapy sessions before being recorded (Brunk, 1990).

Song recordings of either pre-existing or original songs are frequently offered to families in music therapy sessions (Abad & Edwards, 2004; Lander, 2017; Mackenzie & Hamlett, 2005; Shoemark, 1996; Yang, 2016). The recordings support music-making at home (Abad & Edwards, 2004; Williams et al., 2011) and carrying out Activities of Daily Living (ADLs) (Yang, 2016). Family members who are unable to attend the music therapy session use recordings to support musical activities at home and enhance positive family relationships (Shoemark, 1996). The recordings contribute to familiarity and confidence in joining in when the family attends their next music therapy session (Shoemark, 1996). Music therapists such as Megan Spragg (Spragg, 2023), Rachel Rambach (Rambach, 2010) and Margie La Bella (La Bella, 2009) have released

commercial albums of their pre-composed songs for use in music therapy while others music therapists have released sheet music for their original songs (Talmage, 2013)

In summary, published literature about songwriting and the use of song recordings in music therapy is available. However, very little has been written exploring the therapeutic benefits of using pre-composed song recordings in music therapy. This case study aims to address this gap in the literature.

Background

The Music Therapist

I have been practising as a music therapist for over 15 years with children with disabilities. Prior to starting my PhD research, I had worked in special education schools for children with disabilities in New Zealand for over 10 years. I often used popular songs and nursery rhymes in my sessions but the lyrical complexity and tempos of the song recordings made them less accessible for children with complex needs. For example, the nursery rhyme *Head shoulders knees and toes* required the child to physically and cognitively recognise and tap a range of different body parts in a short period which result in a sensory overload. I found that there were very few commercially released song recordings specifically for music therapy practice, as shared above in the literature review section. Therefore, I chose to utilise my songwriting experience as a professional musician to compose songs for use in music therapy sessions.

The Song Album

An audit of my session goals uncovered that the overarching themes explored experiences in the domains of greetings, fine motor expression, gross motor expression, instrument playing, socialisation, vocalisation and multi-sensory experiences. These areas formed the basis of the songs. I chose one goal per song to allow physical and cognitive processing time for the child (McDevitt & Ormrod, 2013). The lyrics had concrete rather than abstract language (such as metaphors and similes) to ensure that the lyrical message was communicated clearly (Wortham, 2006). The chords were primarily diatonic chords such as major, minor and dominant sevenths, with the occasional use of secondary dominants to add anticipation. The melody was diatonic without accidentals so they were easy to sing. The main melodic variation was a key shift up half a semitone or a tone to sustain engagement. The lyrics were repetitive and tended to focus on the song's intended goal. The lyrics also provided clear

prompts to the child and caregiver on what actions were to be carried out. Thus, the music provided the mood while the lyrics provided the instruction.

I recorded and released these songs as music albums to facilitate their use by parents, caregivers and support networks of children with disabilities (Stelino, 2015; 2020). The album in the case study below is a 10-song album composed to support children in developing their fine motor, gross motor, social and vocalisation skills (Stelino, 2020).[3] It also included sensory-based songs and a hello and goodbye song. The songs were all sung in English. The arrangements followed a contemporary musical style. The instrumentation included acoustic and electric guitars, ukuleles, piano, electronic keyboards, a bass guitar, a drum kit and percussion instruments. The music therapy sessions in the case-study below took place in 2019. The first album (Stelino, 2015) was also shared with the family as the sessions progressed.

The Family

This case study is based on my work with Daniel[4] and his family. Daniel lived in a residential suburb in a large city in New Zealand with his mother Michelle, father Ben and four-year-old brother Will. I worked with Daniel between the ages of one year and 11 months to two years and six months. He had a diagnosis of Angelman syndrome, a genetic disorder which primarily affects the nervous system and commonly results in vision loss, cognitive impairment, and additional physical disabilities (Dagli et al., 2021). Daniel was mainly fed by a gastrostomy tube, though his family had recently started spoon-feeding him.

Daniel spent most of his time at home with his mum and attended a group session at a local early intervention centre for children with a visual impairment once a week. Daniel's brother was often at home during our session. Daniel's father worked during the day and so was unable to attend.

During our fifth session together, Michelle mentioned that Daniel enjoyed nursery rhymes and song activities at the group they attended. I inquired if the family would like a copy of the album of songs I had recently recorded (Stelino, 2020). Michelle was eager to trial the songs I wanted to personalise the songs on the album to suit Daniel. I re-recorded the

[3] The album was recorded in 2019 prior to the start of the music therapy sessions in this case study, however it was commercially released in 2020.

[4] All participants in this study have been given pseudonyms to preserve their anonymity.

vocals to the hello and goodbye songs to include Daniel's name. For example, the lyrics of the first line of the Hello song were modified from "Hello everyone hello" to "Hello Daniel hello." I gave the family the album at session six. Michelle was excited to receive this album. We listened to the album together. She found it "very cool, having the music tailored with his [Daniel's] name in it," and "pretty special."

Methodology

My research was underpinned by a constructivist epistemology and a relativist ontology (Crotty, 1998). This theoretical framework aligned well with my clinical orientation as a 'person-centred' therapist, following the person's interests, needs and leads (McMillan, 2004). My research approach aimed to generate an understanding of how therapeutic music-making could further enhance the lives of children and their whānau. This stance identified that each family may have a unique approach to making music with their child, relative to the family's contexts. It also acknowledged that the outcomes of the research may have been different if the research had been carried out with different families and/or a different music therapist.

The research was undertaken as per the ethical standards of Te Herenga Waka – Victoria University of Wellington Human Ethics Committee (ID: 0000025960). Ethical considerations included being mindful that I worked within the personal space of a family home and I chose to approach this invitation to enter their home with respect and empathy. I also took a strengths-based approach that recognised and supported the family's strengths and skills to enhance their sense of self-esteem and self-efficacy (Thompson, 2012a). I held a dual role as music therapist and researcher. I conducted interviews with parents that were used as a data source and this may have created potential bias in the case study reporting (Waterfield, 2018). Working within a collaborative model, it is hoped Michelle was comfortable doing the interviews since we worked with a collaborative model. Reflecting on the interviews and hearing the transcripts reveal that Michelle appeared to feel comfortable sharing her experiences. However, there is always the potential that this was not the case, which would have resulted in answers that were affected by the interviewer-interviewee power imbalance (Nunkoosing, 2005).

Data for the research was gathered through pre- and post-session interviews with Michelle, my clinical notes and my reflexive journal. The data was analysed using thematic analysis (Braun & Clarke, 2006; Braun et al., 2019). There were six phases for the analysis:

1. Reviewing the written documentation and listening to audio recordings of interviews to refamiliarise myself with the data.

2. Creating generalised nodes in relation to the research question with corresponding text attributed to it. For example, the data about pre-recorded songs was filed under the 'providing resources' node.

3. These nodes were grouped to create themes that created clusters of meaning about an aspect of the dataset relative to the research question. For example, the 'song recordings' data from the node 'providing resources' was collated to sit under the theme 'music therapist provided resources empowers family music-making.'

4. Manual mind-maps were used to map out the themes, identify overlapping themes and create stronger themes. For example, data related to the song recordings was moved from 'The family does more music-making together' to sit under the theme 'pre-recorded songs support music-making at home.'

5. The names of the themes were reviewed to ensure they accurately represented the underlying text. For example, the theme 'caregiver adapts music-therapist-provided-resources as she gets more comfortable using them' was adapted to 'a template for improvisation.'

6. The analytic narrative was written around the themes with relevant quotes.

Findings

The thematic analysis of the data identified themes related to the use of music therapist composed song recordings to support the family's independent use of music with their child. These themes are outlined below.

An Engagement Prompt

Michelle liked that the lyrics were based on actions that could be done with her son rather than abstract concepts. She expressed it as "it's really helpful having the music and then the music helping to prompt the adult to do what you have to do, so it kinda delivers what has to happen." Her reward when playing the songs was "Daniel's smile." I supported this process by singing the song live during our sessions.

The song recordings thus acted as a 'prompt' for the caregiver, with the lyrics guiding how to engage with the child during the song. It supported

the caregiver in exploring how to independently engage in music-making with their child.

A Framework for Family Engagement

The family regularly used the songs to have fun as a family. Between sessions seven and eight, Michelle shared that “we were playing the CD and we were doing the crocodile one and the bubbles and trying to bring it all back again, and, Ben had all the instruments out on the floor, and I was like, can we do one [song] at a time? Because he was just going crazy (laughs out loud).” This was significant as Michelle realised that music was the only activity other than swimming that the entire family could do together. The pre-composed songs thus moved from just a ‘prompt’ to a framework within which the family could engage in joint fun activities. The song recordings also provided Michelle an opportunity to musically share with Ben what we had done in the session and it allowed Ben to engage in music-making with Daniel.

An Easy-to-Use Passive Therapeutic Engagement Tool

Michelle found the songs valuable to give Daniel input when she had low energy levels. Here is a quote from session nine where Michelle discusses this experience:

> I think in the situation we were in, where maybe a child can’t feedback, that CD that you gave us was excellent. Like, when I had no energy and didn’t wanna sing the song, and I feel like he’s getting some sort of input, even in a stage where he is seizing and stuff. Plus, he’s getting something constant and is hopefully feeding into his brain somewhere. So, I found that helpful when I felt really tired and uninspired and felt like I was just fulfilling a need to keep him alive. I’d just put that on, and it’d make me feel like I was doing something more than just keeping him captive in the house.

Thus the use of the songs extended from a framework of active engagement to a resource for passive therapeutic engagement when the caregiver was busy. It also helped provide the caregiver with comfort that the child was receiving therapeutic input while the caregiver had to attend to other urgent tasks.

A Benchmark for Engagement

Recordings provide a consistent framework for engagement. The song tempo, delivery, etc. remain constant and offer an easy benchmark to compare the child’s engagement. This can be a positive and/or negative experience. During session eight, Michelle shared that Daniel had

recently been unwell. He was immobile and lethargic. She played the song recordings but found that he could not do the activities he used to do, which was “upsetting” and “heart-breaking.” Though the songs provided Michelle with optimism, the grief about her child’s challenges and the lack of forward motion at times could make Michelle feel upset. I reflected that music appeared to have a role as an emotional vessel. Music could elicit joy, but also sadness.

A Template for Improvisation

As the sessions progressed, there was an exciting development. I found out that the initial “building block” of a song recording allowed Michelle to feel comfortable to improvise and extend this concrete resource. She modified the songs to make them fit and make everyday activities more “fun” and “musical.” This is shared in the quote below at session nine.

> I’ve been modifying some of your songs, but I didn’t actually do it intentionally. I just did it and I’m like, ah, this is cool! Do you know that “Clap your Hands” one? I do that with “Gonna brush, brush, brush, your teeth.” So, we now like incorporating songs into what we are trying to do. I think it helps me like, if there is no cooperation, just to keep, you know, making it a fun thing.

Michelle had begun modifying the lyrics and borrowing the “rhythm” from my songs to create new pieces to fit her given purpose. I was pleasantly surprised to see how an element of the song formed the basis of an improvisation. I also wondered if my concerted effort to create simple, accessible melodic and rhythmic lines in these song compositions could have assisted Michelle in isolating and using musical elements in a new context. The use of pre-recorded songs as tools for improvisation added a new resource to Michelle’s options when working with Daniel and built her confidence to try new things.

Michelle began to improvise freely as well. She shared, “Sometimes I just sing whatever I want to say to him. Make it playful, but there’s no rhythm, we were having fun.” For example, she said she had made up a song for when he was putting on his clothes. She felt it helped Daniel develop his understanding of language by learning the meaning of phrases such as “finish and stuff.” Daniel responded to her songs by “giggling, as if to say, I know what you are doing, I know what you’re saying, mum.” She found it a step forward as “before, he didn’t care that I was doing it. So, for him to laugh, every time I did it, he’s making a connection, that’s been pretty cool.” Michelle thus found that she could use the pre-composed songs as the initial “building block” from which she could engage in child-centred improvised songs that helped her improve her bond with her son while

also assisting with making daily activities more fun. Here is a quote from session nine, to summarise Michelle's approach.

> Having it [songs] for routines has just been something that happened, just the song got stuck in my head and adapted it, so I was doing it in time. It's become part of the routine. That's quite cool! That's like a little building block!

The song recordings thus provided Michelle with a supportive musical structure through which she was eventually comfortable engaging in live improvised music making.

Discussion

This case study focuses on two elements of songs: Pre-composed and recorded. It demonstrates that both are important elements in families' development of independent musical therapeutic engagement. Pre-composition allows time for the music therapist to reflect on the intended outcome to a greater extent than in-session songwriting. Song pre-composition shares similar concepts to existing literature such as simple, concise, repetitive lyrics, and limited pitch range in the melody with stepwise melodic motion (Brunk, 1990; Farnan, 1987). Lyrical focus is suggested to be action-based rather than abstract, which aligns with the concept of ensuring songs are task-orientated (Farnan, 1987). Personalisation of the recording allows it to be viewed as special and more valued by the family. This can motivate the family's use of the recordings (Johnels et al., 2022). Customising recorded song resources can be time-intensive for the music therapist. However, the extra time is offset by increased engagement by the family.

The family benefitted from song lyrics that provided prompts. The use of song lyrics as prompts is a time-honoured tradition with most children's action songs containing actions within the lyrics. Music therapists have used nursery rhyme lyrics as prompts to help children explore social and educational concepts (Mackenzie & Hamlett, 2005). Music therapists can consider incorporating actions within their song lyrics.

Song recordings allow music therapists to take advantage of music listening providing a passive therapeutic input. Michelle led a busy home life and therefore having the provision of therapist-created input provided a listening resource potentially more tailored to Daniel than alternatives such as mainstream children's songs and videos.

Families may prefer to support their independent music-making with recordings as it minimises the pressure for families to independently

engage in singing and making music. The song recordings allowed Michelle to share the session content with Ben (Shoemark, 1996) and provided a soundtrack for family engagement as the songs enabled Daniel to participate in family activities. Recordings of songs suitable for children with complex needs can thus enable the whole family to engage in joint music-making with their child.

The song resources acted as a starting point for the family to sing the songs live. Singing the songs live allowed them to sing them in ways that match and reflect the child's mood and behaviour (Thompson, 2012b). This attunement via music represented communicative musicality between the caregiver and child (Malloch & Trevarthen, 2009). It allowed for musical elements to create communication between the two partners. Michelle began extemporising the songs in improvising the songs to suit Daniel's needs while maintaining the musical and dynamic characteristics of the song (Wigram, 2004). She adapted the songs to create situation songs; improvised songs related to an actual occurrence in the therapy setting or the therapeutic relationship (Kolar-Borsky & Holck, 2014). Music therapist composed song recordings can provide a scaffold for families to integrate music therapy concepts into their home lives.

Limitations

The research findings are based on the research and analysis of one music therapist and one case study. Although the findings resonate with existing literature in family-centred work, the results need to be read in the context of the research setting. It is crucial for music therapists working with families to explore and compare this work to their practice to further the development of this niche area of music therapy practice. These findings are relevant to pre-school children with complex needs. The child's young age and multiple needs highly impacted the conclusions and recommendations. Older children and those with different levels of conditions may have other pressures on the family, so the suggestions may need to be adapted to suit their family's varying needs.

Conclusions and Recommendations

Personalised, family-centred music therapist-provided songs can offer a starting point for therapeutic engagement. The songs facilitate the parents as therapy partners by providing a conduit for the family to engage in the therapy. Songs as resources, can act as building blocks that give the family tools and confidence to independently use music actively with their

child. It motivates the family to explore improvised child-centred live music-making. It is suggested that the provision of song recordings be included as part of music therapy sessions to help the independent therapeutic use of music by families of pre-school children with complex needs outside the music therapy sessions.

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"Where are you from?" Navigating Oppression, Power and Privilege in Music Therapy Spaces: A Critical Autoethnography Exploring Intersectional Identities

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Review

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Abstract

This research explored a second-generation, New Zealand born Filipino music therapy student's experience using a critical auto-ethnography to explore their intersectional identities while on placement in aged-care settings. Using a thematic analysis, four themes emerged: 1) Locating the self; 2) connection in and around therapeutic interactions; 3) dissonance in and around therapeutic interactions; 4) restorative practices. The findings revealed insights into the importance of taking accountability for privilege and unchecked bias, while also practising self-compassion for minority identities. Taken together, these ideas can enhance a music therapist's sense-of-safety as they navigate the complexities found within the therapeutic relationship.

My intersectional identities profoundly shape the ways I exist and interact with the world around me. This research was no exception, so I feel it is important to begin by sharing these parts of me to provide context for my

experiences and positionality. I am a second-generation, New Zealand born Filipino. I am a son of two Filipino immigrants and a person of colour (PoC). I am non-disabled, neurotypical, and cis-gendered. I grew up in a secure middle class family home and English is my first and only spoken language. I am in my mid-twenties.

Emerging Research Context

My placement took place across eight different aged residential care (ARC) facilities (rest homes, hospitals, palliative units, and dementia care) primarily in the greater Wellington region. I worked across community-settings, rest homes and hospital units, and dementia units, working with residents one-to-one and in group settings. The diversity of environments meant I met many people in a short period of time, and I began to encounter racial microaggressions about my brown skin colour. Microaggressions are defined as "everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalised group membership" (Sue, 2010, p. 3). Despite being born and raised in Aotearoa, I was frequently asked by staff members and residents, "where are you from?", and "how long have you been in the country?" Residents asked my supervisor, "I want to know where he's from" rather than addressing me directly. In another case, a staff member introduced me to a group of music therapy participants as a Kiwi despite explicitly introducing myself to them as a second-generation Filipino.

I was initially curious to explore how my identity as a male music therapist might manifest during placement. I was fortunate to have many positive male-role models throughout my formative years who demonstrated gentle, reflective, and kind ways of being. This led me to develop an interest in the idea of masculinity and how young boys may or may not be socialised into caring roles. The notion of 'caring masculinities' is emerging within feminist and critical-studies literature (Elliott, 2016), although regarding music therapy, male-identifying music therapists are a minority within the profession (American Music Therapy Association, 2019; Molyneux et al., 2016) and detailed accounts from male music therapists concerning their masculinity are sparse.

My interest in gender was quickly replaced by the need to respond to the attention my brown skin drew and the subsequent racial microaggressions. Before starting placement, I had considered myself equally Filipino and Kiwi; a Kiwi-pino (pino derived from Pinoy, a widely used slang term similar to the way New Zealander's are called 'Kiwi'). The

racism I experienced challenged this notion; how was I to navigate only being seen as one thing when my lived experience told me otherwise? During this identity fracturing, I also encountered privileges stemming from my identity as a non-disabled and neurotypical person. ARC facilities were a completely new environment for me, and I found myself stumbling into unchecked ableist biases. I was unsure how to navigate the simultaneous experience of racism and holding more power in my positionality. In response, my research shifted away from exclusively exploring masculinity, and towards my intersectional identities as a whole to capture the wide range of experiences I had begun to encounter.

Research Question and Aims

The research question for my exegesis was: "How do I manage intersectional identities and hidden privileges during therapeutic interactions with aged-care residents?"

My research aimed to:

- Identify experiences of oppression I experience as a PoC and simultaneously perpetuate as a non-disabled, neurotypical, young student music therapist.
- Develop insights around self-care and the navigation of negative experiences in music therapy.
- Develop tools to navigate differences within the therapeutic relationship.

Literature Review

Intersectionality in Music Therapy

Intersectionality (Crenshaw, 1989) suggests that a person's gender, culture, ethnicity, class or whether they live with a disability shape how people experience the world around them (Bhopal, 2018). It draws attention to how experiences of inequality, such as sexism, racism, eurocentrism, ableism, and classism (and more), do not exist in isolation to one another (Crenshaw, 2016), and their intersections position people within a nexus of privilege and oppression (McKinzie & Richards, 2019). Intersectionality has become increasingly relevant in music therapy, as the people we work with may hold multiple minority identities which may make them more vulnerable to social injustice (Seabrook, 2019).

Privilege and Oppression

Viewing identity with an intersectional lens allows us to see how people can exist in multiple social situations; an identity may afford privileges in

one environment, while being the cause for subjugation in another (McFerran, 2021). Privilege, in this sense, refers to a special advantage, benefit, or entitlement that stems from a particular identity marker, such as ethnicity, skin colour, gender or sexuality (Black & Stone, 2005). There has been growing recognition for less visible privileges like immigration status, the ability to speak and read English, or differentiation between working class and middle or upper class (Turner, 2021). Oppression can be considered both an action and a state-of-being (Whitehead-Pleaux, 2018), and concerns interactions between majority and minority groups. According to Baines (2021), these interactions concern differences in class, race, gender, ableism and colonialism. This research takes a similar stance. Oppression was encountered during moments of injustice or inequality, and often concerned the minority identities of myself and music therapy participants. Microaggressions or unintentional harm brought on by unchecked biases are forms of oppression mentioned thus far.

Intersectionality-Informed View on the Therapeutic Relationship

Intersectionality (Crenshaw, 1989) brings to attention the ways an individual can exist across multiple contexts and how they may experience privilege or oppression. This line of thinking can also be extended to our identities as practitioners, clinicians, and/or therapists. These labels can inadvertently position us as appearing more knowledgeable than our participants (McFerran, 2021) and assumes that we are immune from bias, or excused from perpetuating systems of inequality because we have undergone studies, training, or registered with a governing body (Hahna, 2017). There exists a power imbalance between therapist and participant as the former is present as a professional, whilst the latter is present to address aspects of their health and wellbeing (Seabrook, 2019). This dichotomous view positions the therapist as an expert, while relegating the participant as “needing to be fixed” (Davies, 2022, p. 21).

Intersectionality allows us to see how music therapists and clients can occupy and move between spaces of privilege and subjugation by way of their identities, and further supports the notion that a therapeutic relationship is a political entity that is not immune to broader societal injustice and oppression (Hadley, 2013). Drawing from my own experience, microaggressions subjugated me as a PoC relative to the residents, yet I simultaneously held power over them as a result working in a professional capacity as a student music therapist.

Music Therapy in Aged Residential Care

The discourse above considers how language can shape perceptions of music therapists and participants alike. In this section, I describe some ways music therapy is used practically across residential care spaces to provide context for the musical interactions detailed later in the findings. Music therapy can be active or receptive (Edwards, 2015). Within aged-care, active forms can encompass instrument playing, improvisation, movement, and singing, while receptive forms can encompass listening and discussion-based practices. This can all be underpinned by Small's (1998) concept of "musicking", which "covers all participation in a musical [activity], whether it takes place actively or passively" (p. 9). Music therapy offers a flexible and relational approach to support the well-being of older adults, such as supporting their identities, providing opportunities to access and build community, and bolster quality of life for those (but not limited to) living with degenerative disease like dementia. These various areas will be discussed below.

Identity

Hays and Minichiello (2005) reported that music is a "symbol for defining their own sense of self and identity" (p. 4), and it was connected to life-experience and memories. Song-based reminiscence is a method that captures these sentiments (Grocke & Wigram, 2006). Reminiscence includes verbal discussion of memories which can be prompted using objects and artefacts (like photographs), or through music (Istvandity, 2017). Listening to personally significant music that is tied strongly to key life events can be a deeply impactful experience that prompts memories of important relationships or developmental milestones (Ridder & Wheeler, 2015). These experiences have been noted to positively influence well-being among older adults (Istvandity, 2017).

Supporting Connection and Mental Health

Music can be a "social glue" (Hays & Minichiello, 2005, p. 6) that can safely and non-confrontationally bring isolated residents together. In group settings, residents can interact with one another directly during group singing, instrument playing, and song requests (Ridder & Wheeler, 2015), or through receptive-based reminiscence activities (Grocke, 2015). Additionally, music can facilitate communication in other modalities when spoken language is inaccessible (Hays & Minichiello, 2005).

Werner et al., (2017) notes how music therapy is more effective in alleviating depressive symptoms in older adults compared to non-therapist facilitated musical activities. This is attributed to the person-

centred and relational nature of music therapy. Receptive music therapy methods are described as having similar positive impacts on mental health as they can evoke reminiscence, affectively stimulate and relax when necessary, and connect listeners socially (Grocke, 2015). Moreover, receptive methods can help residents express difficult emotions like frustration, irritation, and sadness (Jang & Kunde, 2021).

Dementia Care

The music therapy principles outlined above are also relevant when working with residents living with dementia. McDermott et al., (2014) explain that music therapy can provide residents a safe and comforting environment to engage in reminiscence in ways that avoid disorienting them from their present moment. Music is seen as an accessible resource for those living with dementia to remain connected to their identity and sense of personhood by connecting with significant songs (Elliott & Gardner, 2018). Alongside the music therapist's ability to shape music to relax residents when they are agitated, or energise when apathetic, music therapy provides a space where are not required to be "in the moment" and can be validated wherever they may be in their memories (Dowlen et al., 2018).

Methodology

A critical autoethnography was used in this research. Autoethnography is defined as "an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experiences (auto) in order to understand cultural experiences (ethno)" (Ellis et al., 2011, p. 1). The critical element is added when the research(er) seeks to understand the lived experiences of socially marginalised folk in order to highlight systematic injustice and inequity (Adams, 2017; Boylorn & Orbe, 2016). This method allowed me to examine how I exist and acted within ARC facilities, and in music therapy spaces.

Data consisted of personal reflexive and reflective journals, session notes, and supervision discussions (practice and academic). These sources were collected over a six-month period. A thematic analysis was used to analyse the data. This is the "process of making sense of the data and abstracting broader ideas than the explicit words on the paper" (Fugard & Potts, 2019, p. 3). I took guidance from Braun and Clarke's (2022) six phases of thematic analysis, which included 1) data familiarisation, 2) developing initial codes, 3) sorting codes into candidate themes, 4) reviewing themes, 5) refining, re-defining, or re-coding where necessary, 6) establishing themes and writing. NVivo 12 was used to

code the data and sort them into themes. For clarity, I have used italics in this article when quoting directly from my journals, session notes and supervision discussions.

Māori music therapy participants were not explicitly involved in the research, yet this research occurred in Aotearoa. It felt important to consider several principles held by the Te Tiriti o Waitangi statute held by Te Herenga Waka, Victoria University of Wellington (2022).[5] Principles of Rangatiratanga (self-determination), Mahi Tahi (partnership and mutually beneficial outcomes), and Kōwhiringa ("about ensuring that Māori can be Māori, in whatever form that takes") were particularly relevant and seemed to parallel the person-centred and critical approaches used in my practice.

Findings

Four themes emerged across all data sources:

1) Locating the Self
2) Enhancing Connection in and around Therapeutic Interactions
    a. Musical Interactions
    b. Ethnicity and Culture
    c. Age and Gender
3) Dissonance in and around Therapeutic Interactions
    a. Therapists' Experience with Subjugation
    b. Confronting Privileges and Participant Subjugation
4) Restorative Practices
    a. Supervision
    b. Reflection
    c. Boundaries

Data extracts are provided alongside personal commentary of the findings. While these extracts are presented linearly and categorically below, the themes are interrelated, and can be organised in a non-linear and interconnected way (see figure 1).

[5] It is important to acknowledge that I did not directly reference Te Tiriti O Waitangi and have instead referenced a document written by Te Herenga Waka, Victoria University of Wellington. At this point in my learning journey as a music therapy student conducting research within an academic context, this document felt sufficient. As I continue my learning, I recognise the colonial nature of this reference and would choose to refer to Te Tiriti directly.

Figure 1: Themes in Action

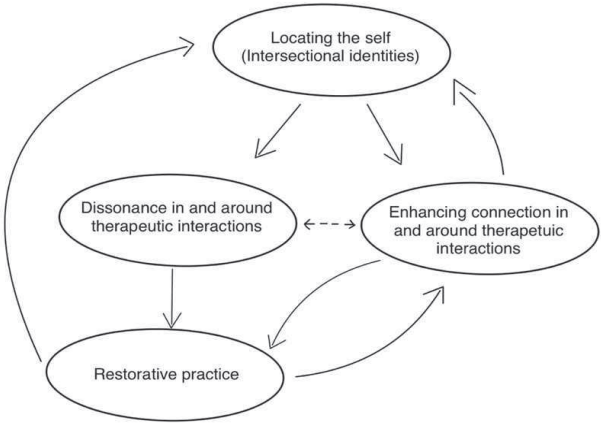

Image description: This figure shows a non-linear and interconnected relationship between the four themes. Each theme is positioned in a speech bubble and the movements between them are represented with arrows. The theme “locating the self” is positioned at the top, “dissonance in and around therapeutic interactions” and “enhancing connection in and around therapeutic interactions” are placed side by side in the middle, and “restorative practice” at the bottom. The arrows flow through the themes, showing the way that they flow to and from one another and ultimately the arrows converge on the theme of “locating the self” to suggest that our experiences feed back into our identities. Dotted arrows between the “dissonance” and “connection” themes in the middle indicate the way that these themes can coexist in a non-binary way as a given therapeutic interaction can be considered both positive and negative depending on which of our identities is foregrounded.

In the exegesis submitted to the university, I included voices of other music therapists from published journal articles or reflexive commentaries written by Akash Bhatia (2021), Natasha Thomas (2021), Dennis Kahui (2013), and Hilary Davies (2022). My research supervisor recommended including these voices alongside mine to further support generalisability outside my own experience as a Filipino. Each therapist held unique intersectional identities, including (but not limited to) identifying as neurodivergent, disabled, Black, Māori, or cis-gendered. Due to constraints on space, I have chosen to focus on my experiences and identities, although I wish to pay tribute to these music therapists for their part in my learning journey.

Theme 1: Locating the Self

Unexpected racial microaggressions required me to shift my initial focus on masculinity to cultural identity. Throughout my placement, I was asked "where are you from?" with an alarming frequency and in attempts to process my confusion, I wrote:

> *I'm finding these occur a bit more frequently now that I'm meeting lots more people […] Still not sure how to deal with these questions.*

Despite being born and raised in Aotearoa the frequency of this question was confronting. Early in my learning I was not cognitively aware that I was being triggered. The sense of security surrounding my "Kiwi-ness" began to erode, and so did my mental health. Grappling with this, I wrote:

> *I feel wholly unprepared to answer this question. On a cognitive level, I know the answer. I am a 1st generation Filipino. To be 1st generation is to be born in New Zealand. I am a citizen by birth. The answer to this question on an emotional level is vastly different. To ask where I am from is to ask me where I started. It implies my upbringing, and every major milestone. Where do I start? All the way at the beginning? Do I start with [street I grew up on], or the legacy of colonisation? Do I start with the cycle of generational trauma? Assimilation? I cannot speak my mother tongue. Yet my skin is brown. I am wholly unprepared and unready to answer such a question. I am, I AM from "here". Earth. I am human just like you. But I am also so different than you.*

The intense feelings of otherness made it very challenging to connect with the residents during music therapy. In attempts to address these feelings, I unknowingly copied my Pākehā supervisor's mannerisms and idiosyncrasies, down to the tone and cadence of their voice, whilst running group sessions (which consisted largely of white-presenting residents, typically of European ancestry). Realising that I had not been acting authentically made me uncomfortable. Discussing this with my supervisor, I was reminded that my job as student music therapist was to learn, and to:

> *Figure out who I am in [ARC] contexts, [and] how to be genuine and authentic while being young, brown, and male.*

Data revealed that perfectionism was another source of my anxiety and apprehension. The nature of my placement meant I typically had another experienced music therapist onsite with me, co-facilitating sessions.

Subconsciously, I expected myself to work at their level. Supervision was important in untangling these thoughts, to which I later wrote:

> *… know that I am a student and I CANNOT TRY TO BE PERFECT*

Theme 2: Enhancing Connection in and around Therapeutic Interactions

Connection enhancing moments (CEMs) appeared widely throughout the data. These interactions occurred before, during, and after sessions and ultimately enriched the therapeutic relationship. CEMs included musical and non-musical interactions with participants, and tangential figures like caregivers, ARC staff, or whānau.

Musical Interactions

CEMs often related to positive moments where residents broke into smile or song and became more animated. Conversations facilitated by song-lyric discussion and reminiscence were particularly important for deepening connection. For example, lyrics from "Edelweiss" and "Home on the Range" invited residents to reminisce around their childhood homes. Residents were often quick to express their appreciation when I sang these songs, and comment on my "lovely voice*",* or told me to *"*come back soon." There was even one instance where a resident suggested that me visiting them was like "[having] one of the family members around…"

Keeping in mind the feelings of otherness and isolation that followed racial microaggressions, I found these comments very encouraging. Songs provided a way to discuss non-musical topics, like family or life-adventures, which aided in rapport building and learning about each other more deeply. Musical interactions provided opportunities to the residents and I to connect reciprocally regardless of how different our intersectional identities appeared. It was pleasing to discover the things we had in common with one another.

Ethnicity and Culture

Shared ethnicity and culture also facilitated CEMs and enriched relationships. For example, other Filipino care staff were quick to notice my presence despite not engaging closely with one another. A Filipino caregiver (with whom I had no prior interaction) greeted me in Tagalog, saying "Kamusta" (hello). I wrote about this interaction later, saying it "*made me feel at home…*"

Unprompted comments around my cultural appearance often left me feeling uncomfortable, however, the data suggest that music made talking about race less confronting. Considering my Kiwi identity for example:

> *I noticed I was using Kiwi imagery/music. I don't recall feeling weird about it in the moment…*
>
> *I noticed a "kiwi" moment that I would say was genuine. Having been talking about the ocean, I mentioned that "we're" quite lucky in New Zealand to never be too far away from the ocean.*

Music also facilitated the discussion of grief and loss. During an interaction with a resident who was grieving the gradual loss of their family, we found mutual comfort in talking about our families and using music to keep the memories of them alive. I reflected:

> *It didn't feel strange to talk about my Filipino background when I talked about my dad's family, and my Lola. In this moment, there was a sharing of grief and remembrance. It felt extremely genuine.*

Age and Gender

Discussion of age and gender were less present in the data but remained important when considering intersectional identities. I was typically the youngest person at an ARC facility. I noted that the residents expressed:

> *…Enjoyment that a 'young person' like me is learning these old songs…*

I was also one of the few men on site, as the caregiving staff largely consisted of women. Navigating my masculinity here was not challenging for me, although when working with a group of male residents, I reflected that:

> *My low bass voice helps miles and makes me feel 'in place.'*

The findings indicate that our intersectional identities influence how we create CEMs with music therapy participants. Our multiple identities open various avenues of connection and can create positive feelings of appreciation, security, and closeness. When identities differed, music allowed for more reciprocal and non-confrontational ways to learn about one another.

Theme 3: Dissonance in and around Therapeutic Interactions

There were moments where differences in intersectional identities created feelings of dissonance between me and the residents. Dissonance is a gut feeling that refers to discomfort and internal tension

in response to challenging interactions or conflict. Experiencing dissonance often made it harder to stay present within enriching and connecting interactions.

Therapists' Experience with Subjugation and Dissonance

Racial microaggressions are particularly relevant here. My cultural appearance invited curious comments, and I received unprompted statements like:

> *You've got an accent on you…*
>
> *You must have some Spanish ancestry in you…*

Such comments were received while ethnicity or culture were not explicitly being discussed. I felt irritated and defensive as a PoC. As a music therapy student, I was more concerned with trying to remain responsive to the residents. In these early stages I believed that this meant putting the residents' needs above my own. This caused me to suppress the pain I felt due to my cultural self being exposed. Despite my best efforts, my attention kept returning to the racial microaggressions.

> *I have a limited capacity of attention at the moment [...] Being so absorbed by the challenging things prevents me from noticing the residents who are engaging and having a good time.*

Other interactions were more ambiguous. For example, a group session ended on the theme of classic Kiwi foods. After closing the session, a resident approached me and started a conversation. They eventually commented:

> *… on Sundays, New Zealanders have Sunday roast…*

Some assumptions can be made as to whether the resident's referral to New Zealanders included me. Perhaps they assumed that because of my appearance, that I must not be Kiwi and thus, not aware of Sunday roasts. These ambiguous interactions occurred frequently. They were initially uncomfortable, but eventually became irritating to engage with. I reflected on this:

> *… I wonder how different this interaction would have gone if I had willingly shared that information about myself, rather than having it coaxed out of me…*

It became extremely laborious to respond and remain vigilant to these forms of microaggressions. I found that I was reserving energy in

anticipation, and this negatively impacted my ability to feel present and remain responsive to the residents.

Confronting Privileges and Participant Subjugation

This sub-theme draws attention to ways music therapists might unknowingly harm our participants. Such moments are characterised by low-experience levels and nervousness and relate to my privileged non-disabled and neurotypical identities. Earlier in my learning I would speak without thinking and unchecked biases would reveal themselves. For example, some ableist biases were revealed when I asked a music therapy participant, living with neurological impairments, to introduce themselves. Unbeknownst to me, this resident was non-speaking, and it wasn't until a caregiver introduced them on their behalf, I realised my misstep. I reflected on this, saying:

> *… I will definitely learn from this, but regardless, this mistake was due to my unconscious ableist beliefs. In the moment, I assumed that everyone was ABLE to verbally introduce themselves.*

Subjugation can be less direct. For example, I typically had access to residents' case files and medical history, and this created massive feelings of dissonance. To me, it felt as if:

> *… I was violating [their] privacy. The act of flicking through a profile really makes me feel too powerful…*

These subtle acts of subjugation were especially relevant in secure dementia units. On multiple occasions I had to sneak out behind the password protected doors after some residents/participants followed me to the exit after a session. Being able to return home at the end of the day also made me feel too powerful, and the March to April 2022 COVID-19/Omicron outbreak only exacerbated these feelings. This occurred approximately a month into full-time placement, and I was beginning to feel the early stages of burnout:

> *I was feeling incredibly drained last night, so much so that I almost didn't come to placement today. The looming cloud that is covid, is starting to get to me.*
>
> *I'm going to take placement off as I'm really unsure how I'll cope. I can hear myself trying to tell myself/ convince myself to go to placement as I'm 'not really that sick… right now…'. I believe that this is due to some form of guilt or that I'm trying to justify my level of sickness; to quantify my well-being.*

I felt relieved being able to stay home during the outbreak while ARC facilities were in lockdown as it provided me a moment to catch my breath, however, these feelings were often overshadowed by how privileged I felt:

> *I'm still feeling so anxious and drained. I really can't comprehend what the residents must be experiencing. Things move too fast. [The residents] don't have a choice. I have so much choice.*

At this stage, I did not have the tools or insight to navigate the power I felt in relation to the residents. The experience of having to simultaneously confront such privileges and navigate racial microaggressions brought me to a standstill. I became avoidant and apprehensive of placement, and after returning to ARC once lockdowns were lifted, I ruminated heavily. I questioned whether:

> *… I was suited for this work…*

Theme 4: Restorative Practices

This final theme illustrates the restorative practices I discovered in response to CEMs and dissonances. Restorative practices included reflection, implementing boundaries, and supervision. These made dissonant experiences more manageable, and reinforced CEMs.

Supervision

Supervision was key in navigating dissonance in and around therapeutic interactions. With guidance from my supervisor, I was able to think out loud in a safer space which allowed me to reach my own conclusions. This was important in developing my reflexivity and learning to solve problems my way. Having supervision at a regular frequency also gave me a checkpoint to aim for which was particularly helpful when I was struggling. It was comforting to know that support was just around the corner.

One challenge supervision supported me in navigating concerned resident-preferred music, and the generational gap between the residents and myself. The music was not difficult to play, however, I found it difficult to relate to. My supervisor observed that I appeared distant while singing, and affirming this, I expressed it felt like I was filling space rather than contributing meaningfully to the residents' well-being. My supervisor encouraged me to:

> *… find something that I personally enjoy in the music [and to] be involved in it…*

I slowly became more attuned to the melodies, rhythms, lyrics, or harmonic structures of these songs which allowed me to breathe life into the music and stay more present. Supervision helped me move from simply making noise to using music as a health tool while running sessions.

Reflection

I kept a small reflection notebook on hand throughout the duration of my placement. I used this to externalise anxious thoughts or to capture dissonant interactions, and I discovered that this practice helped me avoid rumination. For example, I checked in with myself throughout the day:

> *9.30am: I'm feeling particularly anxious this morning. I can't 'hear' the anxiety so much as I can feel it buzzing around in me…*
>
> *10.30am: Anxiety isn't as palpable, but I could still feel its effects in the session with [resident]. It was hard to focus…*

This practice did not prevent anxiety. Instead, externalising these thoughts helped me hold these feelings and validate my emotions. I also used reflection to explore how I conceptualised music therapy. My supervisor offered novel ways of thinking about my role as a student music therapist, suggesting that being a music therapist is:

> *… a career rather than a job. Something you do your entire professional life/ passion…*

This prompted me to reflect on how I'd previous thought about the profession. Seeing music therapy this way implied a long-lasting and continual process of development rather than a job we simply show up for. This re-framing helped me relax the unrealistic "I should be able to" standards I had for myself.

Boundaries

Earlier in my learning, I avoided using the word 'client' after learning about the connotations such language can have in creating power divisions within the therapeutic relationship (McFerran, 2021). Unexpectedly, this opened me up for dissonant experiences. For example, I experienced a very distressing countertransference following a one-to-one session due to a lack of therapeutic distance between the participant and myself. My mental health plummeted, and I found myself dissociating frequently in my personal life. The duration of this challenging episode encouraged me to reflect deeply around my boundaries. I realised that a level of distance in the therapeutic relationship is needed, and that ultimatums are not

helpful. I began to understand the contextual nature of boundaries, and the nuance within them. I reflected:

> *… "client" helps provide some needed distance as I continue to learn how to manage boundaries effectively. Is McFerran's (2021) argument too black and white?*

As placement continued, I naturally gravitated to the words "residents" or "participants," feeling they provided a comfortable level of distance, without forgoing warmth within the therapeutic relationship. Reflections around distance also prompted me to consider how I might detach from music therapy at the end of the day. I learned that it is possible to unintentionally take aspects of our work home with us. My practice supervisor encouraged me to think broadly, and suggested I think:

> *… about my* [name] *badge as a 'uniform'/ I'm on duty/ working/ therapist hat on*

Discussion

Towards Accountability

Power and oppression manifest in different ways in and around music therapy. It can appear in the language we use to describe and conceptualise the people we work with, which can be a product of unchecked biases. For example, language plays a role in how we think about the world around us and create meaning and beliefs (Drewery & Monk, 1994). Thompson (2022) suggests that music therapists are responsible for shaping the narratives of our participants' experiences of music therapy and this inherently affords us a great deal of power. Thompson (2022) notes further that pathological/ deficit-based language (i.e. suffering from, burdens, issues) are still present in the literature, and adherence to such language acts as a "mechanism through which clinicians assert their perceived expertise" (Low et al., 2022, p. 482).

Music therapists are not immune to personal bias (Hahna, 2017), nor are we "automatically given the title of 'ally' [or] display ally behaviours and actions unless we have taken considerable time working on self-awareness, education/ training…" (p. 259) around our positions in systems of power and oppression (Oswanski & Donnenwerth, 2018). In this sense, accountability in music therapy spaces is the act of critical reflexivity. Being reflexive about how our various identities position us throughout different environments provides pathways for music therapists to develop self-awareness surrounding their privileges or unchecked biases. This asks us to own up to parts of ourselves we'd much prefer to

keep hidden. The intention behind this is not to diminish ourselves or engage in negative self-talk, but rather critical reflexivity allows us to think about the difficult aspects of our work in generative ways "… so that an inclusive and respectful agenda for music therapy [can] evolve (Pickard et al., 2020, p.11).

Our Minority-Selves and Self-Compassion

Music therapists can experience subjugation through microaggressions directed at their minority identities. Reflecting on how we may be triggered by these experiences is confronting. However, engaging reflexively may lead to rich insights and ultimately deepen the therapeutic relationship (Goedert, 2020). In addressing our triggers, ideas around self-compassion are important.

Musical holding and attunement are associated with how we as music therapists relate to our participants. Bunt and Hoskyns (2002) suggest the image of a parental figure holding a young child in ways that are "non-invasive and finely balanced" (p. 40). When directed at ourselves, holding can provide a steady foundation upon which we can build compassion for ourselves. 'Self-attunement' is described as the action of tuning in with our internal thoughts and emotions (Koloroutis, 2014), and shares similarities with mindfulness practices which advocate for non-judgmental, patient, and kind attitudes towards ourselves (Robertson, 2012,). Being able to tune into ourselves is perhaps the first step towards self-compassion, however, some elements of mindfulness may not fully translate to minoritized experiences.

Considering microaggressions, there is a fine line between being non-judgmental and downplaying their impact. With the growing acknowledgement of accountability, it is important to remind ourselves not to overcompensate for our privileges at the expense of own well-being. A non-judgmental attitude towards microaggressions asks that we separate our triggers from our personal history, which invalidates our subjective experiences of harm. Germer and Neff (2013) capture this beautifully, urging us that we "can't ignore or deny your pain and feel compassion for it at the same time" (p. 2).

Self-compassion differs from therapist self-care, which usually refers to specific actions or practices that manage occupation stressors. Unfortunately, actions of self-care can be perceived as conditional, that it is earned and can only be practiced guilt free when we have worked hard (Hersh, 2022a). As described by Germer and Neff (2013) self-compassion is "simply compassion directed inward" (p. 856) and includes taking "the stance of a compassionate 'other'" (p. 857). This gives us the

impetus to hold ourselves with the same level of empathy as we would our participants. Self-compassion is not conditional. It allows us to handle ourselves, and all our intersectional identities "with as much care and tenderness as possible" (Hersh, 2022, p. 32).

Towards an Intersectional-Informed Practice

Intersectionality can inform how we can navigate contradictions that arise in and around therapeutic interactions. This includes the experience of holding our privileged and minoritised identities simultaneously, as well as engaging with connecting and dissonant moments. For example, I had discussed my attempts to rationalise the racial microaggressions I received from residents as their way of making connections and overcoming barriers to socialisation in ARC contexts (Bogati & Pirret, 2021; Boyd et al., 2021). In this context, I was asked to acknowledge the residents' experiences with isolation and loneliness while simultaneously attempting to navigate my own oppression. For a long time, I was unable to articulate these contradicting experiences, however, intersectionality provided useful ways to frame these experiences, as it "exposes the complexity of social life, including simultaneity of oppression and privilege for *all* social actors" (Grzanka, 2020, p. 249). Thus, intersectionality allows us to live within complexities and acknowledge that they can co-exist. It is possible to take accountability for our privilege and practice self-compassion at the same time. Transformative justice and disabilities advocate, Mia Mingus (2019) captures this eloquently:

> What if accountability wasn't rooted in punishment, revenge or superficiality, but rooted in our values, growth, transformation, healing, freedom, and liberation? What if the work of accountability was held as so supremely sacred, that people who got to practice it – truly practice it – were considered lucky. (Mingus, 2019, paragraph 8)

Herein lies the usefulness of self-compassion, such that it permits us to practice accountability without guilt. It suggests that being accountable can be something beautiful, rather than punishing.

Limitations

Autoethnographies draw from the researchers subjective experiences, and for some, this raises concerns surrounding generalisability and how the findings can be applied to other contexts (Méndez, 2013). Ellis et al. (2010) identify concerns around informed consent and how others can be unknowingly implied in the research. To ensure confidentiality of those

implicated, the researcher needs to remove any identifying information pertaining to the individual or interaction, however, this can compromise the essence of the cultural phenomena in question. Concerns of self-disclosure are also worth discussing. I shared experiences of racism and generational traumas; I acknowledge that this may be triggering for some and cannot predict how reading these experiences might impact the reader. It is important to balance oversharing while not censoring lived minority experiences.

Conclusion

This research presents the importance of critically and reflexively engaging with our intersectional identities. The findings illustrate that our identities appear in every action we take during music therapy and in every interaction with our participants. Awareness of the way in which they position us within systems of power and oppression is essential. Music therapy is not a neutral space, void of systemic pressures and oppression. Acting as such erases and invalidates our participants' lived experiences with subjugation. The same can be said for our minority identities as music therapists, where denying our pain or overcompensating for our privileges does more harm than good. As music therapists, it is necessary that we practise critical reflexivity to reveal how we occupy systems of oppression. It is important that this act is not punitive, and that we show compassion to ourselves.

This research is my declaration "I am here" and was done "in the spirit of centering the margins" (Davies, 2022, p. 17). By bringing attention to underrepresented voices, a space is created where minority realities can be validated. Witnessing others with shared or similar life experiences can be empowering and show us that we're not alone in our struggles. This "can nourish you on occasions when you need something other than food to keep you going" (Bochner & Ellis, 2013, p. 3).

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Book Review

Art Therapies in International Practice: Informed by Neuroscience and Research (2022)

Edited by Caroline Miller and Mariana Torkington (Routledge)

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Citation

Kuswanto, R. (2024). [Review of the book Art therapies in international practice: Informed by neuroscience and research, edited by C. Miller & M. Torkington.] *New Zealand Journal of Music Therapy, 22*, 46-49.

Music therapy and art therapy are both specialised and developing professions which share the commonalities of the innate human need to express and create relationships with each other. In my clinical experience as a registered music therapist, I note there are some studies exploring the integration of other art therapies modalities such as dance/movement therapy, fine art, and drama therapy with music therapy, but the application of such integration is less well documented. Gilroy and Lee (1995) introduced the idea of integrating art therapy and music therapy and highlighted the need for more research and deeper rationale to chart the development of art therapies over the years. Additional neuroscience-informed practice and research would indeed create potentials for more collaborative work between art therapy modalities to increase therapeutic efficacy.

The terminologies of art, art therapy, and art therapies can be intertwined when different forms of art tools are incorporated. When defining art therapies, the volume *Art Therapies in International Practice: Informed by Neuroscience and Research* prefers to categorise expressive art modalities used in therapeutic settings under the term “art therapies.” By this they mean that drama therapy, art therapy, dance therapy, and music therapy share the same concepts of using creativity to enhance the therapeutic relationship.

The main editors of this volume are Caroline Miller, a drama therapist and clinical psychologist, and Mariana Torkington, a registered art therapist. Both Miller and Torkington are based in Aotearoa New Zealand and actively contribute to academic journals and publications, supporting the development of art therapies across the country. Miller's previous publication *Arts Therapists in Multidisciplinary Settings* (2015) was also a collection from art therapies' authors, with a focus on art therapy professionals working in multidisciplinary teams, delivered through a series of case examples. Compared to the previous volume, this most recent volume is highly discipline-focused, comprising eleven chapters written by art therapies professionals from New Zealand, Australia, Malaysia, USA, Singapore, South Africa, and the UK. Included are clinical case reviews and honest personal reflection on the implementation of drama therapy, art therapy, music therapy, and dance therapy in addressing a range of therapeutic goals.

The compilation was initiated during the COVID-19 period in 2020-2021 and became a source of support among art therapy professionals, encouraging and affirming each other's works during the crisis while maintaining the continuation of evidence-based practice. The main theme of the book is to explore the significance of neuroscience-informed rationale in the therapeutic process of developing trust and safety within the parameters of each therapy. A neuroscience approach could be seen, for instance, in chapter 10 where Palmer's discussion was underpinned by the concept of the mirror neurons system and mechanism to increase the therapeutic relationship and empathy in the practice of community dance therapy. In chapter 3, Dunne and Madrigal adopted the neurobiological approach of understanding internal biochemical processes and observable physiological changes during the process of Narradrama as Three Act Play (NTAP).

The foreword was presented by Noah Hass-Cohen, whose early publications focused on creating a theoretical framework for art psychotherapy and the neuroscience approach in art therapy clinical practice. One of Hass-Cohen's publications was cited by other contributors in this volume (chapter 5) marking the importance of her contribution in the field. The foreword gave a structure and preview of how neuroscience research is significantly connected and utilised in every form of creative art therapies as they target and activate different parts of the brain at the same time. Hass-Cohen's presentation of the intersection between neuroscience and psychodynamic theory was helpful as this is a common theme throughout the volume, also outlining the book's approach with quantitative data predominantly presented as evidence.

In further support of Hass-Cohen's foreword, Miller highlights that creative processes used by art therapies induce brain development, stimulate the senses, and trigger changes in the nervous system (chapter 1). She states that the intention in exploring neuroscience research in art therapies was to "provide rationale, offering the possibility of targeting parts of the brain, helping with measuring changes of behaviours" within the scope of practice (p 18). In a music therapy context, a Neurologic Music Therapy® theoretical framework is one of the most effective approaches to provide rationale for the effect of music on the brain. Some authors in this volume elaborated on the neuroscience framework in their therapeutic process, including registered music therapist Alison Talmage discussing the work with communication for adults with neurogenic difficulties (chapter 8). Sian Palmer took another neurologic perspective utilising the concept of mirror neurons in dance therapy (chapter 10). Kim Hau Pang used a client-centred approach that was underpinned by neuroscience and neurobiology models in a hospice setting (chapter 6).

By presenting different modalities and perspectives on art therapies, this volume provides rich insights into what type of neurologic-based knowledge each contributor was targeting. This is highly beneficial for practitioners, offering many possibilities for them to integrate art modalities to target different domains of the brain, whether it is memory recall, behaviour changes and observations, or functional purposes such as communication.

When reading through the chapters, readers may find that trauma-based caseloads dominate the volume with approaches gravitating towards a psychoanalytic framework. Initially, I was hoping to explore extensive neuroscience theories in relation to which part of the brain was affected during certain experiences in Narradrama, dance therapy, music therapy, and art therapy. As I read through each chapter, I could see how neuroscience and neurobiology aspects are linked to trauma exposure, especially how they could be used in art therapies to establish a safe space and trusting therapeutic relationship (Oberle et al., 2021). In Aotearoa New Zealand, trauma-informed practice and care has been implemented to support not only the wellbeing of affected individuals, but also the whānau (family) and the community, which requires a certain degree of trust and security to extend the therapeutic relationship (Te Pou, 2021).

The format of the volume highlighted the importance of utilising research and neuroscience models in art therapies practices. I appreciated the use of sample images that were incorporated to support the case studies and evidence. The book presented diverse perspectives, with contributors

from different continents and backgrounds. It also showcased holistic or multi-theoretical approaches to clinical practice in art therapy, despite the strong emphasis on neuroscience implied by the title.

Overall, I would recommend this book for all art therapy professionals and other allied health professionals or educators who are seeking non-invasive therapeutic approaches in mental health, neurologic conditions and acquired neuro-rehabilitation settings. This volume invites collaboration between art therapy professionals in neuroscience-informed multi-disciplinary projects, with its diverse multi-theoretical approach. As mentioned in Miller's final reflection, further collaborative research between neuro-focused professionals is necessary. It is essential to support the expansion of clinical and evidence-based practice in arts therapies.

Publisher Link:

https://tinyurl.com/4ey5wt4f

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Book Review

Disseminating your Action Research: A Practical Guide to Sharing the Results of Practitioner Research (2024)

Craig A. Mertler (Routledge)

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Citation

Talmage, A. (2024). [Review of the book Disseminating your action research: A practical guide to sharing the results of practitioner research, by C. A. Mertler.] *New Zealand Journal of Music Therapy, 22*, 50-52.

Disseminating your Research Practice (Mertler, 2024) has been a useful resource while planning dissemination strategies for my current music therapy doctoral action research. Although the intended audience is educational action researchers, the book's tips for presenting and writing in diverse formats suggest broader relevance, including music therapy advocacy through reports of professional practice and practice-based research. The Introduction frames dissemination within action researchers' aspirations to "change the world" (p. 3) – a value that chimes with the transformational hopes of music therapy practice and research. For most music therapists, writing projects are unpaid and secondary to the priority tasks of securing work and developing a practice. This book provides practical information that may support music therapists hoping to carve out a little time to share their work through presentations, written publications, and online media.

Following the Introduction, the book contains ten chapters grouped in four sections. Each chapter concludes with a helpful summary which I tended to read first to orient myself to each new topic. Section I provides an overview of action research (Chapter 1) and practical guidelines for action researchers (Chapter 2). These chapters provide a useful starting point

for anyone considering action research, which has been recognised as an accessible methodology for music therapy (Stige & McFerran, 2016).

The remaining sections and chapters focus on the practicalities of dissemination to diverse audiences. Section II suggests “products” (formats) to reach a wider readership. Chapter 3’s discussion of written reports includes academic writing conventions, a generic structure for articles or other reports, and practical suggestions for the writing process. Oral and poster presentations are addressed in Chapter 4, with further guidelines about posters and infographics in Chapter 5. I valued the author’s advice about considering the audience, constructing titles and descriptions (abstracts), and presenting solutions to problems. Section III focuses on strategies for submissions to peer reviewed journals (Chapter 6), in-person and online presentations (Chapter 7), social media (Chapter 8), and other digital media (Chapter 9). I would have preferred greater integration of these sections, rather than the separation of formats (Section II) and strategies (Section III), but the clear chapter headings were easy to navigate.

Section IV (Chapter 10) builds on the Introduction, offering further encouragement to present and publish. The author is realistic about time constraints, encouraging administrators and employers to value and support this important work. He also frames practice-based research – and I would extend this to practice-based reports – as “*customizable professional growth and learning*” (p. 166). In music therapy, practitioners and participants experience challenges and engage in practical problem-solving. Whether we approach these through reflective and reflexive practice or through small-scale research projects, our processes and novel conclusions are often valuable beyond the immediate context – worth sharing with others and adding to the ever-growing evidential foundations of music therapy practice.

A disappointing aspect of this book is the quality of the images – all greyscale, sometimes blurred, and some with small text. One example of a poster presentation seems dated, resembling a school science-fair display (p. 63), while further examples are predominantly text-based with few visuals (pp. 64 & 74). The style seems a little bland for readers used to visual communication, apps such as Canva, and emerging AI tools. I hope that a future edition would provide more visually stimulating examples – perhaps through online supplementary resources, a common contemporary publishing convention.

For music therapists, advocacy is a constant necessity as we work towards greater professional recognition and increased public access to

services. Proposed funding changes for disability services in Australia show that evidence is sometimes ignored or misunderstood (Australian Music Therapy Association, 2024). In Aotearoa too, we have received confusing and contradictory messages about changes in individualised funding, and government agencies have shown an inadequate understanding of music therapy practice as an allied health service, rather than a recreational and respite activity (Ministry of Social Development, 2024). Collective advocacy requires all concerned individuals to speak up and to write about the value of music therapy. This book provides a helpful introduction to different forms of dissemination. I recommend it to all music therapists, particularly novice presenters and authors, as well as to tertiary educators supporting emerging practitioners and writers.

Publisher Link:

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Theses and Publications Alert 2024

Emily Langlois Hunt
Co-Editor, New Zealand Journal of Music Therapy

This annual listing highlights music therapy theses and scholarly writing by New Zealand Registered Music Therapists beyond this journal. Many congratulations to these authors.

PhD Thesis (2024)

Molyneux, C. (2024). *Together in sound: A narrative study of music therapy groupwork with people living with dementia and their companions*. [Doctoral thesis, Angela Ruskin University]. Anglia Ruskin Research Online (ARRO). https://hdl.handle.net/10779/aru.25672248.v1

Solly, R. (2024). *He hauora! He hauora!: The use of taonga pūoro in hauora Māori*. [Doctoral thesis, Massey University]. Massey Research Online. https://mro.massey.ac.nz/handle/10179/69743

Master of Music Therapy Theses (2024)

Bellringer, D. (2024). *How were professional boundaries developed and navigated in my practice as a student music therapist?* [Master's thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/wgtn.25359382

Choong, S. S. Y. (2024). *How can I incorporate electronic music making using music technology in music therapy practice with adolescents experiencing mental health challenges?* [Master's thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/wgtn.25376014

Hegarty, S. (2024). *A tapestry of climate and community: An arts-informed community autoethnography of a student music therapist working with a community impacted by Cyclone Gabrielle in Aotearoa.* [Master's thesis, Te Herenga Waka - Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/wgtn.27115738

Hewitt, A. (2024). *Raranga: Supporting rangatahi hauora through the integration of kapa haka in music therapy practice.* [Master's thesis, Te Herenga Waka -

Victoria University of Wellington]. Open Access Te Herenga Waka - Victoria University of Wellington. https://doi.org/10.26686/wgtn.25365904

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Publications (2024)

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