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# The New Zealand Journal of Music Therapy

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# Contents

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# Editorial

Tēnā koutou, tēnā koutou, tēnā koutou katoa. Greetings to our readers in Aotearoa New Zealand and across the world.

It is my pleasure to bring you the 2017 issue of the *New Zealand Journal of Music Therapy* (*NZJMT*), another rich mix of contributions reflecting the eclecticism of music therapy within our land and beyond our shores. This shared value of diversity was apparent in responses to both the 2016 survey (Molyneux, Talmage, & McGann, 2016) and the 2017 journal survey (Talmage, 2017). When reading and reviewing Wheeler and Murphy's (2016) outstanding *Music Therapy Research* (3rd ed.)[1] for this journal, I was struck again by the challenge – but also opportunity – to select forms of inquiry and dissemination congruent with the social, cultural and professional contexts of our work. The contents of this issue reflect this well: four contrasting articles, six book reviews, and a publications alert.

Invited essays provide an opportunity to highlight significant topics and authors, and undergo the same rigorous peer-review process as all articles. In this issue, Sarah Hoskyns reflects on the value of improvisation in case study research, and encourages music therapists to sustain philosophical congruence and musical processes when engaging in research.

Megan Berentson-Glass tells a wonderful story of collaboration in participatory and concert experiences for young people with special needs – an outstanding example of innovative professional practice. This narrative account, enriched through media links (a video, a radio interview, and a parent's blog posts), is particularly recommended reading for those music therapists who believe they cannot publish because they are "not doing research". Practice-based articles are important too.

[1] Reviewed books are excluded from the Editoral's reference list, but available in the contents page and within the reviews.

Two articles represent student research projects. Brieonie Jenkins (a psychology student at the University of Auckland) and co-authors report on participant experiences in neurological choirs, with a theoretical framework that draws on concepts of singing for wellbeing, self-determination theory, flow and social capital. Kumi Sato (an American-trained, Japanese music therapist, completing postgraduate research in disability studies) and Shigeki Sonoyama report on a small-scale behavioural study. Although not a common contemporary approach in New Zealand, music therapists may encounter behavioural approaches within interprofessional teams, and this project illustrates single-subject designs within an everyday setting, an accessible model of practitioner research.

Of the six book reviews in this issue, three are highly recommended, recently revised editions of well-known music therapy publications. Claire Molyneux reviews an important book for all concerned about decolonisation and cultural competence in Aotearoa New Zealand. We also include two musicology texts, exploring the diverse cultural and social contexts of music. A new initiative is our publications alert, highlighting and published writing by NZ music therapists (beyond this journal). Readers are encouraged to contact authors directly if they cannot access texts.

I am also delighted to highlight here the inaugural (2017) Music Therapy New Zealand Morva Croxson Prize for emergent writers, with the winning writing to be published in next year's journal. Sarah Hoskyns, my predecessor as NZJMT editor (2014-2015), sowed the seeds of this project, and the competition name warmly acknowledges Morva Croxson, a pioneer music therapist in New Zealand. I am grateful to Sarah Hoskyns and Daphne Rickson for their feedback about the proposed competition format and judging criteria. We appreciate the expertise of an esteemed panel of judges: Denise Grocke, Emeritus Professor of Music Therapy, University of Melbourne, Australia; Claire Molyneux, NZ RMTh, Music Therapy Lecturer, Anglia Ruskin University, Cambridge, England; and Dr Vini Olsen-Reeder, Pukenga/Lecturer, Te Kawa a Māui/School of Māori Studies, Victoria University of Wellingon, New Zealand.

Finally, I would like to thank Music Therapy New Zealand for the opportunity to continue in my role as journal editor. Thanks too to the 2016 authors for their feedback, through a brief survey, and to Peta Wellstead for advice earlier this year. Without our authors' expertise, motivation and commitment, there would be no journal. Without our dedicated team of local and international reviewers, there would be no journal. Without committed practitioners, readers and advocates for music therapy, there would be no journal. Together, we can fill and share our knowledge baskets.

*Nā tō rourou, nā taku rourou, ka ora ai te iwi.*
With your food basket and my food basket, the people will thrive.

## References

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Alison Talmage
Editor

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# The Place of Improvisation in Case Study Research in Music Therapy

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**Keywords:** Music therapy training, improvisation, research method.

## Abstract

This article explores an aspect of the findings from a completed doctoral study using qualitative case study methodology. The field of inquiry was teaching and learning in music therapy, and the participants in the study were international practitioners, researchers and students in the discipline. Music therapists in many international contexts in the 21st century are trained to be responsive improvisers, meeting the needs of a wide range of participants with flexible music-making. Using the musical and reflexive skills of music therapists in research has been gaining increased traction in the music therapy literature, both in qualitative and mixed methods research (Wheeler & Murphy, 2016). The experience of using musical improvisation as a stimulus for reflection with research participants was an enlightening process in this study and is illustrated in the article. Moreover, the creativity of research exploration, using reflexive methods to build ideas about practice, to "improvise theories" and to make meaning in what musical or arts practitioners do was seen to have particular value by the researcher and participants in this study. Although such qualitative findings cannot be generalised, it is anticipated that readers may recognise these themes as relevant to their own work.

## Introduction

I have been intrigued and entranced by improvisation as a therapeutic process and way of being in music therapy since I began my practice in the 1980s. Making use of the concept and practice in my research in recent years has felt like a personal homecoming and it is something I hope to integrate and develop in future studies and practice. Music therapists have written about improvisational approaches and models for practitioners in the discipline over many years (Beer, 2011; Bruscia, 1987; Carroll & Lefebvre, 2013; Gardstrom, 2007; Gilbertson, 2013; Lee, Berends, & Pun, 2015; Nordoff & Robbins, 2007; Pavlicevic, 2000; Priestley, 1975; Wigram, 2004) and while it is not necessarily a required technique musically in all music therapy approaches, it is certainly a key skill discussed internationally. It exists for example as part of identified competencies in the American Music Therapy Association Professional Competencies (2015) (at professional entry and advanced levels) and in the Music Therapy New Zealand Standards of Practice (Music Therapy New Zealand and New Zealand Music Therapy Registration Board, 2012).

In my doctoral research, I interviewed music therapy educators, researchers and students individually and in groups about what approaches they had experienced that could integrate research and practice (Hoskyns, 2013). The research used case study methodology and employed a variety of data sources, including preliminary focus groups, semi-structured interviews at two training programmes (one in Europe, one in Australasia), field notes from classes and events visited, recordings and notes taken from two improvisation and discussion sessions at the end of each site visit, and a reflexive research journal which spanned the research process. The thematic analysis is presented in full in the doctoral thesis (Hoskyns, 2013) and illustrated in chapter 52 of *Music Therapy Research* (3rd ed.) (Hoskyns, 2016). This current article focusses on a small but significant part of the data and findings: that is, the documentation and reflection on the two improvisation sessions from each of the site visits. There are two main aims for the writing: firstly, to demonstrate the use of improvisations and

subsequent reflection as a data-gathering technique with some participants from the study; and secondly, to illustrate how other, more subtle aspects of an improvising approach could be part of the research process. Meadows and Wimpenny (2017) have recently synthesised a range of qualitative research studies exploring clinical improvisation with varied methodologies and research questions, and noted the emerging use of improvisation as part of the research methodology. Beer (2015) in particular has advocated strongly for the potential use of improvisation as an exploratory research technique (also demonstrating its application during a number of stages of the research inquiry and analysis) in a recent special issue on arts-based research approaches in *Music Therapy Perspectives*. She was singing my song, and I was delighted to find such advocacy.

Researchers have for some years now been aiming to identify and utilise theoretical and research approaches which honour the art of music and which can be considered indigenous to the music therapy discipline (Aigen, 1991, 2005; Austin & Forinash, 2005; Kenny, 2005, 2015; Ledger & Edwards, 2011; Lee, 2003; Ruud, 1998). More recently Schenstead (2012), Gilbertson (2013) and Viega (2013), for example, have engaged very particularly in the practice of improvisation and composition in Master's and doctoral studies in music therapy, and pushed the boundaries of how a traditional literary thesis might be presented. Schenstead developed heuristic "self-research" using regular flute improvisations and reflexive journaling as her data. Gilbertson reviewed a long period of reflexive journaling on clinical improvisations with a young person following severe brain injury. Viega used reflexive arts-based methods including recordings and song creations to explore hip-hop therapeutic song-writing process with young people. Viega and Forinash (2016) have since updated the rapidly expanding field of arts-based research (ABR) and emphasised steps to increase rigour and acceptance of the approaches considered, and to encourage music therapists in an ongoing way to grow the field.

All research methods undoubtedly need to be "fit for purpose" and to serve the needs of the research question, so there are obviously only

some contexts in which it would be appropriate to improvise music with a participant and then to reflect upon its meaning. This study used participants who were trained musicians and music therapists, and thus there could be a ready willingness to use improvisation as part of the research process. It links to the peer-supervision usage of improvisation as reflection, as evidenced in Young and Aigen's (2010) supervision-focussed study, discussed later in the article. However, there could also be potential for music therapy clients who were willing to also engage with this research method, and this will be discussed in the final stages of the article. It does seem from experience in this research, that involving people in music-making in an open way can provoke the imagination, make connections, and allow the "unforeseen" or unexpected to come to the fore. This can be especially valuable where one might be seeking depth of meaning and reflection about a topic. And particularly in complex even murky areas of thought where we may be unsure how to respond clearly or in direct language. Mary Priestley (1975) wrote about the inspiration of her learning from composer/improviser Professor Alfred Nieman, with whom I was also privileged to study improvisation in London in 1980. Nieman observed to Priestley's improvisation class one day, (cited below in the newer second edition of her pioneer text):

> Music faces us with the realisation that there are two worlds: the inner and the outer. The inner is often incommunicable, a spiritual world which is difficult to enter from the outer world where we normally speak to one another. Music is a bridge for us by which we can reach this inner world. That is why this free expression is so vital for music therapy. You are privileged people to be able to communicate with this deepest part of human beings. (Priestley, 2012, p. 17)

I read Priestley's book in 1979 as a final year undergraduate, excited to begin postgraduate training in the next year, and I remembered similar moments with Nieman in my early music therapy journey, as he sought to offer experiences to innocent tutees about what rich connection

music could provide, in his wise and passionate way. It is this suggestion of a bridge or connection to our inner thoughts that does – I think – create the potential for free improvising to evoke meaningful data for participants and researchers in qualitative research strategies. I shall endeavour to offer some meaningful examples to indicate how this process unfolded in my study.

## Definitions of Improvisation and how it was used in this Study

The Oxford online dictionary defines the act of improvisation as being "a piece of music, drama, etc. created spontaneously or without preparation" (Oxford Dictionary, 2017). Many musical cultures use aspects of improvisation in the performance and composition of music, though ways of describing it have varied in the history of music scholarship (Nettl, 2013). Darnley-Smith and Patey (2002) focus on a translation from the Latin *improvisus*, meaning "the unforeseen", and suggest particular connections in this definition with the free association technique of analytic therapy (p. 62). Clinical improvisation, which is a specialist use of music improvisation in music therapy, is described by Wigram as "the use of musical improvisation in an environment of trust and support established to meet the needs of clients" (Wigram, 2004, p. 37). Pavlicevic (2000) observes the complex subtle interweaving of two roles - communicative personal interaction and spontaneous musical engagement - in this process, which she describes as "MT improvisation" (p. 270) and uses the theoretical term "dynamic form" (p. 276) which she notes is neither purely musical, nor purely psychological: it is a fusing of both.

Meadows and Wimpenny (2017) reviewed and synthesised the use of clinical improvisation in research studies published between 1990 and 2015 and found three core themes defining and grouping the characteristic approaches that music therapist-researchers have taken, including: professional artistry, performing self and meaning-making. It would seem that the current research study's use of improvisation as a

research approach would fall within the third theme identified by Meadows and Wimpenny, i.e. the broad area of making meaning.

Improvisation in the context of this study has quite a specific use which draws from the ways it has been used in music therapy practice (as a clinical device) and also its use in peer supervision of music therapists. There were three levels or roles of using improvisation in this meaning making process in this study, which expand on the specific data gathering strategy, identified in point three below. However, points one and two are also integral parts of my observed use of improvisation in the research, so I begin more generally.

1. A personal (usually client-centred) style as a therapist-researcher, where the aim is to tune in, listen and understand in-the-moment what another person is communicating. We cannot plan or anticipate what another person will show, bring, play or speak. The intent is to be responsive and alert, ready to move with their instincts. This kind of approach has a particular value in qualitative research in any interviewing or facilitating where you want to honour the voice of the other person or people.

2. A characteristic of musical engagement with people where voices and or instruments may be used, and where both parties (or more if it is a group) are encouraged to play in-the-moment with each other and for themselves. There may be a theme to inspire the playing or some limitations given (e.g. a mode is created on a xylophone by removing notes; or a rhythmic pattern initiated by one party) but the focus is on "seeing what happens". When working with music therapy students or professionals (as in this study), this was more equal on all sides, with no-one leading or facilitating. If using this kind of approach with music therapy participants or clients, the improvisation may more in the definition of clinical improvisation noted above.

3. An exploratory technique whereby the participant reflects on something while they "muse in music". The music in this process may be framed in various ways as suggested above, but in the current research project the invited participant was asked to consider a question from the research topic, offered a choice of instruments/voice to play, played music with the music therapist-researcher, and then reflected in an open-ended but guided way about the music created, and how patterns or meanings created might elucidate the question. In this process, the improvisation acted as an enhanced interviewing process as the participant was then invited to discuss and reflect on the music in relation to the research question.[1]

Each of these three aspects of improvisational style (personal interaction, making music and reflecting with the participant on our co-created improvisation) were present in developing the data for the project. It felt meaningful and profound to use skills as an experienced arts practitioner in my study, and my only regret has been not being quite courageous enough in the research design to have used it with all my participants. In this study, two participants volunteered to take part in the improvisation sessions, out of four or five people in each site visit. At each site, other participants were not available to attend at the end of day because of other commitments and they had a free choice to attend or not. So the data remained a small aspect of each site visit, but I was able to reflect on in a useful way for my own research understanding in my reflexive research journal. Nevertheless, I do not mean to be prescriptive in expectation or approach in this article, but just to show how I have found a good fit in my work as a researcher and practitioner in discovering a place for improvisation in my research activities.

[1] Other sorts of data creation and analysis, of course, might be possible. For example, using recordings and notation of the improvisations, such as Lee undertook in his doctoral research (Lee, 1996, 2006).

## Brief Summary of the Research Context

My doctoral research used an instrumental qualitative case study methodology (Stake, 2005) to consider the question of how research and practice could be integrated in music therapy training, including the strengths and challenges that might be involved. The focus was on the varied perceptions of music therapy teachers, students, supervisors and researchers, about this "problem", and a thematic analysis was developed from a range of data sources in three main stages. The qualitative research involved a high level of researcher input, and there were many possibilities of favourable and positive interpretations of the materials. Member checking of manuscripts, and peer debriefing helped to balance the researcher viewpoint in this study, alongside reflexive critique of the process, developed with my research supervisors who were also encouraging and questioning.

# Research Design

## Recruitment

Nineteen participants were recruited for this study. (This included four students, three researchers, three supervisors, and nine lecturers, who were involved in seven different international training programmes). The recruitment for focus groups was conducted by advertisement and letters of invitation at a World Congress, and then by purposeful sample at a European training programme (where staff members were alerted by the programme director and chose to attend or not). Two music therapy programmes in Europe and Australasia were identified as possible sites for a visit, and then approached to be involved. One programme declined, and I had a list of further options to approach. Site visit recruitment of interviewees was handled by programme directors, who forwarded an email to students, supervisors, lecturer researchers, and the first two to volunteer in each category were selected.

## Data Collection

As is common in qualitative case study research, this study used a range of data sources which were brought together and triangulated in the analysis process.

1. In the first stage of data collection, the data sources were two focus groups. The focus groups helped to raise ideas and widen my own perspective about the challenges and strengths of combining research and practice.

2. The second stage (during which the improvisations played a part) involved two week-long site visits respectively to an Australasian and a European music therapy training course – one where research was to the forefront and a second where practice was a strong leader. The main data sources were a series of interviews with 4-6 staff and students, and collected field notes on attendance at classes, supervisions and department events, and documentation of improvisations.

3. The third phase of the research involved bringing together themes from stage one and two, alongside concepts developed from my ongoing reflexive researcher journal.

## Data Analysis

Braun and Clarke's (2006) framework for thematic analysis across varied data sources was used in this study (Hoskyns, 2016). Data was coded using in vivo and descriptive codes, and then further organised into pattern codes. In each stage of the research, preliminary categories were developed, and these were further refined to connect with new thematic material in the later stages of the research. As in any qualitative research, the growth of my own researcher-understanding was a focus for capture and understanding in the write-up of the findings. I developed a reflexive writing approach during the course of the study, which allowed me to monitor the growth of my own wisdom over time. Consideration of improvisation as a mode of work became

increasingly important to my analysis and writing in the last stage of the writing up of the thesis.

## Overview of Findings

The findings from this research focussed around three core themes relating to how research may be integrated with practice in MT education. I presented these as the following key ideas representing the importance of:

- cherishing students' fire and curiosity (about practice and research);
- facilitating the acknowledgement and management of change in the student journey; and
- helping students to embrace and manage complexity in their music therapy education.

Across the themes, collaborative engaged learning between students and supervisors was valued, as was moving beyond "research competency" towards deepened personal learning and creative capacity in research and practice. Training programmes approached this in diverse ways suited to the varied cultural context of the education setting, and it was clear that integrative strategies for practice and research were often perceived as inspiring for students and teachers despite tensions experienced in their development. As the research was constructivist in its foundation[2], it is acknowledged that the viewpoints were particular and subjective to the participants concerned, but meaning and connection may be shared by other interested parties and readers may find their own insights in parallel experiences.

In the next section of the article, I provide two examples from the thematic analysis of qualitative case study research to illustrate how the process of improvisation and consequent reflection on the creation of

[2] Kuper, Reeves and Levinson (2008) define constructivism as "a belief about knowledge which holds that the reality we perceive is constructed by our social, historical and individual contexts" (p 405).

meaning contributed to the understanding of my research analysis. The first example of co-created improvisation involved a lecturer-supervisor participant named "Hope". The second example involved music therapy student "Naomi"[3]. Both participants were present at separate site visits in Australasia and Europe.

## Two Improvisation-Reflections: Data and Meaning

The two participants who took part in their individual music making session – Hope and Naomi – were both involved in a verbal interview earlier in the day at their respective music therapy programmes. Through the interview we had built some mutual understanding of their story and experience of research and practice, and the music-making was offered as an additional space to elaborate and to complete the research data gathering visit to their respective settings. Their contributions to the research data were particularly illuminating in my analysis. I made use of reflections on two improvised pieces created with them to introduce and close the findings sections of the thesis. These experiences with the participants were very interesting examples of co-creating meaning – a really fascinating way of "*interviewing"* somebody, if you like. We held the topic of integrating research and practice in mind, played the music that "emerged" from being in the room together and then discussed it, and in each case some new insights emerged. Hope's reflections helped me to fix and fill out the meaning of one of the three major themes in my analysis which I defined as "embracing and managing complexity". Naomi's improvisation and feedback provided an introduction to the findings as a whole, as an example of the inductive process of seeing what comes up when you survey your data is improvisatory in itself.

[3] "Hope" and "Naomi" are pseudonyms for the two research participants, chosen to disguise identities.

## Vignette 1 – Lecturer Hope: "All these Meta-layers"

> *"It was extraordinary! It took me right back into the research, the layers in the improvisation… the realisation that you were in the research on the same journey I have just completed… All these meta-layers!"*

So said Hope, as we began to talk after a sonorous end and long, quiet (15 second) pause to our improvisation together at the completion of my site visit to her programme. Hope and I knew each other but had not met for a number of years. I had been her examiner at the end of her music therapy training, years before.[4] She had worked as a supervisor and lecturer since, and had engaged in a research thesis a couple of years prior to my visit. The resonance created for us – two music therapists, reflecting musically on the experience of developing research ideas about practice – is offered here as a particular illustration of how music provided Hope and I with a way to "hold the whole in mind", i.e. the experience of music itself creating integration of practice and research, which was the central idea in the research question. There were motifs that developed together in our music which were fragile and delicate, with a range of possible meanings, which we discussed animatedly afterwards. Although this was all improvised, there was something about the "elasticity" of music that allowed many layers and held sensuous, purely music, memory-based or associative possibilities together in one whole. The music shifted and changed. Hope and I slipped roles between student and researcher and therapist, and ideas were in the foreground and background at different

[4] The multiple roles of music therapists in small communities is acknowledged here. I knew (from previous experience in training) a few of the participants in the study, and in this case Hope and I acknowledged at the start of the meeting that we had met previously both in her exam but then also occasionally as colleagues. Hope was the one participant in the first site visit improvisation session and actively volunteered to attend. Although the possibility of exploiting power dynamics was important, Hope checked the notes and interpretations offered, and I noted and adjusted these according to her feedback.

times. The experience was very unusual for us both I think, at one and the same time lucid, but multi-layered and complicated! The following vignette is an extract from my research journal, written following my listening to the recording, in the few days after the encounter took place in 2010.

> *We created a piece for piano, metallophone and temple blocks, and in thinking about what we would do, we were both quite clear about making choices… not vague, or deferential. I moved the piano stool from one side of room over to the piano, and Hope offered that she would like to play the piano once I had done this. A large metallophone initially caught my eye and I suggested that I would also like to play a set of temple blocks, which reminded me of improvisation classes at the Guildhall School of Music and Drama, London with Professor Alfred Nieman in 1980 – the temple blocks were always one of my favourite choices. I suppose I was recalling being a student. We were both keen to explore the idea of a musical reflection on our interview experience.*
>
> *Hope and I talked briefly, and I suggested that we might take the theme of "Research and practice and their integration", but was happy to leave it open, if Hope preferred. She thought the title was OK, and we just went into music from there. We needed to finish our session within 30 minutes, so I had suggested that we play for 10 minutes, then could talk for a further 10, and then round off our time. From my perspective, the music was easy to "fall into". I wasn't really thinking consciously about the title, but just concentrating on sound moment-by-moment. I think I started after a pause together, playing a simple interval (a major seventh on metallophone), and Hope responded gently with a right-hand chord after a second repeat of the seventh. It felt straightforward and natural. Hope then weaved a little figure in her right hand, a yearning sigh, F-natural falling to E. I*

*picked up on this and raised to G. The piece flowed and built, and as it became more energetic, I moved to temple blocks and voice. It ended back where it began with metallophone and piano, Hope a steady presence throughout.*

*Hope noted – with surprise afterwards, I remember – that the music had a very specific correspondence to her research experience. Piano and metallophone had been the instruments of choice in the music she analysed as the central part of her study, so the sound world we made was very evocative of the practice and the research. Various things also reminded her as she was playing and she seemed very engaged and knowing what she wanted to do throughout. I had quite vivid experience of really enjoying the mutual sounds we made as music therapists. I didn't feel particularly responsible for holding the sound together (as music therapist might) and noted to myself the easy flow.*

Two particular ideas occurred to me in my own experience of the music as I wrote in my research journal:

1. *It was lovely to play supported by Hope's piano playing. Around 15 years previously I had been her examiner. But here she was now a most capable experienced music therapy improviser and I really recognised how skilful she was in her music.*

2. *It was also funny to go back to the idea of Alfred Nieman at this moment. Hope was reminded of being a therapist, while I was plunged into being the student! I remember Alfred enthusing to us how important group improvisation was as a tool. I was a bit sceptical at his claims at the time, whilst having a very inspiring and memorable time in his classes. I think I was a little bit scared of how observant he was to be truthful. I was 20, out of the egg, with a lot to learn. He probably knew a bit too much about us from our music.*

This was also powerful for us both, as Hope's description of her research experience during the interview had been very painful. In her interview, we had discussed that maybe her choice of topic had been too ambitious, that perhaps the supervisor hadn't given suitable support and that the examiners didn't understand musical process so she felt her findings were not considered at all in the evaluation of her research. Taking her important practice into research had been harsh and unforgiving, and she did not feel like repeating or extending research at this point. So this "revisiting" in the music had proved profound and we discussed this afterwards in our reflection. For me the improvising and talking experience revealed how we can hold different roles at the same time, and that motifs and concepts can be in the background, or come into spotlight depending on what is needed and how music can hold many meanings at once. Hope's reflection on the "meta-layers" made some real sense to the complicated responses and processes of my varied interviews and allowed me to conclude that tolerating and managing complexity was an important dimension to the connection and integration of practice and research. This eventually became a third major theme in the findings, in connection with other generated sub-themes relating to complexity.

## Vignette 2 – Student Naomi: Finding Patterns and Experiencing "Dichotomies"

In an improvisation with Naomi, first-year student interviewee at her music therapy programme, we sat together in a fairly small room in the afternoon at the end of my visit with a collection of tuned and untuned percussion. We also had about 30 minutes for the session, to include music-making and talking. I read a few notes out about the interview we had shared earlier in the day, and suggested that we invented a piece together on anything interesting that caught her attention from recollecting the interview, or just leave it open with the idea of integrating research and practice (the subject of my research) being the reason for coming together. As with Hope's session, I didn't have any particular expectations about this music. It was just another space or process to reflect. My brief outline of the field notes, which I read out to

Naomi, highlighted her decision not to do music for a Bachelors' degree, and then coming back to music therapy, and then choosing her research topic (choosing between a clinical project and a spirituality topic), and her experience as an honours student conducting some undergraduate research. The following extract is taken from my research journal following listening to the improvisation.

> *The improvised piece was in three sections. Naomi checked if it was OK to start, and after a short pause, she began with a tiny motif, exploring the notes on a metallophone (in a kind of mode). The notes were set up in this particular pattern and are illustrated below (Figure 1):*

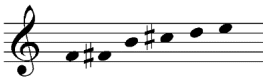

Figure 1. Pitches on metallophone.

> *I fitted in the spaces Naomi made with the motif – playing some accompanying off-beat rhythms on a pair of rosewood claves, and later on a cabasa (a metal shaker that you can twist or tap to make the sound). The motif expanded and grew between us, Naomi responded to my rhythmic shaping, and I responded to her phrases (Figure 2).*

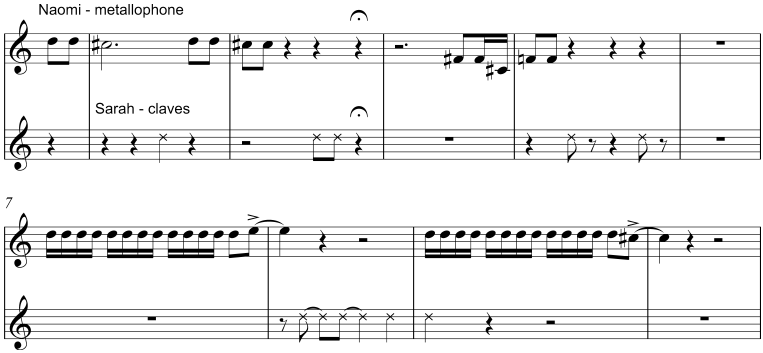


Figure 2. Dialogue in improvisation on metallophone and claves.

*In the middle section we played together on the djembes, and then Naomi returned to the mode and theme on the metallophone and I joined in with voice in a kind of call-and-echo dialogue. We expanded and "stretched" the theme, playing it in sequence, using voice as echo. After playing we talked and I said: "It's funny isn't it, playing music with somebody for the first time?" And Naomi said yes and articulated her surprise when she found that the metallophone notes were set up in that particular mode, (they weren't in usual diatonic order) and it created a certain sort of feeling in her – it suggested something uncertain. With the first little theme on the metallophone, Naomi said she didn't think about this beforehand. She didn't think: "What am I going to do?" It just came to her. She said: "That mode gave me a sense of indecision. It evoked mysteriousness and something a bit mischievous." As researcher, I found this interesting on reflection and particular in the context of the improvisatory form I had thought about for analysing the study data. Naomi responded to the "form" of her musical surroundings, the notes in a particular pattern, and an idea just came up and then developed between us in the improvisation.*

*Naomi then went on to say: "When you were reading back to me I saw "dichotomies" – research and practice and my choosing this way or that way". Later she observed that in the middle of the piece, when we were both playing djembes, and there was a dialogue – a kind of conversation between the two instruments and she said she thought: "Ah! These two things can co-exist. I made my own decision – I chose for myself."*

Thus, pattern and meaning "emerged" from the music for Naomi and myself, and the idea of Naomi's choosing – emphasising her curiosity and her interest, and the sense that research and practice can coexist – seemed an enlightening and interesting springboard for analysis. I

think the surprise and illumination that happened as a result of the musical environment creating a metaphor of **dialogue** between two issues (the two possible routes for her study being suggested by a drumming dialogue) separate but coexisting, was genuinely interesting. As with Hope's experience, the musical engagement allowed us to appreciate multiple layers, and to allow an alternative way of thinking about things, which for me as researcher was particularly valuable.

## Discussion and Summary

The two encounters with a student and a supervisor-lecturer allowed me expansive freedom of thought, which also appeared to be true to some extent for the participants. Ideas they had not thought of in the original interview came into view. I felt I got to know Naomi a little better through sharing music with her, and Hope and I were able to process and digest an emotional encounter we had made in the original verbal interview, and to find some other meaning to the research-practice journey. The process also provided a new artistic slant on my topic, which felt more integrated and comfortable in my own learning as a researcher. In this concluding section, some themes from the improvisational process are reviewed and summarised.

### Loosening the Mind

There was a particular aspect of the journey into free music-making that I experienced somewhat as a surprise. While being focussed on developing my research, these encounters with the two people allowed me particularly to be softer in focus – less directly looking for answers, and more able to see diverse and rich meanings, and also to pay attention to what occurred in front of me. We experienced this as being somewhat "looser in our minds" and a little more open to suggestion, intuition and perhaps to the building of connections. In both cases I think it was a mutual journey of recognition and exploration. It seems that the music acts as a kind of provocation, enabling participants and researchers to think more laterally and intuitively about the subject of focus.

Music therapists have used this kind of exploratory technique in peer-supervision sessions and in training students to promote insights. Odell Miller (2009) draws attention to Priestley's practice "Intertherap" as an innovator in the field in the 1970s, in her survey of supervisory uses of music. She emphasises – as do Young and Aigen (2010) – the contribution of a collection of practitioners using these methods, such as Jahn-Langenburg, Scheiby, Austin and Dvorkin, who contributed substantially to Forinash's (2001) edited text on music therapy supervision. Pederson (2009) also writes in detail about musical improvisation as a reflective tool in an ongoing supervision group of colleagues and with students. I first encountered such work when co-teaching with colleague Dr Elaine Streeter for the music therapy programme at Guildhall School of Music and Drama, London. We ran supervision support workshops in the 1990s for on-site supervising music therapists. It was a practice tool for sharing experience about challenges in supervision of students, and Elaine suggested it as a strategy, creating simple group improvisations on topics, or setting scenarios around problems and exploring music first and then discussing associations and connections we made afterwards. Very often creative shifts occurred and people could suggest new music practices for students or client work, as a result of the process. Young and Aigen (2010) give detailed examples of the musical processes that enhanced their mutual understanding during supervision and also suggest there was fluidity in their work, between the music and the talking: "Verbalization led to work in the music and musical improvisation also led to verbalized insight" (Young & Aigen, p. 133).

I would emphasise there was particular value in this kind of flexibility as a *research* process. The initial interview raised specific ideas, the music allowed an imaginative, loosened, playful musing and the subsequent reflection returned to a further step of insight from the participant and/or the researcher. As in supervision, perhaps the most significant insights come from the collaborative understanding between parties. In my own study, I am aware this mutual process was rather limited and recommend others to engage in shared meaning-making as a fuller feature of such a process in future research.

## Building Connections and Finding Meaningful Links - An "inductive" Process

As I was engaged in analysis of transcripts of interviews and was looking for patterns in the codes I had made of the texts of focus groups in the first stage of this research, I was aware of a link between doing this "search for meaning" in texts, and finding meaningful patterns in music improvisations that we might build with people in music therapy. Inductive analysis – a process of seeing things "come up" to you (rather than looking for some specific ideas that you have pre-determined – a more deductive approach) feels rather like this free improvisation experience. The free-improvising violinist Nachmanovitch, has an interesting description of this kind of "feeling your way" approach to music describing it like a walk in a new city:

> A walk, following your intuitive promptings, down the streets of a foreign city holds rewards far beyond a planned tour of the tried and tested. Such a walk is totally different from random drifting. Leaving your eyes and ears wide open, you allow your likes and dislikes, your conscious and unconscious desires and irritations, your irrational hunches, to guide you whenever there is a choice of turning right or left. You cut a path through the city that is yours alone, which brings you face to face with surprises destined for you alone. […]
>
> As the pattern of people and places unfolds, the trip, like an improvised piece of music, reveals its own inner structure and rhythm.
>
> (Nachmanovitch, 1990, p. 19)

Some of the first ideas that emerged for me or "came up in the data inductively" from the initial coding of the focus groups were to do with curiosity, aliveness, and excitement about what you were doing and a questioning and searching. (These formed the bulk of my first findings chapter). However, there were other strong ideas that appeared to have meaning in my first examination of data – for example, the importance

of participants' history, the struggles people had with timing and balancing learning, the massively complex area that was clinical practice and research. These collections of ideas seemed to fit with materials that have formed the substance of the two further main themes about change and complexity. The suggestive and imaginative processes of the two improvisation sessions really helped my understanding – especially of the complexity theme (as indicated above). Not only did they open up my thinking, they also solidified and helped me form organisational patterns, in which I could present the findings as a whole. In the words of participant Hope, "All these meta-layers" was a kind of epiphany, bringing together the meaning of many other strands in my analysis. The work with music improvisation had played a substantial part in helping to reveal this.[5]

## Working in the Mode of the Discipline – Creative Possibilities

As noted in the introduction, music therapy researchers have emphasised the value and satisfaction they have experienced in using musical and therapeutic process and understanding to develop theory and research methods. Ideas of beauty, aesthetics, and arts-based and indigenous music therapy frameworks have raised confidence and pride in the special qualities of the discipline, and allowed music therapists to integrate their skills as practitioners, artists and scholars. Bruscia (2004) has described improvisation as "the very essence of therapy" (p.18) and suggested that it provides particular ways of learning how to explore and inhabit the worlds of others. It also makes us interested in alternatives. As a therapeutic tool, of course, this is especially

[5] Hope later reflected to me (after seeing my response to the improvisation and valuing of her "in vivo" phrase) that she often found such moments of insight after improvisation pivotal in her recent music therapy work. She had been improvising with an older gentleman reflecting with him on his personal phrase about being "just a plumber" and how rich and moving the work had become as a result. She expressed her appreciation of the collaborative journey.

important, but how useful also as a potential research vehicle to understand others' ideas and perspectives. There are also many directions we can take, as Nachmanovitch (1990) suggested in his analogy of an engaged journey without a map, and there is special power in this freedom of thought. The individual researcher can use her/his artistic sensibilities to respond, develop meaning and appropriately invent new knowledge.

Reconnecting with my "improvising home" in doctoral research was certainly a creative inspiration to me. Instead of understanding research process as one of accumulating, sorting and documenting my knowledge, I began to use a more reflexive writing style, and to value slower-brained activity, which allowed meaning to come together in subtle complex ways. I read Claxton (1997), who emphasised the often meandering ways in which creative capacity flourishes: in Claxton's thesis, imaginative interpretation develops if you are a little less intentional and "hare-brained" and use the slow-cooking tortoise mind. I found affinity with Edward de Waal's description of "vagabonding" as a research strategy – allowing yourself to follow leads and directions provided by your context, and to encourage yourself to be surprised (De Waal, 2011, p 72). In this way, I found musical organisation of themes as a way to structure the study findings, using thematic forms as metaphor for the writing structure (including ground bass, theme and variation, and motifs of association). Kenny's (2015) exploration of conversational duets with colleagues and mentors presents the journey of her theoretical life in collaboration with music and people. She urges music therapists to:

> Stay, stay in the presence of the aesthetic.
>
> A tonality emerges from our playing. It is the foundation for ritual performance. It is a right and a responsibility. It is home.
>
> (Kenny, 2015, p. 459).

In a related way, McCaffrey & Edwards (2015) and Beer (2015) emphasise the potential for art-process in research contexts to reveal

unexpected pathways and new strands of thought that are relevant and valued by participants and researchers in music therapy. In McCaffrey's work with reflexive journals and song composition, a new level of reflexive understanding was achieved and the song itself had meaning and life of its own. My experience with musical, personal and writing improvisation in research has supported the assertions of these and many other esteemed colleagues before me.

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# Harmony through Collaboration: An Accessible Concert Project

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**Keywords:** Collaboration, community music therapy, community musician, special education, accessible concert.

## Abstract

This report details the process and outcomes of an accessible concert project which took place in New Zealand in 2015. The project was a creative partnership between a number of organisations, which culminated in students at a local specialist school participating in a day time concert held in the performing arts venue at a local art gallery and museum. The accessible concert and some of the workshops were filmed, the purpose being to create a video showcasing the potential of collaborative arts projects in the community. This film and a number of photographs are widely available on social media (links to which are included within this report); therefore, information about settings and people involved already exists in the public domain.

## Description of the Project

This project[1] provided an opportunity for students from Mahinawa Specialist School[2] to work collaboratively with a community musician (Julian Raphael, of Community Music Junction)[3] and a chamber music trio (Trio Amistad[4], comprising Simon Brew – saxophone, Jane Curry – guitar, and Rebecca Steel – flute), to perform for their friends, family, and members of their extended community at a local performance venue. This came about as a result of the music therapist approaching organisations in an attempt to access something new and different for the students at Mahinawa. Planning meetings involving Sue Jane – Education and Outreach Coordinator for Chamber Music New Zealand (CMNZ)[5], Julian and myself, Megan Berentson-Glass – the music therapist from Mahinawa, occurred in the lead-up to the active music-making, and Julian visited Mahinawa to meet the students and gauge the possibilities for shared music-making throughout the school. Students accessed workshops with Julian, based at their school, over the course of three weeks and participated in a performance event at the end of this period. Musicians from the trio were invited to also attend the workshops, and did so from the second week of the project. The accessible concert was an energy filled event, including a large-scale drum circle, singing, ukulele playing, movement to music, and considerable audience participation (Figure 1).

Many parties were involved in this project over its entirety. As well as those mentioned above, music therapist Neil Jourdan joined the school team partway through the project and was heavily involved in the workshops and concert. Pataka Art + Museum[6] provided the

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[1] This article is based on a presentation for the Australian Music Therapy Conference (Berenson-Glass, 2016).

[2] http://www.schoolground.co.nz/kapimana

[3] http://communitymusicjunction.co.nz

[4] http://chambermusic.co.nz/whats-on/trio-amistad

[5] http://www.chambermusic.co.nz

[6] http://www.pataka.org.nz

performance venue free of charge, and Arts Access Aotearoa (AAA)[7] provided funding for the project and a film crew for a workshop and the concert, later creating the film *Connecting Through Music* (Arts Access Advocates, 2016).

Julian, community musician, has considerable experience working with people from all walks of life, and discussed this within *Connecting Through Music*. In this video, and the extended footage taken for this, he advocated that making music together is a simple and effective way to enable people to feel connected. He went on to express his belief that everyone has the ability to successfully participate in music making in their own way, stating that "When you're working with music, other things don't seem to matter: language, disability or different abilities… They're not factors that get in the way of making music. You simply adapt your music to the group you have with you."

Julian has been working on a song leading approach, which he calls "Informal Group Singing" (Raphael, 2015), with a focus on the music making occurring in the moment, rather than in a future performance, and on the process rather than the outcome. Included in this approach are techniques such as improvising using vocables (syllables without meaning) mid-song to prolong the musical experience, while maintaining interest, creating the opportunity for those involved to become fully immersed in the music and further develop a sense of connection with others through the activity. It is in this focus on the process that we can see the clear overlap between Julian's approach to his work, and that of a music therapist. In this setting, this meant that there was a familiarity for students and staff in Julian's way of working with what was being presented musically at the time, which supported the transition to a new person facilitating music in the school. The shared focus also helped quickly create a positive working relationship between Julian, Megan and Neil.

Chamber Music New Zealand aims "to increase appreciation and enjoyment of music throughout Aotearoa", with a vision of "Live

[7] http://artsaccess.org.nz

chamber music engaging and inspiring all New Zealanders as a treasured element in our lives" (Chamber Music New Zealand, 2016, p.8). In order to do this, they provide such activities audio described chamber concerts, masterclasses, and the secondary schools chamber music contest, as well as touring chamber music across New Zealand. Since 2012, they have also provided an accessible concert programme, with two or three projects annually.

Mahinawa Specialist School supports around 70 students with a variety of diagnoses and special educational needs, including a high percentage of students on the autistic spectrum. The school is based over five sites, including a specialist facility for older students and four satellite classes in local schools. Students range in age from five to 21 years. While its Porirua College site is specifically for students with special educational needs, it aims to promote an inclusive education model, with students accessing and connecting with their local community wherever possible (including work experience placements) and maintaining links with local schools. Students in the satellite classes have access to learning opportunities within the host school, and other learners from these schools are welcomed into the satellite classes at times across the school day, including involvement in the music therapy or specialist music groups.

Mahinawa School currently employs two registered music therapists as part of the specialist team (permanently comprising occupational therapy, speech language therapy, physiotherapy, music therapy, and a music specialist, with behaviour specialists contracted as needed.) As music therapists in special education, our work is informed by both the more traditional ways of working with children with special education needs, such as the improvisation-based and child-led Creative Music Therapy (Nordoff & Robbins, 2007) and the more recent influence of the community music therapy model of music therapy in education (Rickson & McFerran, 2014). Both music therapists within Mahinawa School work with students in a variety of ways across the school day, including individually, in small and large groups, and in inclusive groups across the school community, whether this is at the college site

or in the satellite classes at local schools. We also provide support and resources to teachers, to embed music within their programmes throughout the school day.

## Comparable International Projects

While the project being described here is clearly informed by the principles of community music therapy, it was not specifically a music therapy project. This was a creative partnership between many people and organisations who shared a similar belief – that everyone should be able to access music and music making, and the benefits that this brings.

As more music therapists embrace the principles of community music therapy, there is increasingly an acceptance that performance with and for others can be a valid aspect of the therapeutic process, and that the audience also hold a vital role in this. Stige and Aarø (2012) write that:

> What is nurtured in community music therapy is a participatory notion of performance, where the interaction between performer(s) and audience is acknowledged as an important aspect of the process. When this works, a musical performance is not only a personal performance, but a performance of community. (p. 225)

Projects such as the one being described here have been happening with increasing frequency both nationally and internationally, as reflected in the growing body of literature. In the Music for Life (MFL) project in South Africa, music therapists worked collaboratively with community musicians, co-facilitating after school music groups for disadvantaged children, with the aim of offering the children "a positive social group to belong to" and "a safe environment where they could build healthy relationships with their peers" as an alternative to the gang culture which many of them had experienced (Oosthuizen, Fouché, & Torrance, 2007). The project is an ongoing one with many opportunities for performance built in across the year. In MFL, the music therapists see their role as providing support to the participants

and the community musicians, managing group dynamics, communicating with the musicians when adjustments are needed to the music or the way it is being presented, and supporting individual group members as needed. This therapists' role is similar to that of the music therapist involved in the El Sistema music education programme at St James Music Academy in Vancouver, Canada, who also provides support to both the students and the teachers in order to maximise the success of the students within the programme (Owen & Mazabel, 2016)

At the Easter Seals music therapy programme in Canada, teens and young adults with physical disabilities, who accessed existing music therapy groups, were offered the opportunity to workshop collaboratively and perform with local musicians, volunteers, and the music therapists. It was found that "the goal of giving a performance provided an additional dimension to the growth and development of the group, generating excitement at the prospect of sharing their music with friends and family in a supportive environment" (Gosine, Hawksley, & LeMessurier Quinn, 2017).

Rickson and McFerran (2014) share a teacher's perspective of a similar large-scale collaborative music event which brought together an orchestra, a string quartet, a vocalist, a community musician, and a number of students with special education needs who attend a unit at a mainstream high school (pp. 68-78). Here too the role of the music therapist was one of supporting all the parties involved, to enable the optimal participation of and success for the students involved.

## Stages of the Project

There were many stages involved in the journey of this project, broadly categorised for the purposes of this report as Preparation, Music-making and Follow-up.

### Preparation

The preparation phase began in late 2014, when I made initial contact with CMNZ, seeking opportunities for students at the school to access

community events or performances in some way. This is the sort of opportunity which is offered to learners in mainstream schools, but which learners with special needs often miss out on as their sensory movement needs or vocalisations may be considered disruptive to others. In *Creating Music Cultures in the Schools*, Rickson and McFerran (2014) identified that "it is a fundamental premise within the Community Music Therapy literature that enabling possibilities for community participation and opportunities for empowerment through music is an important contribution that therapists can and should make" (p. 24).

Sue responded to this contact immediately, with information about the CMNZ "Accessible Concert" programme and offering a place on this for the following year. Details of this programme were then shared with the management team at the school, and with much excitement and a level of trepidation the school agreed to be involved.

During this preparation phase, I maintained considerable contact with Julian and Sue. This included meetings and regular email contact, to ensure the music-making phase was best able to meet the needs of the students participating. See below ("The role of the music therapist(s) within the accessible concert project") for further details.

## Music-making

The music-making phase consisted of weekly workshops for the students at Mahinawa School, facilitated by Julian and supported by the music therapists and other school staff. For the purposes of the concert, the students were grouped in one of three workshop groups, based on location (college aged site, local Porirua satellite classes, and Kapiti Coast satellite class). During the workshops, Julian introduced a number of different songs and activities to the students, to determine the level of participation of the students and the possibilities for the music making. In this respect, the process was very flexible, as some activities were only used once and others were repeated and developed over the course of the workshops as the students became familiar with them and the trio members became more involved. This level of

flexibility enabled Julian to explore how the students engaged with the music and develop the concert programme based on that.

The workshops in the college site consisted of drumming (using African djembes), singing, and the use of assorted small percussion instruments, particularly maracas. A number of students chose to express themselves through dance during these workshops as well. In the Porirua satellite grouping, which consisted of primary school aged students, the activities were primarily action songs, which enabled opportunities for self-expression and for much needed movement breaks (though students were also free to move around throughout the workshop process). The final satellite grouping also worked on songs, with a focus on the use of ukuleles, as the music specialist at this site had been teaching many of the students to play simple one or two chord songs, and therefore this was something they were very familiar with.

On the day of the concert, almost all of the students travelled by bus (a first for some of the students) to the venue to participate in this event. The concert lasted for 45 minutes, and was followed by a number of brief speeches before the students returned to school. While the programme of the concert had been prepared, there was still a feeling of improvisation at times during the concert, in part because all the students had never been together as a group in one space before. They also had not heard the trio play as a group, and many of them were clearly fascinated by this experience, watching intently, dancing to the music, or vocalising. This can be seen in the video *Connecting Through Music* and in photos from the event (Figures 2 – 4). The students were encouraged to remain on the mats and chairs within the performance area, but were able to move around as needed, some moving to sit with members of their family, others dancing or exploring the performance venue (a large, rectangular room which doubles as a dance studio). The room was very safe for people to explore, being on one level, with staff seated at the exit points, and there was a quiet space easily accessible for anyone who needed a sensory break.

## Follow-up

The final stage was the follow-up phase. Shortly after the concert, feedback was shared by the participants, with unanimous agreement of the success of the project for all involved, and particularly for the students. Considerable parental feedback was also received which supported this, and requested further such opportunities. This follow-up phase was completed with the release of the AAA video, which took longer than anticipated as the film increased significantly in length due to the amount of high-quality material available, and funding needed to be found to support this. The video is accessible on a number of platforms (including various websites and YouTube), and clips from it were shown to around 300 people at the AAA annual award ceremony in 2016 where CMNZ won the Arts Access Creative New Zealand Arts For All Award 2016, "for its commitment to developing new audiences for chamber music through its accessibility programme" (Arts Access Advocates, 2016; Chamber Music New Zealand, 2016).

## The Role of the Music Therapist(s) within the Project

I was heavily involved in the preparation phase of the project, as this was vital in ensuring the best possible outcome for the students involved. Regular contact with Sue was maintained throughout the process, including to source a suitable venue for the concert. Together we visited the potential venue, where I focused on accessibility, safe parking, breakout spaces, accessible toilet facilities, quality of acoustics (and how they might impact on students' sensory issues), and any potential hazards. Once this venue was agreed on, I took photographs of this and of the people involved in the concert process including the film crew and musicians, as not everyone would have contact with these people prior to the event, depending on which site they were based at. These photos and practical information about the event and venue were provided to the teachers to create visuals and social stories to prepare the students. These were important as unfamiliar situations may cause anxiety for a number of the students.

The CMNZ accessible concert workshop process usually occurs over one intensive week, culminating in the concert. However, the school management team and I strongly felt that the students would benefit from a less intensive arrangement over a greater length of time, allowing them more time to process what was happening and to better prepare for the concert. This was strongly advocated for during the initial planning meetings. Fortunately for the school, this project took place in the city where Julian was based, and it was possible in this instance for him to visit each of the three Mahinawa sites once per week over a period of three weeks, rather than daily in the week of the concert.

We provided information to the families about the project, and sought permission for photos to be taken, as a professional photographer would be attending the concert to document this for CMNZ. An article and a photograph of four students during the first workshop was sent to the local community paper to advertise the concert, and was in itself a high point for the students involved, who were extremely proud to be in the paper.

The final aspect of preparation involved meetings and communication with Julian, to support his planning for the workshops. This included information about what motivated different groups of students, what their attention span might be like, how they might choose to interact both with the music and with the new people in the room, proximity to Julian to ensure maximum involvement – for example, in direct line of sight for the students with visual impairments, or beside him for students for whom direct feedback from Julian would be highly motivating. Also discussed was how Julian felt the therapists would be best used within the workshops – such as utilising Neil's considerable skills on the djembe within the drum circle, adding a strong rhythmic element to the music making and encouraging the students to drum at times when Julian led from the guitar.

During the music-making phase, both therapists helped to support Julian by interpreting what was happening among the student group and what different behaviours meant. We supported individuals where

necessary, liaised with staff, modelled both participation and support for the students (as everyone, including staff, was expected to be actively involved), and provided ongoing feedback to Julian.

One student was not able to attend the groups, due to the sensory overload these created for him. To enable him to participate in another way, his teacher and I worked together to link the workshops and the concert (filmed by the occupational therapist) to his classroom interactive whiteboard via Skype, and the student was able to watch in a comfortable setting. He and the teacher had access to djembes as well, and they joined in the drumming from this distance.

On the day prior to the concert, Julian, Sue, Neil, the trio and I met at the venue for a run through of the performance. It was not possible to bring the students, but this did provide an opportunity to focus on the music itself, to confirm the order of the programme, and to do necessary last-minute preparation. This ensured that on the day of the concert Neil and I were able to answer any questions the staff and students had, and were able to manage the transitions between items and minimise the impact of these on the students.

During the final week of this phase, we also liaised with the film crew. Fortunately, the crew were very understanding of the necessary boundaries required to ensure that the music remained the focus for the students rather than the crew and their equipment. In the follow-up phase, the video project evolved considerably, which required significant input from me. Further written permission was required from families, which I sought, as the intention grew to include sharing the video on social media. Sue, Julian, Simon Brew (the saxophonist from the trio, who attended a number of the workshops) and I were all interviewed for the video. Finally, I viewed the photos and video footage prior to editing, to make sure that there was no footage of students for whom permission to film was not given, and that everything shown would be acceptable to the families. All photos (including Figures 1-4) and footage shown across various media are used with permission, and people involved in the project have given their permission to be identified, including the school.

## Expectations, Reality, and Outcomes

Being involved in a project of this sort was a novel experience for many of the participants, who were initially unsure what to expect. In reality, it was an incredibly positive and rewarding experience for those involved, which encouraged many to think further about their relationship with music, or the possibilities for the future.

For the Mahinawa School Principal and the Board of Trustees, the most positive outcome was that for first time ever the entire school was able to get together in one place. The project was considered highly beneficial for building a more cohesive school community, and for the school as a whole to be progressively more visible as part of the wider local community. Based on this positive experience, the principal felt confident to send a small group of students of mixed abilities and ages to participate in a local schools' cluster concert in 2016, where they showcased a number of their *Kapa Siva*[8] items and musical activities from the combined music therapy group (see below for details of this group). This was very well received.

For the students at Mahinawa, the benefits were numerous. While some were initially nervous about performing for others, this quickly eased once the concert began. The pride and excitement with which they spoke about the concert for a considerable time afterwards was a clear indication of the enjoyment they experienced, and being involved in the project enhanced their feelings of self-worth and value as members of their community.

In the longer term, the success of the project has had an ongoing influence on the provision of music therapy services at Mahinawa. Once the management team saw first-hand the benefits of music-making in large groups, they agreed to trial a "combined music therapy group", which Neil and I co-facilitate. These sessions consist of almost all of the students (around 35 students across six classes) and many of the staff at the college site, and have become an eagerly anticipated event in the

[8] *Kapa Siva* is the term for the Samoan performing arts.

school week for those involved. We have found that participation in a large group is particularly motivating for the students. Being a member of a large group means less time for focused attention on people individually. This has the effect of reducing pressure on individuals, and has appeared to encourage greater spontaneity and exploration from some of the students, whether through vocalising, dancing, playing the drums, or interacting with others. This has provided a safe and encouraging arena for the students to develop self-expression and creativity, and to build self-confidence. The group has also afforded opportunities for students to take on leadership roles, such as conducting the group, within the music making. Senior students have also been encouraged to support the younger or less able group members, and staff are encouraged to actively join in the sessions as participants as well support for the students. This time spent making music together, and the increased interactions between different students at the site, have served to further develop a sense of school community.

For the families involved, the expectations and outcomes are best demonstrated through the words of Rebekah Corlett, mother of one of the students involved in the project (Corlett, 2016).

> We entered the room as strangers [...] Parents of the children and young adults who attend Mahinawa Specialist School in Porirua. I felt nervous, scanning the unfamiliar surroundings and mentally noting all the possible sensory nasties that have been known to send my daughter, Sophia, aged seven, into an autistic meltdown in a split second.
>
> I wasn't alone. I looked around and saw a room full of parents similarly perched on the edge of our seats hoping that our child isn't "the one" who kicks off first!

For Rebekah, the reality far exceeded the expectation. She describes the response of the room in general, and her daughter, to the music of the trio, and the unexpected interaction they shared at this time. This was "a rare but real interaction with my daughter".

Later she writes:

> For me personally, I left with so much more than I arrived with. […] I felt connected – to Sophia, to her school, to our community, and to every other person in that room. Parenting a special needs child can be a very lonely experience, so it was a powerful feeling to connect and feel included. It felt like one big family.

Rebekah also writes her own blog, "I Am Rebekah Corlett"[9]. Her post, "The power of music" (Corlett, 2015) shares her perspectives on this project further, and is highly recommended reading. Rebekah and Julian shared further reflections in an interview for Radio New Zealand (Corlett & Raphael, 2016).

Simon Brew, from Trio Amistad, also talked in the video about the impact the project had on him. He spoke about how powerful the experience had been, describing how during one of the workshops he was totally immersed in the music making and the connection between people, and he experienced a "rare and special feeling" (Arts Access Advocates, 2016) which performers only get a few times in their careers. He stated that he left that day with a "real buzz".

The impact of the project on Simon's concept of performance was apparent in his interview for the film, when he talked about the importance of relaxed performances. He described the frequently formal nature of chamber music in our era, and his belief that broadening the accessibility of concerts and offering them in a variety of different formats would enhance both the experience for the audience and the music itself, through greater engagement from all involved.

For CMNZ, the award in 2016 acknowledging the valuable work they are doing through their accessible projects, and the positive feedback from all involved has only strengthened their resolve to continue to provide these. The award enabled them to begin a mentoring programme, with registered music therapists in both Christchurch and Hastings working

[9] http://iamrebekahcorlett.tumblr.com

alongside Julian to provide the 2016 accessible concerts, with the intention that they would then each facilitate a project in their respective regions in 2017. CMNZ have also recently received sponsorship from the IHC Foundation[10] for a three-year Accessible Concert Mini-Series, ensuring these concerts can be offered into the future. In 2017, all projects have either a registered music therapist or a music therapy student involved.

On a personal level, working with an experienced community musician was an interesting and enjoyable professional learning opportunity for me. It was a chance to observe a facilitator who was highly skilled at working with large groups, and to see in action his "Informal Group Singing" approach. Discussing the process with Julian throughout the project provided a chance to see the students and their music-making from a different perspective. It was also a pleasure to be able to be involved in music-making with the students without the pressures involved in actively facilitating a large group, where you are always thinking about the next step. We were constantly monitoring the groups and supporting participation, but we were also able to relax and simply enjoy the process, which was a real delight. This was clearly a mutually beneficial arrangement, as Julian stated in feedback after the event:

> It was most beneficial to have you both [Megan and Neil] willing to follow and join in the musical dialogue with a clear understanding of the intention and the effect the music was having on the gathering […] Having music therapists alongside and in support allowed me to remain focused on crafting the music and not be distracted by occasional outbursts or lack of response.
> (J. Raphael, personal communication, August 27, 2016).

[10] http://www.ihcfoundation.org.nz

Figure 1. Julian Raphael encouraging audience participation, with Mahinawa students and staff. (Photo: Hannah Beattie.)

Figure 2. A student enjoys interacting with her teacher during the concert. (Photo: Hannah Beattie.)


Figure 3. Dancing to the music. (Photo: Hannah Beattie.)

Figure 4. A new member joins the trio. (Photo: Hannah Beattie.)

## Practical Recommendations

Based on the experience of this highly successful collaborative project, I would recommend the following for anyone considering a large-scale, collaborative project in the future:

### 1. Involve a music therapist!

This project, and those referenced above, all evidence the benefits of having a music therapist involved. Their breadth of knowledge, from the music itself, to group dynamics, to understanding of the individual needs of participants, enables them to effectively support all participants in the process and ensure the most cohesive and successful outcome for the project.

### 2. Have support from management

It was vital having the full support of the Mahinawa management team throughout this process. Their willingness to try something new, and to support this financially where needed (e.g. providing buses to transport students to and from the venue, paying mileage for the facilitator to travel to the satellite sites), and allowing us flexibility in our timetables to actively support the project, all served to ensure a positive outcome for the students.

### 3. Have a long planning / preparation phase

It is difficult to over-estimate the time involved in this. Things such as gathering written permission for involvement in a project can take a very long time, particularly if this is taking place in an area where English is the second language of many of the families, and where interpreters may be needed to ensure full understanding of the information and the project.

## 4. Be clear about expectations prior to beginning the workshop process

Discuss roles, responsibilities, and expectations in advance. Ensure everyone involved has the opportunity to ask questions, and to fully understand the process. In this instance, some of the teachers involved were understandably cautious at first, however once their questions and concerns were answered, they became fully engaged with the process and played an important role in making it successful.

## 5. Allow time for the workshop process

While this is always going to be impacted by funding, where possible, a longer workshopping process is recommended (particularly with the population involved in this concert). Not only does this enable time for the participants to become comfortable with the facilitator and familiar with the routine and structure, but it also allows time for the considerable benefits of the workshop process itself.

## 6. Prepare the participants

Supports such as visuals of people involved, social stories, and class outings to the venue ahead of time were all important in preparing the students, lessening the stress inherent in unfamiliar situations, and ensuring a greater level of engagement in the workshops and concert.


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# Quality of Life for Individuals with a Neurological Condition, who Participate in Social/Therapeutic Choirs

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## Abstract

As New Zealand's population ages, the prevalence of neurological conditions will increase. As such, there is a vital need to ensure that we are able to provide easily accessible, appropriate and effective therapeutic support to these individuals. Participation in a choir has been proposed to have a number of benefits, including improved mood, health and social support across a variety of populations including those with neurological conditions. This cross-sectional observational study used mixed methods to characterise the quality of life of individuals who participated in therapeutic and social choirs facilitated by music therapists. Participants were a convenience sample from the CeleBRation and Cantabrainers neurological choirs, New Zealand (NZ). Quality of life was measured with the NZ WHOQOL-BREF and compared to the reference values of people with disabilities from the WHOQOL-DIS and the New Zealand reference values for the NZ WHOQOL-BREF. Content analysis was conducted on participants' answers to open ended questions from a choir participation questionnaire. Findings show that

people with a neurological condition who participate in a choir have some higher quality of life scores than the reference values of people with disabilities from the WHOQOL-DIS. Choir participants' mean overall quality of life was 3.4 (SD= 1.04). Environment was the highest domain score (M= 15.86, SD= 2.09). The mean item score for choir participants was higher than the upper 95% CI for the WHOQOL-DIS reference values. Choir participants perceived positive improvements including physical, psychological and social benefits as a result of choir participation.

## Quality of Life

Quality of life conceptualises health and wellbeing in terms of an individual's subjective sense of satisfaction. It does not include objective health measures or statistics (Billington, Landon, Krägeloh, & Shepherd, 2010). Quality of life values a "happy" life over a "healthy" life, and a "happy" life is possible even when someone is not physically "healthy". Many people who live with disability, chronic or progressive illness are nevertheless satisfied with their own feeling of wellbeing (Billington et al., 2010). The World Health Organisation's quality of life measures have been developed to reflect this perspective, and seek to capture an individual's perception of their position in life. This perception is influenced by culture, environment and personal values. Meeting personal standards, goals or expectations is entwined in a high quality of life (WHOQOL Group, 1994).

## Theoretical Framework

The theoretical framework for this study draws on several interrelated concepts – singing for health, self-determination theory, flow and social capital – to explain the value of choir participation.

### Choral Singing and Quality of Life

Choirs are one of the most popular ways to make music; large numbers of people participate in choirs, motivated by their love of singing (Clift,

Nicol, Raisbeck, Whitmore & Morrison, 2010). New Zealand too has experienced a considerable growth in community singing, supported by the Song Leaders' Network Aotearoa[1]. Singing has no barriers to entry; it requires no talent, practice or equipment (Clift et al., 2010) although there can be psychological barriers and poor self-perception, arising from prior negative experiences (Hicks, 2017).

Singing is more than a pastime. Singing, particularly group singing, can have a range of physical, psychological and social benefits. Participation in singing has been found to benefit a wide range of people including healthy adults, older adults and individuals with chronic illness or disability, including neurological conditions (Bailey & Davidson, 2003; Bidwell, Calder, Colhoun, & Monthy, 2012; Clements-Cortés, 2013; Cohen, 2009; Skingley & Bungay, 2010). Receiving these benefits is thought to positively influence quality of life, which is of increasing interest given the prevalence of neurological conditions, both worldwide and in New Zealand[2].

Singing has been found to benefit people with mental health, chronic illness and neurological disorders (Camic, Williams, & Meeten, 2013; Dingle, Brander, Ballantyne, & Baker, 2013; Fogg-Rogers et al., 2016; Gale, Enright, Reagon, Lewis, & van Dersen, 2012; Grocke et al., 2014; Lee et al., 2015; Raglio et al., 2015; Stegemöller, Radig, Hibbing, Wingate, & Sapienza, 2016; Sun & Buys, 2013). Results are consistent across experimental interventions and community singing groups (Clift et al., 2010; Clift & Hancox, 2010; Johnson et al., 2013; Livesey, Morrison, Clift, & Camic, 2012). These studies used a range of methodologies, most commonly a mixed methods design, using interviews or surveys with quantitative measures of quality of life and wellbeing (conceptualised in a variety of ways). Mechanisms behind singing's positive benefits and contribution to quality of life can be conceptualised in terms of self-determination theory, social capital and flow. These concepts are of direct relevance to the present study, which

[1] http://www.songleaders.org.nz

[2] The prevalence of specific conditions is beyond the scope of this article.

examines quality of life for people with neurological disorders who participate in therapist-led social singing groups.

## Singing for Healthy Adults

Two large scale studies examined quality of life of 600 and 1124 members of community choirs in England (Clift et al., 2010; Clift & Hancox, 2010). These choral singers recorded high average scores on the WHOQOL-BREF. Livesey et al. (2012) explored how choral singing could benefit the mental health and wellbeing of amateur singers. Open ended questionnaire responses from 169 participants with low and high scores on the psychological domain of the WHOQOL-BREF were selected from a larger data set. Themes which emerged showed that social, emotional, physical and cognitive benefits were attributed to choir membership. These themes did not differ by socio-demographic or wellbeing categories, indicating similar perceived benefits of singing regardless of age, gender or wellbeing.

These themes hold true for older adults in community choirs. For example, Johnson et al. (2013) examined the perceived benefits associated with choral singing and quality of life in 117 older adults. Participants completed self-report measures for depressive symptoms, choral benefits and the WHOQOL-BREF. Statistically significant relationships were observed between singing and three of the WHOQOL-BREF domains: psychological, social relationships and environmental. Higher reported choral benefits positively correlated with higher overall quality of life. Johnson et al. (2013) found that these relationships remained significant when age and depressive symptoms were controlled for. This cross-sectional design cannot establish whether a positive experience of choral singing causes a higher quality of life. It does, however, identify a trend wherein participants who perceived greater benefits of choral singing perceived their quality of life as better than those who did not perceive benefits from choral singing.

Group singing can be particularly beneficial for older adults. Skingley and Bungay (2010) interviewed 17 members from Silver Song Clubs, community based choirs for older adults in the UK, with various facilitators. Participants perceived benefits of the clubs that are consistent with the literature, stating that they

noticed improvement in health and wellbeing, cognitive stimulation and social interaction as well as improved memory.

Bidwell et al. (2012) found similar statements from their examination of the experiences of older adult members of the Rockers of Ages – four groups, facilitated by community musicians, in areas of Christchurch city that were severely damaged in the 2010 and 2011 earthquakes. Sixty-nine survey responses, from an estimated total of 85 choir members, showed that singing and social contact ranked as the highest benefits of choir membership respectively. Participants attributed a number of positive benefits to their regular participation in choir, including increased wellbeing and friendships, and reduced isolation and stress. As most choir members participated in these surveys, these results are representative of the choirs.

These themes were also found in a weekly singing programme for older adults, facilitated by music therapists, evaluated by Clements-Cortés (2013). After 16 weeks of participation no quantitative changes in any measures for general health, self-esteem, anxiety and quality of life (Assessment of Quality of Life scale) were found. However, follow up interviews revealed the expected perceived benefits such as companionship, fun, positive emotions and reduced anxiety. The small sample size and nature of the sample may have decreased the sensitivity of the quantitative instruments to the outcomes described in the interviews. For example, many participants had low pre-test anxiety scores which could account for the lack of impact of choir on anxiety levels.

## Singing for People Living with Neurological Conditions.

The present study built on preliminary evidence from the SPICCATO[3] feasibility study that the quality of life of people living with stroke or Parkinson's disease was positively influenced by participation in a neurological choir (Fogg-Rogers et al., 2016; Talmage et al., 2013).

Stegemöller et al. (2016) investigated differences in voice, respiratory pressure and quality of life (VRQOL and WHOQOL-BREF) in participants with Parkinson's disease. Participants received either high (twice

[3] Stroke and Parkinson's: Investigating Community Choirs and Therapeutic Outcomes.

weekly) or low (once weekly) “dosages” of music therapy. After eight weeks both high and low groups showed statistically significant improvements in voice and health related quality of life. These results complement the qualitative results from Fogg-Rogers et al. (2016) with participants from the CeleBRation Choir. Thematic analysis of semi-structured interviews revealed consistent themes. Participants found choir enjoyable, and singing was perceived to improve mood, language, breathing and voice. Choir was also perceived to be helpful in managing some consequences of Parkinson’s disease and stroke such as isolation, communication difficulties and low mood. However, Shih et al. (2012) did not find any significant improvements in quality of life (VRQOL) for participants with Parkinson’s disease after twelve 90-minute group singing sessions. The differences between these findings seem to represent a trend in the literature wherein qualitative studies seem to be better able to capture the benefits of choral singing. Accounts of these benefits attributed to singing exist even when they are not quantified in measurements of quality of life, wellbeing, anxiety or depression.

Dementia is another area where singing interventions are actively investigated. Recent research suggests that Alzheimer’s pathology is delayed in brain areas responsible for long term musical encoding (Jacobsen et al., 2015). These areas may only be in the early stages of degeneration, even when overall Alzheimer’s progression is in late stages. This suggests that musical intervention could be useful in Alzheimer’s disease and possibly other dementias. Results however, are mixed, conceivably due to the difficulty in capturing accurate scores and due to the degenerative nature of the illness. Camic, Williams and Meeten (2013) evaluated measures of mood and quality of life (WHOQOL-BREF) in ten people with dementia and their carers before and after participation in a ten week “singing together” group facilitated by a qualified community musician with expertise in facilitating group music making as a professional choir leader. The physical condition of the people with dementia deteriorated slowly over the study period. Mood and quality of life scores remained stable. Stable scores, despite degeneration of the condition of the people with dementia, may

suggest that group singing has a protective influence over mood and quality of life.

Raglio et al. (2015) found similar consistency of scores over time in participants with dementia. Individuals with dementia received either standard care (SC), a listening to music intervention (LtM) or active music therapy intervention (MTI) for ten weeks. Compared to baseline (time T0) quality of life scores at follow up (time T2) did not show a statistically significantly increase or decrease for any group. Quality of life scores for the LtM group (T0 M=6.5, T2 M=6.2) and MTI (T0 M=5.9, T2 M=5.5) were more consistent than SC scores (T0 M=6.9, T2 M=4.3). Results were only reported for the scales considered by the researchers to be directly addressed by the interventions (overall score, emotional wellbeing, interpersonal relations and personal development). Unfortunately, final results were not reported for material wellbeing, self-determination, social inclusion and physical wellbeing. There is evidence from other studies that choir can positively influence social inclusion and physical wellbeing (Bailey & Davidson, 2003; Dingle et al., 2003; Fogg-Rogers et al., 2016; Grocke et al., 2014; Monti, Aiello and Carroll, 2016; Skingley & Bungay, 2010; Sun & Buys, 2003).

This study was concerned with how choir participation may influence quality of life for people with neurological disorders. The literature suggests that choir participation may promote physical and psychological improvements. Social support may be built by the inclusive environment of the choir (Camic, Williams & Meeten, 2013; Dingle, Brander, Ballantyne & Baker, 2013; Fogg-Rogers et al., 2016; Gale, et al., 2012; Grocke et al., 2014; Lee et al., 2015; Raglio et al., 2015; Stegemöller et al., 2016; Sun & Buys, 2013). These are common difficulties experienced by people with neurological disorders therefore it is thought that improving these areas can improve quality of life (Cubo et al., 2012; Tang, Lau, Mok, Ungvari, & Wong, 2014).

## Self-determination Theory

Self-determination theory is based on the interplay of human motivation and optimal functioning (Deci & Ryan, 2012). According to

self-determination theory, humans have three basic needs: competence, relatedness and autonomy. This theory is directly supported by two choir studies (Livesey et al., 2012; Stewart & Lonsdale, 2016) and indirectly supported by much of the qualitative research about choirs. Singers discuss common themes relating to competency, relatedness and autonomy which are the key factors required to achieve motivation. Competence revolves around our desire to understand the outcomes of our actions. Relatedness is the need to experience connection with others. Autonomy is about free will, having the ability to act according to personal interests and values, not necessarily independently (Deci & Ryan, 2012).

Self-determination theory recognises two types of motivation: autonomous and controlled. Activities we engage in can increase our motivation, which in turn leads to increased psychological wellbeing (Deci & Ryan, 2012). Perceived psychological wellbeing is a domain in the WHOQOL-BREF and is important to overall quality of life (Billington et al., 2010). According to self-determination theory, in order to achieve motivation basic needs must be met (Livesey et al., 2012). Choral singing can contribute to competence through fostering a sense of achievement and positive reward. Livesey et al. (2012) found that choral singers spoke of receiving praise as part of their participation in choir, which led to feelings of achievement. Choral singers also spoke of feeling in control of improving their singing skills. Livesey et al. (2012) also found that singers spoke of both autonomy and relatedness.

## Flow

The concept of "flow" can be thought of as living in the moment (Nakamura & Csikszentmihalyi, 2002). When "in flow", the person is operating at full capacity. Experiencing flow encourages people to engage in activities because they enjoy the experience. In order to enter a state of flow, the activity must be well matched to the person's skills. The activity should be neither too hard nor too easy, have clear goals,

and provide the opportunity for feedback (Nakamura & Csikszentmihalyi, 2002).

Theoretically, flow can protect against adversity and pathology, which can affect quality of life (Buetow, Talmage, McCann, Fogg, & Purdy, 2014). However, it is unclear if these benefits come from achieving the state of flow or participation in the activity (Buetow et al., 2014). Flow is found to be both more powerful and more enjoyable in social situations (Walker, 2010). Group singing can promote feelings of flow, as participants feel socially connected and become absorbed in the challenges of the experience (Buetow et al., 2014). Choir members have reported enjoying singing as an absorbing experience and a way to distract from daily worries (Livesey et al., 2012; Skingley & Bungay, 2003). Research indicates that singing is cognitively stimulating and that this cerebral stimulation contributes to a flow experience (Livesey et al., 2012).

## Social Capital

The concept of social capital embodies the positives of community life and includes concepts such as solidarity, social participation and cooperation (Langston, 2011). Social connectedness is thought to be an indicator of high quality of life (Rosso, Taylor, Tabb & Michael, 2013). Social capital has been divided into three parts, values and norms, communities, and trust (Louhivuori, Salminen, & Lebaka, 2005). High social capital is linked to better health outcomes for older adults (Davidson et al., 2014; James, Wilson, Barnes & Bennett, 2011; Rosso et al., 2013).

James et al. (2011) followed 1138 older adults, without signs of dementia, for a period of 12 years. The rate of cognitive decline for those with regular social contact was 70 per cent less than for the other study participants. Davidson et al. (2014) evaluated the perspectives of community dwelling older adults after an eight-week singing programme. They found that participants emphasised social aspects of the programme; this supports the idea that social capital is increased through group participation, and that choral singing provides an

opportunity for group connectedness. It is possible that a choir is a community within itself, providing the benefits of a positive community to its members.

## Hypotheses

The benefits of choral singing, which are consistent over a wide range of populations and circumstances, are likely to be reflected in a high quality of life for participants. With this in mind, this exploratory study aimed to characterise the quality of life of a group of choir participants and compare these findings to a group of healthy, predominantly younger New Zealanders and an international sample of adults (of a similar age) living with similar disabilities (Power & Green, 2010). Based on this review of the literature, the following results were predicted:

1. People living with a neurological condition living in New Zealand who participate in a choir will have higher quality of life scores than the reference values of people with disabilities from the WHOQOL-DIS (Power & Green, 2010).
2. People in the choir sample will perceive positive improvements from participation in choir. These improvements will be in mood, health and social support.

## Study Design

This study was a cross-sectional mixed-methods observational study, aiming to determine choir members' perceptions about participation in a choir and to evaluate their self-rated quality of life.[4] Quantitative and qualitative data were collected through written questionnaires. Participants were a convenience sample of choir members. The characteristics of choir members are diverse in terms of age range,

[4] Ethical approval for the study was received on 13 July 2016 from the University of Auckland Human Participants Ethics Committee (approval given for three years, reference number 016891).

types of neurological condition and communication abilities. Members have been attending for different periods of time. Hence, we anticipated obtaining responses from a diverse range of participants.

## Participants

Participants were recruited from the CeleBRation Choir (Auckland) and the Cantabrainers Choir (Christchurch) via an announcement at a choir session and email follow up. These are therapeutic, social singing groups for people living with neurological conditions[5], and are led by registered music therapists[6] with speech science support and research (CeleBRation Choir) or co-facilitation by a speech-language therapist (Cantabrainers). The inclusion criteria required participants to have a neurological condition, or be a family member or carer of a choir member with a neurological condition, at the time of the study data collection (July – August, 2016).

Data collection for the CeleBRation Choir members occurred immediately before or after their regular choir session, over a period of six weeks. Members of the Cantabrainers Choir completed their questionnaires over a two-day period. Participants who wanted assistance were supported by a person of their choice. The supporting person could read questions aloud, mark answers or both as directed by the participant, but they were not able to answer on behalf of the participant. The supported participant directed the support person by speaking, pointing, nodding or making affirmative body movements. Participants were able to indicate their desire to leave a question blank. Questionnaire materials were formatted to be aphasia friendly with 14pt font and double line spacing (Rose, Worrall, Hickson, & Hoffman, 2011, 2014). Increasing the font size and spacing was expected to facilitate participation for everyone, not just those with aphasia.

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[5] For further information about this approach, see Talmage et al. (2013).

[6] Registered with the NZ Music Therapy Registration Board, http://www.musictherapy.org.nz/registration.

There were 41 participants in total, 17 from the CeleBRation Choir and 24 from the Cantabrainers Choir. As the two choirs had weekly attendance rates of about 40 members each, this was a response rate of approximately 51% for the combined sample. Participant characteristics are presented in Table 1.

## Study Measures

### Quality of Life

Quality of life was measured using the NZ WHOQOL-BREF. The scale is multi-dimensional: it presents a four-domain quality of life profile (physical, psychological, social relationships and environment). The psychological and social domains contained items added specifically for New Zealanders in the New Zealand standardisation study (Billington et al., 2010). Two comprehensive questions to capture subjective quality of life and health satisfaction sit alongside the domain scores. Items are scored on a five-point Likert scale from one (most negative option) to five (most positive option). For more information refer to Table 2 and associated literature (Billington et al., 2010; Power & Green, 2010).

### Choir Participation Questionnaire

Willems (2010) argues against the use of quantitative quality of life measures for people with disabilities suggesting that differences in question interpretation can confound the outcome. Willems (2010) proposes that the best way to evaluate quality of life in people with disabilities is simply to ask them about it. Participants completed a choir participation questionnaire covering a range of factors specific to choir including location, timing and frequency. It also sought to capture participants' perceptions of the impact of the choir on their mood and condition, and the aspects of choir that participants enjoyed the most.

Quantitative items were scored on a Visual Analogue Scale (VAS). This scale is typically used for characteristics that are difficult to measure directly (Wewers & Lowe, 1990). It involves a score range of 0 to 100 represented by a millimetre scale line, oriented from negative to

Table 1.

| Demographic characteristics of the sample | | | | | |
|---|---|---|---|---|---|
| | | CeleBRation Choir | | Cantabrainers Choir | |
| | | Number | % | Number | % |
| | Participants | 17 | 41.5% | 24 | 58.5% |
| Age | | | | | |
| | 30–44 | – | – | 2 | 4.9% |
| | 45–59 | 3 | 7.3% | 4 | 9.8% |
| | 60+ | 14 | 34.1% | 18 | 43.9% |
| Sex | | | | | |
| | Female | 8 | 19.5% | 7 | 17.1% |
| | Male | 8 | 19.5% | 12 | 29.3% |
| Ethnicity | | | | | |
| | NZ European | 9 | 22.0% | 20 | 48.8% |
| | European | 1 | 2.4% | 2 | 4.9% |
| | Indian | – | – | 1 | 2.4% |
| | Other | 3 | 7.3% | 1 | 2.4% |
| Number of conditions | | | | | |
| | Single | 9 | 21.9% | 13 | 31.7% |
| | Multiple | 8 | 19.5% | 11 | 26.8% |
| Diagnosis | | | | | |
| | Parkinson's | 7 | 17.1% | 9 | 22.0% |
| | Stroke | 5 | 12.2% | 7 | 17.1% |
| | Aphasia | 5 | 12.2% | 4 | 9.8% |
| | Cerebral Palsy | – | – | 2 | 4.9% |
| | Other | 4 | 9.8% | 5 | 12.2% |
| Marital status | | | | | |
| | Single | 1 | 2.4% | 3 | 7.3% |
| | Married | 9 | 22.0% | 14 | 34.1% |
| | Living as married | 1 | 2.4% | 1 | 2.4% |
| | Separated | – | – | 2 | 4.9% |
| | Divorced | 3 | 7.3% | 3 | 7.3% |
| | Widowed | – | – | 1 | 2.4% |
| Education | | | | | |
| | Primary | – | – | 1 | 2.4% |
| | Secondary | 4 | 9.8% | 15 | 36.6% |
| | Tertiary | 10 | 24.4% | 8 | 19.5% |
| Employment | | | | | |
| | Retired | 10 | 24.4% | 17 | 41.5% |
| | Part time | – | – | 1 | 2.4% |
| | Unemployed | 1 | 2.4% | 6 | 14.6% |
| | Other | 3 | 7.3% | – | – |

Table 2.

| | No. of items | Areas addressed by the NZ WHOQOL-BREF |
|---|---|---|
| Item 1 | | |
| Overall quality of life | 1 | Quality of life |
| Item 2 | | |
| Health satisfaction | 1 | Health satisfaction |
| Physical domain | 7 | Capacity for work, reliance on medicine, activities of daily living, mobility, sleep and rest, fatigue, energy, pain and discomfort. |
| Psychological domain | 6 | Positive feelings, personal beliefs, thinking and concentration, body image, self-esteem and negative feelings. |
| Social relationships domain | 3 | Social relationships, sexual activity and social support. |
| Environmental domain | 8 | Physical safety and security, environment, finances, opportunities for acquiring new information and skills, participation in and opportunity for leisure and home environment |
| New Zealand items | | |
| Psychological domain | 4 | Ability to meet expectations feeling respected by others, managing personal difficulties and having a sense of control over their life. |
| Social relationships domain | 1 | Feelings of belonging. |

positive. Some researchers have cautioned against the use of VAS for stroke patients (Hilari & Boreham, 2013). Although visual hemi-neglect can occur post-stroke, there was no evidence of this affecting participants' use of the horizontal scale. Across participants completing the questionnaire independently, a range of responses using both sides of the scale were evident. Qualitative items were presented as open-ended questions with space for participants to write their answers below each question. Five participants' answers were recorded verbatim by their carer (n=4) or the researcher (n=1).

# Data Analysis

## Comparison of the Choir Sample to WHOQOL-BREF Disability Normative Values and NZ WHOQOL-BREF Reference Values

Confidence intervals were used to compare differences between mean item scores on the NZ WHOQOL-BREF and WHOQOL-BREF disability normative vales (from the WHOQOL-DIS sample) (Power & Green, 2010) and the New Zealand reference values (Billington, Gu, & Krägeloh, 2015), divided by gender. The New Zealand reference values were analysed by gender as there were gender effects in this sample and overall group data are not reported. The WHOQOL-DIS sample included about 2600 people from 15 countries with a range of physical disabilities, these included Parkinson's disease, sensory impairments and multiple sclerosis (Power & Green, 2010).

## Qualitative Data

A textual content analysis was applied to qualitative responses following a directed content analysis approach (Hsieh & Shannon, 2005). This analysis was concerned with understanding themes behind choir participation. Responses were read through multiple times to understand the content; then evaluated one at a time, in order of participant. Responses were disassembled into key words and concepts which were added to a tally chart. Repeated keywords or concepts added a check mark to the tally. Multiple items could emerge from each response.

These categories were organised under the NZ WHOQOL-BREF domain headings: physical, psychological, social relationships and environment. The environment, for the purpose of these qualitative analyses, was assumed to be the environment of the choir session.

## Results and Discussion

The data gathered supports both hypotheses. Choir participants had higher (better) scores on the NZ WHOQOL-BREF than the reference WHOQOL-DIS sample. While this is a positive finding it is important to note that the nature of this study means that we are unable to determine a causal relationship; it may be that participants had a higher quality of life than participants in the WHOQOL-DIS sample for reasons unrelated to choir. Clear themes emerged from participants' responses to the open-ended questions on the choir participation questionnaire. Participants indicated that perceived physical, psychological and social improvements were a result of their choir participation. These social relationships, along with the choir environment, were areas mentioned as contributing as an excellent choir session for participants.

The results of the study will be discussed in this section as they relate to the two hypotheses, their limitations and directions for future research.

### Hypothesis 1: The Quality of Life of Choir Participants

Within the choir sample there were no significant differences on any of the NZ WHOQOL-BREF scores between individual choirs or across number of conditions participants had. This suggests that if the choir participants receive benefits from choir participation, these benefits are similar for all members. If choir members have a high quality of life, despite living with a neurological condition, then perhaps this is related to choir participation.

Based on a simple comparison with the comparison sample and determining whether scores fell within the 95% confidence interval, the choir sample had higher mean scores for 22 of 26 items of the NZ WHOQOL-BREF compared to the WHOQOL-DIS sample (Power & Green, 2010) (Appendix A, Table A1).

These results are consistent with literature where healthy choir participants report high quality of life (Clift et al., 2010). The findings of the present study contrast with research by Shih et al. (2012), who did

not find any changes in quality of life scores of people with Parkinson's disease after a singing group intervention; however, they used a different quality of life scale, the VRQOL.

It was anticipated that choir participants would have lower scores than the New Zealand reference values, as these values are from studies with healthy adults (Billington, Gu, & Krägeloh, 2015). There were six items out of 26 where the mean scores of male and female choir participants were higher than the upper 95% confidence interval of the New Zealand reference values (see Appendix B). Four of these items were within the environment domain. As there are eight items in the domains, there may not be differences in the overall environment domain score. The remaining items were in the social relationships and psychological domain. As it is sometimes assumed that people with neurological disorders have lower levels of insight into their situation than a physically healthy person, the validity of these findings could be questioned. However, the participants rated their quality of life as lower than the New Zealand reference values in the physical domain, which suggests good insight.

The environmental domain was the highest domain within the choir sample (M= 15.86, SD = 2.09). It also contained the most items for which choir participants scored higher than the WHOQOL-DIS sample and New Zealand reference values. This was an unexpected finding. This domain covers the physical environment, home, satisfaction with health/social care, personal safety, and opportunities for leisure and acquiring new skills. It is possible that satisfaction with the environment and ability to participate in choir are intertwined. While the choirs related to this study are open entry, practical considerations such as transport can be barriers to participation. As choir members have access to transportation to attend choir, and possibly other activities, this may mean that the choirs, and those willing to participate in research, are made up of people with high quality of life in this area.

### Limitations.

The cross-sectional study design is unable to conclude that the quality of life scores relate to choir participation and it is unknown if any of the participants in the New Zealand reference group or the European disabilities group are choir members. The choir sample size was modest; the response rate of around 50% may indicate a non-response bias in the results (Griffin et al., 2010). It is possible that choir participants who were feeling more impacts from their conditions (such as communication difficulties) did not feel that they could participate. This may mean that this study includes members who are relatively healthy, which could lead to scores which are not representative of all choir participants.

## Hypothesis 2: Perceived benefits of choir participation

Data from the choir participation questionnaire[7] were used to relate the choir sample's NZ WHOQOL-BREF scores to benefits related to choir participation. Participants' answers strongly indicated that they perceived physical, psychological and social improvements to be related to their choir participation and that receiving these benefits contributed to an excellent and enjoyable choir session. This suggests that these perceived benefits are motivators to attend choir.

An inductive process of thematic coding revealed the following interrelated themes and subthemes:

1. Physical improvements:
    - Breathing
    - Volume
    - Speech
    - Tone and pitch

[7] Individual responses are not included in this article, for reasons of space and ensuring participant confidentiality.

2. Psychological improvements:
    - Enthusiasm
    - Mood
    - Confidence
    - Concentration
    - Learning
3. Relationships:
    - Camaraderie, friendship and other members
    - Being involved
    - Choir leaders and volunteers
4. Choir environment:
    - Choir leaders and volunteers
    - Tea break
    - Good atmosphere
    - Good music
    - Fun

There was a high mean level of agreement that participating in choir improved mood (M= 71.81, SD= 22.28) and condition (M= 68.44, SD= 23.05). However, the large range of responses (mood: 8 – 100, condition: 15 – 100) suggests that many choir participants did not perceive improvement, yet attend regardless. Qualitative responses to item 13 ("If you have felt any changes as a result of the choir, what do you think they are?") mentioned perceived positive physical, psychological and social changes as a result of the choir. These improvements are consistent with qualitative literature on the perceived benefits of choir participation (Bidwell et al., 2012; Clements-Cortés, 2013; Fogg-Rogers et al., 2016; Grocke et al., 2014; Skingley & Bungay, 2010).

When asked to state the characteristics of an excellent choir session and to describe any aspects about choir that they liked, participants mentioned receiving perceived physical, psychological and social benefits. Participants' answers strongly indicated that they perceived these benefits to be related to their participation in choir and that receiving these benefits contributed to an excellent and enjoyable choir

session. Overwhelmingly, participants mentioned the social nature and the environment of the choir session as essential elements in a successful, enjoyable choir session. This suggests that these perceived benefits are motivators to attend choir. Many of these aspects sit within the theoretical framework, suggesting that an excellent and enjoyable choir session provides the theoretical mechanisms through which quality of life can be improved.

Participants perceived physical improvements in breathing, volume of voice, and speech. For people living with Parkinson's disease and stroke, the most common conditions in this study sample, physical consequences of their condition can be barriers to quality of life (Cubo et al., 2002; Tang et al., 2014). It is possible that improving these areas could improve relative quality of life. Choir participants also perceived improvements in their enthusiasm, mood and confidence. Feelings of low mood are common for people with neurological disorders. As with physical limitations this can be a barrier to quality of life (Cubo et al., 2002). Psychological improvements from musical participation are consistent with the literature where music therapy has been shown to improve mood for people living with Parkinson's disease and stroke (Pacchetti et al., 2000; Särkämö et al., 2008).

Consistent with Livesey et al. (2012), cognitive stimulation was an important aspect of choir sessions for members. Participants mentioned cognitive stimulation coming from excellent sessions involving lots of singing with a challenge that was not too difficult. Talmage et al. (2013) provide examples of how music therapists ensure that materials used are within reach for their choir members, assessing and incorporating relevant and appropriate techniques and strategies in order to facilitate achievement. Livesey et al. (2012) also found that participants reported that choir participation gave them autonomy and control over improving their skills. It is possible that the participants in this study see choir participation as a way to take control of their condition and that they attend choir because they are motivated to improve their conditions thus improving their quality of life.

Qualitative responses heavily endorsed the social benefits participants felt they received from participating in choir. Isolation may be one of the biggest barriers to quality of life for people with neurological disorders (Tang et al., 2014). Isolation is often caused or increased by the physical and psychological impacts of the condition, particularly as it relates to speech (Tang et al., 2014). As mentioned above, people living with Parkinson's disease and stroke often have trouble with speech (such as breath control and volume) which can cause them to withdraw socially (Cubo et al., 2002; Tang et al., 2014). Low mood can have similar effects (Alguren, Fridlund, Cieza, Sunnerhagen, & Christensson, 2012). Participants mentioned that they enjoyed belonging to a group. They valued the opportunity to socialise with people who have similar challenges. This is consistent with Davidson et al. (2014) who found that participants emphasised positive social aspects of an eight-week singing programme. Singing in a choir is an opportunity for group connection which increases social capital. High social capital is thought to be a contributor to high quality of life (Rosso, Taylor, Tabb & Michael, 2013). Social support is thought to ameliorate the physical and psychological risks to quality of life (Alguren et al., 2012). Responses from choir participants indicate that choir provides a valued opportunity for social interaction, and this facilitates social support which may improve quality of life (Ross et al., 2006).

It has been suggested that participation in choirs is more meaningful than participation in other group activities (Stewart & Londsale, 2016). Clift et al. (2010) suggested that group singing is meaningful because of the group processes and creativity within it. Participation in a meaningful activity has been shown to increase an individual's sense of life control and self-esteem (Cohen, 2009). This is particularly true of older individuals, like the choir sample. Quality of life of older adults can be improved through participation in an activity which they consider to be meaningful (Kane, 2001). The positivity with which choir members described the choir environment may indicate that a feeling of meaningful group connection was high within the group. One participant mentioned "just being here" as something they enjoyed.

### Limitations

The participants' communication difficulties may have affected their capacity to respond fully. Responses to open-ended questions (written by the participant or recorded verbatim by the support person) were usually short, commonly bullet points or short sentences; this may suggest that some participants were not able to fully express themselves using this form of data collection.

It is also important to note that the study may not have captured any negatives that participants attributed to their choir participation. Participants were asked to rate how enjoyable they found choir sessions on the VAS scale. Participants were asked to describe what they liked about choir, they were also asked for comments or suggestions for improving the choir but not specifically asked to describe what they did not like. This may have missed capturing any negative effects of choir participation, which could be incorporated in future research.

## Conclusion and Recommendations

This study aimed to explore how benefits of choir participation may influence quality of life for people with a neurological condition. People living with neurological conditions, such as Parkinson's disease and stroke, can find that the physical complications of the condition reduce social participation. Choir gives members an opportunity for social participation. This participation is an avenue for participants to increase their social support, which leads to a higher quality of life (Ross, Winslow, Marchant, & Brumfitt, 2006). Choir participation can provide the social support needed to mediate the negative impact of neurological conditions on quality of (Lynch et al., 2008).

Choir participants had higher scores on the NZ WHOQOL-BREF than the WHOQOL-DIS sample – a higher quality of life than the reference sample of people with disabilities (Power & Green, 2010). These figures are exciting, but should be treated with caution, and further research is recommended. While this may be due to choir participants' personal qualities or the different context within New Zealand, rather than the

influence of singing in a choir, the qualitative findings strongly support benefits of choir participation for improved quality of life.

Two areas are suggested for future research:

1. **A randomised control trial to determine causality in this relationship between choral singing and improved quality of life.**

   This would compare baseline and endpoint quality of life scores for individuals matched for health satisfaction, alongside a control group.

2. **Evaluating quality of life through qualitative measures.**

   Previous research has identified difficulties in researching this field, due to the inconsistencies found between quantitative and qualitative data, and challenges for people with neurological and communication difficulties. It is possible that qualitative responses may provide a clearer picture of participants' quality of life. This could be achieved through collecting qualitative responses to the items measured by the NZ WHOQOL-BREF, with sufficient time and support for participants to respond fully.

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# Appendix A

Table A1. Choir sample mean item scores compared to the WHOQOL-DIS sample (Power & Green, 2010).

| | Choir sample mean scores | | | WHOQOL-DIS mean score | | | WHOQOL-DIS 95% CI | |
|---|---|---|---|---|---|---|---|---|
| | N | M | SD | N | M | SD | upper | lower |
| Q1 (quality of life) | 38 | **3.95** | 1.04 | 2593 | 3.08 | 0.95 | 3.12 | 3.04 |
| Q2 (health satisfaction) | 38 | **3.29** | 1.04 | 2602 | 2.74 | 1.03 | 2.78 | 2.70 |
| Physical | | | | | | | | |
| Q3 (pain) | 38 | **3.76** | 0.99 | 2580 | 2.84 | 1.22 | 2.89 | 2.79 |
| Q4 (medication) | 38 | 3.08 | 1.09 | 2583 | 3.16 | 1.26 | 3.21 | 3.11 |
| Q10 (energy) | 38 | **3.45** | 0.76 | 2599 | 3.06 | 1.06 | 3.10 | 3.02 |
| Q15 (mobility) | 38 | **3.53** | 0.79 | 2595 | 2.89 | 1.18 | 2.94 | 2.84 |
| Q16 (sleep) | 38 | **3.37** | 1.30 | 2595 | 3.21 | 1.10 | 3.25 | 3.17 |
| Q17 (daily living) | 38 | **3.58** | 0.95 | 2596 | 2.96 | 1.02 | 3.00 | 2.92 |
| Q18 (work) | 38 | 2.72 | 1.25 | 2538 | 2.79 | 1.08 | 2.83 | 2.75 |
| Psychological | | | | | | | | |
| Q5 (positivity) | 38 | **3.89** | 0.65 | 2594 | 3.17 | 1.00 | 3.21 | 3.13 |
| Q6 (spirituality) | 38 | **3.68** | 0.84 | 2583 | 3.33 | 1.03 | 3.37 | 3.29 |
| Q7 (concentration) | 38 | 3.18 | 0.73 | 2597 | 3.28 | 0.96 | 3.32 | 3.24 |
| Q11 (body image) | 38 | **3.62** | 0.85 | 2599 | 3.30 | 1.11 | 3.34 | 3.26 |
| Q19 (self-esteem) | 38 | **3.53** | 0.92 | 2584 | 3.18 | 0.99 | 3.22 | 3.14 |
| Q26 (negativity) | 38 | **3.68** | 0.62 | 2596 | 2.76 | 0.99 | 2.80 | 2.72 |
| Social Relationships | | | | | | | | |
| Q20 (relationships) | 38 | **3.96** | 0.92 | 2587 | 3.56 | 0.97 | 3.60 | 3.52 |
| Q21 (sexual activity) | 38 | 2.92 | 1.14 | 2117 | 2.93 | 1.14 | 2.98 | 2.88 |
| Q22 (social support) | 38 | **4.13** | 0.74 | 2581 | 3.54 | 1.01 | 3.58 | 3.50 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Environment | | | | | | | | |
| Q8 (safety) | 38 | **3.89** | 0.73 | 2589 | 3.27 | 0.96 | 3.31 | 3.23 |
| Q9 (environment) | 38 | **3.99** | 0.62 | 2585 | 3.34 | 0.94 | 3.38 | 3.30 |
| Q12 (finance) | 38 | **3.50** | 0.89 | 2592 | 2.74 | 1.14 | 2.78 | 2.70 |
| Q13 (information) | 38 | **3.79** | 0.78 | 2588 | 3.30 | 1.03 | 3.34 | 3.26 |
| Q14 (leisure activities) | 38 | **3.61** | 0.75 | 2583 | 2.97 | 1.17 | 3.02 | 2.92 |
| Q23 (home) | 38 | **4.39** | 0.79 | 2587 | 3.55 | 0.98 | 3.59 | 3.51 |
| Q24 (health/social care) | 38 | **4.34** | 0.85 | 2592 | 3.35 | 0.93 | 3.39 | 3.31 |
| Q25 (transport) | 38 | **4.20** | 1.08 | 2587 | 3.28 | 1.04 | 3.32 | 3.24 |

*Note*. Choir sample means higher than the WHOQOL-DIS values and outside of the 95% CI are indicated in bold.

# Appendix B

Table B1. Choir sample mean item scores compared to the New Zealand reference values by gender (NZ WHOQOL group).

| | | Choir sample | | | NZ reference values | | | NZ Reference 95% CI | |
|---|---|---|---|---|---|---|---|---|---|
| | M=Male F=female | N | M | SD | N | M | SD | Upper | Lower |
| Q1 | M | 19 | 3.95 | 1.03 | 1205 | 4.09 | 0.83 | 4.14 | 4.04 |
| (quality of life) | F | 13 | 3.85 | 1.21 | 2308 | 4.09 | 0.88 | 4.13 | 4.05 |
| Q2 | M | 19 | 3.47 | 0.90 | 1203 | 3.78 | 0.94 | 3.83 | 3.73 |
| (health satisfaction) | F | 13 | 3.08 | 1.26 | 2310 | 3.70 | 1.03 | 3.74 | 3.66 |
| Physical | | | | | | | | | |
| Q3 | M | 19 | **3.89** | 0.99 | 1219 | 3.71 | 0.97 | 3.76 | 3.66 |
| (pain) | F | 13 | 3.69 | 1.03 | 2355 | 3.68 | 0.94 | 3.72 | 3.64 |
| Q4 | M | 19 | 3.32 | 1.06 | 1219 | 3.71 | 0.96 | 3.76 | 3.66 |
| (medication) | F | 13 | 2.92 | 1.32 | 2355 | 3.70 | 0.94 | 3.74 | 3.66 |
| Q10 | M | 19 | 3.54 | 0.84 | 1219 | 3.70 | 0.9 | 3.75 | 3.65 |
| (energy) | F | 13 | 3.31 | 0.75 | 2353 | 3.49 | 0.93 | 3.53 | 3.45 |
| Q15 | M | 19 | 3.26 | 0.93 | 1219 | 4.08 | 0.88 | 4.13 | 4.03 |
| (mobility) | F | 13 | 3.69 | 0.48 | 2352 | 4.19 | 0.84 | 4.22 | 4.16 |
| Q16 | M | 19 | 3.21 | 1.28 | 1219 | 3.52 | 1.10 | 3.58 | 3.46 |
| (sleep) | F | 13 | **3.62** | 1.44 | 2351 | 3.38 | 1.14 | 3.43 | 3.33 |
| Q17 | M | 19 | 3.43 | 1.12 | 1219 | 3.95 | 0.87 | 4.00 | 3.90 |
| (daily living) | F | 13 | 3.85 | 0.80 | 2352 | 3.90 | 0.93 | 3.94 | 3.86 |
| Q18 | M | 19 | 2.56 | 1.28 | 1219 | 3.74 | 1.00 | 3.80 | 3.68 |
| (work) | F | 13 | 3.05 | 1.24 | 2351 | 3.74 | 1.01 | 3.80 | 3.70 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Psychological | | | | | | | | | |
| Q5 | M | 19 | 3.84 | 0.60 | 1223 | 3.93 | 0.83 | 3.98 | 3.88 |
| (positivity) | F | 13 | **3.92** | 0.76 | 2354 | 3.88 | 0.86 | 3.91 | 3.85 |
| Q6 | M | 19 | 3.53 | 0.90 | 1223 | 3.76 | 0.88 | 3.81 | 3.71 |
| (spirituality) | F | 13 | 3.85 | 0.80 | 2354 | 3.83 | 0.92 | 3.87 | 3.79 |
| Q7 | M | 19 | 3.42 | 0.61 | 1223 | 3.63 | 0.81 | 3.68 | 3.58 |
| (concentration) | F | 13 | 3.08 | 0.76 | 2354 | 3.60 | 0.83 | 3.63 | 3.57 |
| Q11 | M | 19 | 3.53 | 0.96 | 1223 | 3.77 | 0.94 | 3.82 | 3.72 |
| (body image) | F | 13 | **3.69** | 0.85 | 2354 | 3.40 | 1.03 | 3.44 | 3.36 |
| Q19 | M | 19 | 3.37 | 0.96 | 1223 | 3.89 | 0.90 | 3.94 | 3.84 |
| (self-esteem) | F | 13 | 3.77 | 0.93 | 2354 | 3.73 | 0.99 | 3.77 | 3.69 |
| Q26 | M | 19 | **3.68** | 0.58 | 1223 | 3.61 | 0.89 | 3.65 | 3.56 |
| (negativity) | F | 13 | **3.69** | 0.75 | 2356 | 3.51 | 0.91 | 3.55 | 3.47 |
| Social relationships | | | | | | | | | |
| Q20 | M | 19 | 3.29 | 1.03 | 1218 | 3.96 | 1.01 | 4.02 | 3.90 |
| (relationships) | F | 13 | **4.15** | 0.8 | 2333 | 3.84 | 1.09 | 3.88 | 3.80 |
| Q21 | M | 19 | 3.03 | 1.07 | 1218 | 3.50 | 1.24 | 3.57 | 3.43 |
| (sexual activity) | F | 13 | 2.87 | 1.07 | 2330 | 3.49 | 1.24 | 3.54 | 3.44 |
| Q22 | M | 19 | **4.05** | 0.78 | 1218 | 3.92 | 0.90 | 3.97 | 3.90 |
| (social support) | F | 13 | **4.15** | 0.8 | 2340 | 3.98 | 0.96 | 4.02 | 3.94 |
| Environment | | | | | | | | | |
| Q8 | M | 19 | **4.04** | 0.71 | 1223 | 3.95 | 0.79 | 3.99 | 3.91 |
| (safety) | F | 13 | 3.69 | 0.85 | 2356 | 3.89 | 0.83 | 3.92 | 3.86 |
| Q9 | M | 19 | **4.05** | 0.62 | 1222 | 3.82 | 0.79 | 3.86 | 3.78 |
| (environment) | F | 13 | **4.07** | 0.64 | 2356 | 3.81 | 0.85 | 3.84 | 3.78 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Q12 | M | 19 | 3.26 | 1.11 | 1223 | 3.38 | 1.14 | 3.44 | 3.32 |
| (finance) | F | 13 | **3.77** | 0.6 | 2356 | 3.18 | 1.19 | 3.23 | 3.13 |
| Q13 | M | 19 | 3.74 | 0.73 | 1222 | 3.88 | 0.83 | 3.96 | 3.83 |
| (information) | F | 13 | **4.08** | 0.76 | 2355 | 3.82 | 0.86 | 3.85 | 3.80 |
| Q14 | M | 19 | 3.47 | 0.77 | 1222 | 3.55 | 0.95 | 3.60 | 3.50 |
| (leisure activities) | F | 13 | **3.77** | 0.72 | 2354 | 3.29 | 1.05 | 3.33 | 3.25 |
| Q23 | M | 19 | **4.21** | 0.96 | 1223 | 4.09 | 0.95 | 4.14 | 4.04 |
| (home) | F | 13 | **4.46** | 0.52 | 2358 | 4.03 | 1.04 | 4.07 | 3.98 |
| Q24 | M | 19 | **4.26** | 0.87 | 1223 | 3.97 | 0.88 | 4.02 | 3.92 |
| (health/social care) | F | 13 | **4.38** | 0.87 | 2358 | 3.99 | 0.97 | 4.03 | 3.95 |
| Q25 | M | 19 | **4.28** | 1.07 | 1223 | 4.03 | 0.99 | 4.10 | 3.97 |
| (transport) | F | 13 | **4.20** | 1.08 | 2357 | 4.01 | 1.00 | 4.05 | 3.97 |

*Note.* Choir sample means higher than the New Zealand reference means and outside of the 95% confidence interval are indicated in bold.

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# A Behavioural Study Exploring the Use of Originally Composed Songs to Encourage Children at a Japanese Day Treatment Facility to Transition between Activities

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**Keywords:** Music, children, developmental disabilities, single-subject design, behavioural approaches

## Abstract

This behavioural study, with single-subject research design, examined the use of originally composed songs to encourage children with developmental disabilities to put toys away during the transition from free play to a group activity. The participants were three children, aged three to five years, who had been diagnosed with autism spectrum disorder or intellectual disability. One song was employed as a prompt to encourage the participants to initiate tidying up (Intervention I), whereas another song was a reward for completing the task (Intervention II). Observational data were analysed to examine whether there were any differences in the results between two interventions and between participants. The results indicated that all participants improved in Intervention I or II compared with baseline; however, the function of music and its effects differed among participants. The use of music and the participant responses were closely evaluated on the basis of behavioural observations and the time required for task completion. Although we recognise that behavioural frameworks are

less common in New Zealand music therapy, this approach and our findings are relevant to professionals who may wish to work in this way for particular purposes.

## Introduction

As music is used regularly in children's learning environments, experts in the fields of music, special education and music therapy have explored its potential in supporting children with special needs to improve their skills in various areas. Although international studies suggest that the therapeutic use of music helps children with special needs, music therapy has not yet been successfully introduced into special education in Japan. One possible reason is a lack of opportunities for parents, teachers and other staff to learn about it – many are interested, but do not have a clear idea of how music could be integrated into children's daily lives and focused on their individual needs. As behavioural approaches are widely used by Japanese parents and teachers of children with special needs, the integration of music into these behavioural strategies might begin to bridge music therapy and special education. Although we recognise that behavioural frameworks are less common in New Zealand music therapy, this approach and our findings are relevant to professionals who may wish to work in this way for particular purposes.

This study was part of a postgraduate course in disability studies, and was approved by the University of Tsukuba Ethics Committee for Research in the Faculty of Human Sciences. The first author is a Japanese music therapist, who trained in behavioural music therapy in the USA. On returning to Japan, she enrolled in graduate disability studies, to explore the applied use of music to support children with special needs. Prior to the study, she had been visiting the facility twice a week, to volunteer and provide music activities. In addition to her doctoral research, she aims to educate care workers and parents about the integration of music in the daily lives of their children. The second author, who supervised the work, is a Japanese professor with extensive experience in research with children with autism spectrum disorders.

## Literature Review

In the context of a Japanese special education system that favours behavioural approaches, there is a need to investigate whether music can function not only as a prompt, but also as an effective reward for all or some younger children with special needs in particular situations in their natural environment. A brief literature view identified several studies supporting the use of music to help children to achieve therapeutic or educational goals, often focusing on behaviour and social skills.

When looking at the behaviour of children with autism, Lanovaz, Sladeczek and Rapp (2011, 2012) found that the use of recorded music reduced immediate vocal stereotypy[1]. This research built on previous studies suggesting that reducing children's stereotypy might improve learning (Lang et al, 2009). Music has also been incorporated into the Applied Behaviour Analysis Verbal Behaviour Approach, with particular benefits for participants with very high needs, and for reducing echolalia[2] (Lim, 2010a; Lim & Draper, 2011). The improvement of social skills is another common goal. Katagiri (2009) reported improvements in children's emotional understanding when background music was used, together with verbal instructions to teach four emotions: happiness, sadness, anger, and fear. Music has also been integrated with social stories[3], resulting in a decrease in children's challenging behaviour (De Mers, Tincani, Van Norman, & Higgins, 2009; Schwartzberg & Silverman, 2013).

While these studies have shown positive benefits from dedicated music sessions targeting specific skills, other studies have explored a more naturalistic approach, embedding music into the children's daily routines and activities. Pasiali (2004) took social stories, that focussed

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[1] "Vocal stereotypy": persistent verbal responses without apparent meaning, that tend to recur inappropriately (Ministries of Health and Education, 2016).

[2] "Echolalia": repetition of speech produced by others (Ministries of Health and Education, 2016).

[3] The concept of Social Stories was devised by Gray (2017).

on behavioural goals at home, and adapted these as lyrics set to the children's favourite songs. Playing the songs at home resulted in decreased inappropriate behaviour. Kern and colleagues taught classroom teachers original songs for use within existing schedules, to encourage young children to complete daily tasks independently (Kern, Wakeford, & Aldridge, 2007; Kern, Wolery, & Aldridge, 2007). In this study, the use of songs led to improvements in the children's independent hand-washing, toileting, tidying up, and morning greeting, even if they were sung by classroom teachers with no advanced musical background.

The predominant function of music in these studies was as a prompt. The use of music as a prompt derives from its temporal nature – the way in which music marks and structures time, and creates expectation. Within behavioural approaches, a key feature is the use of reward to motivate and reinforce the desired responses or behaviour. However, the effects of music as reward for young people have not yet been fully investigated. Lim (2010b) found that music stimuli worked as both a prompt and an automatic reward, but she did not directly examine the function of music as reward. A meta-analysis two decades ago by Standley (1996) found 98 studies that demonstrated the effectiveness of contingent music as reward, but the participants in most of these studies were school-aged or older. Few recent studies have explored this issue within a behavioural context. However, Register and Humpal (2007) found that musical transition (i.e. using music to support activity changes during the daily programme) was effective in a variety of settings. Building on this finding, the present authors decided to explore the use of songs as prompt and reward, when integrated into children's tidying up routine.

The use of a naturalistic environment and collaboration with existing carers, was encouraged by Twyford (2009). Twyford recommended providing music therapy in inclusive settings (general classrooms, integrating all children) which are the most natural environment for children and encourage generalization of skills acquired in music therapy sessions. When introducing music therapy to the team of

specialist services for children with special educational needs, Twyford also found it is important to encourage parents, teachers and other staff to play an active role in sessions so that they could learn strategies to use once the music therapy provision ended.

Although this study took place in a specialist setting, rather than the integrated setting recommended by Twyford, the use of existing staff was integral to the approach. Building on Register and Humpal (2007) the study aimed to examine whether songs could be effective as prompts and rewards during transition times in the children's daily programme.

# Research Design

## Setting

The study was conducted at a day-treatment facility in Japan for children aged six and under. This educational support centre provides services to meet individual needs, which cannot be addressed in regular preschool or kindergarten. Most children come to the facility a few days a week and attend regular pre-school or kindergarten for the rest of the week. Each child visits the facility from one to five days a week, depending on how much support they need. The children follow their own visual schedules, which include morning gathering, toileting, hand washing, a snack, academic tasks, free play, group activity, lunch, and brushing teeth.

Prior to the study, at the day treatment centre, the transition from free play to group activity was challenging for many of the children. The children were expected to put away their toys and then take a seat in the group activity room. If one child took longer than their peers, the other children needed to wait, became restless, and sometimes started running around. The longer the time needed to tidy up, the more likely the children would find it hard to stay seated. A timer was used as a prompt for the children to start putting the toys away, but this did not

seem to be effective. A more structured transition was needed, and this became the focus of the present study.

## Research Questions

The first author hypothesised that a song as a prompt would encourage children to initiate the task, and a song as a reward would encourage children to complete the tidying task. It was expected that the latency would decrease if the song was provided as a prompt (Intervention I), and that the time taken for a tidying task would decrease, if the song was provided as a reward (Intervention II). Previous research has shown that music function as an effective prompt to help children make transitions (Register & Humpal, 2007), some children need support to initiate tasks, whereas others need support to complete tasks. This study explored whether optimum timing for using the song would be different for each child. If a song as reward made the transition easier for particular children, this option might be beneficial for other children with similar learning needs.

## Participants

The researcher explained the purpose and format of the study to the parents of children who attended the facility at least three days a week. Three families gave written consent for their child to participate in the study. To maintain privacy and confidentiality, all of the participants' names used in this article are pseudonyms – Kei, Ichiro and Shizuka. The parents completed a short questionnaire about their children's musical interests. All three reported that the children had frequent opportunities to listen to music at home, and that none seemed uncomfortable when the music was playing. All of the participants preferred "fun" music to "soothing" music. The researcher had observed similar preferences during music time at the facility.

Kei was a 3-year-old boy with autism spectrum disorder. His developmental age was 14 months on the Tsumori-Inage Infant Developmental Scale, a parent questionnaire commonly used in Japan (Kurita, Osada, Shimizu, & Tachimori, 2003). Kei had no functional

verbal communication and had difficulty understanding directions. The care workers used concrete objects as cues: for example, soap for hand washing, or a lunch box for lunch. Kei loved playing with particular objects, such as colourful beads, and he found it very difficult to finish playing with an object before he was ready. When he refused to follow directions, he often cried or expressed his anger through behaviour. He was able to play alongside his peers, but he had never played interactively. If he needed help, he pulled a care worker's hand towards an object. He was unable to sit still on a chair during group activities and often left the room in the middle of activities.

Ichiro was a 5-year-old boy with an intellectual disability. He had grown up with three older brothers, and this family structure seemed to have helped him to be friendly and to communicate with others spontaneously. Ichiro used single words, as well as behaviour, to express what he wanted. Ichiro loved to listen to music in group activity time. Whenever the researcher arrived at the facility, he recognised her as a symbol of "music time" and ran around to tell his peers they would be having music. He even brought some chairs and helped her set up the room.

Shizuka was a 3-year-old girl diagnosed with autism spectrum disorder. She understood and followed verbal directions well, and did not need visual or physical prompts for daily tasks. She rarely used words to express her needs to peers or staff, although her mother mentioned that she did so at home. Shizuka liked to play with care workers, and led a care worker by the hand wherever she went. She completed more advanced tasks during musical activities, and also sang familiar songs with the researcher.

## Method

Baseline data were collected for three weeks, and Interventions I and II were scheduled to be implemented for five weeks each.

At the time of transition from free play to the group activity, children were required to respond to the sound of a familiar timer, by starting to

put their toys. They were expected to check the next activity on their individual visual schedule, take a seat in the room where the group activity would be, and wait for their peers. During the baseline period, the care workers gave a verbal prompt, such as “It’s time to clean up”, when the timer rang. They waited for one minute without giving any further prompts to see whether the participants spontaneously initiated the task. After this, the care workers used as many prompts as the participants needed to complete the task. These included verbal prompts (e.g., “Where did you find this toy?” “Let’s go. We have a special art project to do today!”), visual prompts (e.g., showing the child the box to put the toy in, demonstrating how to tidy up), and physical prompts (e.g., patting on the back, leading by the hand). The care workers offered verbal praise when a participant took a seat.

During the intervention periods, two songs were used to support the transition from free play to a group activity. The researcher composed two original songs for use in this study (Appendix A), based on the parent questionnaires. Each song had a specific purpose. *Bye Bye Toy* was intended as a prompt to initiate the tidying task, and *We Did It!* was planned as a reward to encourage task completion. Two CD recordings were provided, so that the care workers could learn these songs.

During Intervention I (song as a prompt) a similar procedure was employed, but the care workers sang the song, *Bye Bye Toy*, instead of giving a verbal prompt when the timer rang. The lyrics of the song included directive phrases to encourage the children to start putting the toys away. After the song, which was about 30 seconds long, the care workers waited for one minute (measured on the stopwatch). Then the care workers followed the same procedure as at baseline to give other prompts and verbal praise.

During Intervention II (song as a reward) the care workers again gave a verbal prompt when the timer rang, followed by individualised further prompts if needed after one minute, and verbal praise for taking a seat. When all the children were seated, the care workers sang the song, *We Did It!* The lyrics included phrases to praise the children for completing the tidying task.

## Data Collection

To find out whether the songs motivated the children to initiate and complete the tidying task, timings were recorded. A maximum of 10 minutes was allowed for this transition period – if more time was needed, the timing was discontinued, to minimise any impact on other children's learning opportunities. The care worker working with each participant carried a stopwatch and measured the latency[4] period (i.e. the time before the child initiated the tidying task) by pressing start button when the timer rang and stop when the child initiated the task. The researcher measured the completion time for each participant – from the timer sounding to the child sitting down, whether or not they stood up again and walked around. Data were excluded if children passed toys to a care worker after sitting down, or went to the bathroom before taking a seat.

The researcher recorded the name of each participant's toy, to look for any correlation between the type of toy and the time taken. The children's chosen toys were grouped into seven categories (Table 1). Toy choice was considered in the analysis of the results.

Table 1. Toy categories

| | Category | Toys |
|---|---|---|
| A | Toy vehicles | Toy car, toy train |
| B | Games | Puzzle, blocks, board game |
| C | Pretend play | Toy phone, toy camera, toy laptop, princess play shoes |
| D | Music | CD, musical instruments, sound book |
| E | Small objects | Marbles, colourful pencil caps |
| F | Physical play | Ball, exercise mat |
| G | Outdoor play | Bubbles, swing, sandbox |

[4] In behavioural approaches, "latency" means the amount of time from when a prompt is given until a specific behaviour occurs.

These behavioural observations continued throughout the study. In order to collect detailed data on each participant's learning needs as well as response to the songs, the researcher also wrote daily observational notes.

## Data Analysis

The time measurements recorded for each child during baseline, intervention I and intervention II were graphed and analysed, looking for behavioural trends. The children's choice of toys was also recorded and compared with the time taken to tidy up.

# Results

The time recordings for each child were recorded and graphed. Figure 1 shows the latency period before each participant started putting the toy away, together with the category of toy they had been playing with. Figure 2 shows the length of time each participant spent on the tidying task itself, as well as the category of toy. Due to the scale of the vertical axis in Figure 2, some of the data points appear to be at 0 seconds, although the participants actually took a few seconds to tidy up. The shortest time taken to tidy up was 4 seconds on day 9, by Ichiro. On such days, when the timer rang, the participants were standing or sitting close to the place to which they were required to put the toys, so that they were able to complete the task quickly once they had started. The number of data points varied among participants because frequency of attendance varied (according to parental choice).

## Kei

Kei varied in the time needed to complete tasks. He actually performed better in initiating the tidying task in the baseline phase (Figure 1). However, although his performance was not consistent, the length of time he spent on the tidying task decreased in Intervention II (Figure 2a). Kei played with a category B toy approximately half the time, but

his performance was still inconsistent, even when only the Toy B days were considered.

Before the study, the care workers always carried Kei during transitions, as he was unable to understand the time frame. During the research period, Kei did not always refuse to stop playing, because the care worker encouraged him to put a toy away when he lost interest it and before he chose other toys. This was one reason why he was able to initiate the task faster in the baseline phase. However, his responses to the song or the sound of timer gradually changed – on Day 10, when the care worker started singing the song, he immediately walked away from the toy he was playing with, although he took time to come back and put the toy away.

## Ichiro

Ichiro initiated the tidying up task faster during Intervention II than at Baseline or in Intervention I. The variation between days also decreased in Intervention II, suggesting a more consistent response. Conversely, he took less time to complete the tidying task in Intervention I (Figure 2b). Ichiro mostly played with Toy C or Toy D during Intervention I, whereas he preferred physical play during Intervention II. These choices of toy or play could explain why he needed more time to initiate the task in Intervention I and to complete the task in Intervention II.

When Ichiro heard *Bye Bye Toy* in Intervention I, or the timer in Intervention II, he became very excited, anticipating the group activity. Then he usually began running before tidying up, and his peers sometimes cried or became upset when he tried to force them into the activity room. These incidents meant that Ichiro required more time to initiate and complete the task during Intervention I. The care workers responded by reminding him that his peers would come along once they had put their toys away. On Day 21, when a care worker talked to him in advance and reminded him to tidy up when he heard the timer, he was able to follow this direction, and completed the task by himself.

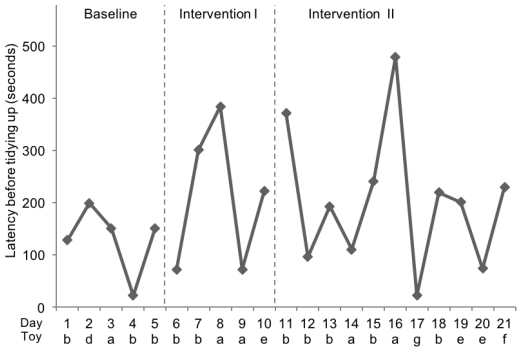


Figure 1a. Latency before the tidying task was initiated (Kei).

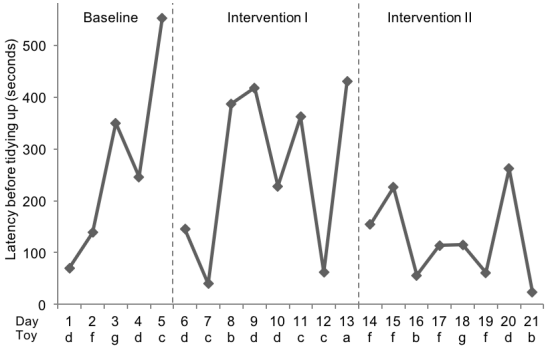


Figure 1b. Latency before the tidying task was initiated (Ichiro).

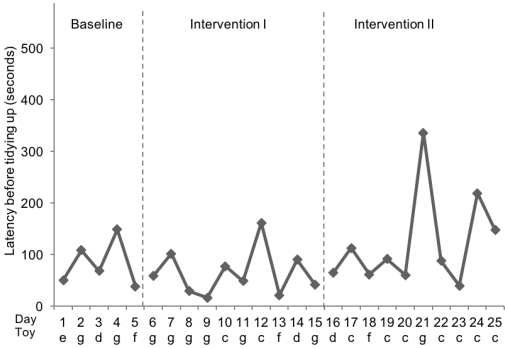


Figure 1c. Latency before the tidying task was initiated (Shizuka).

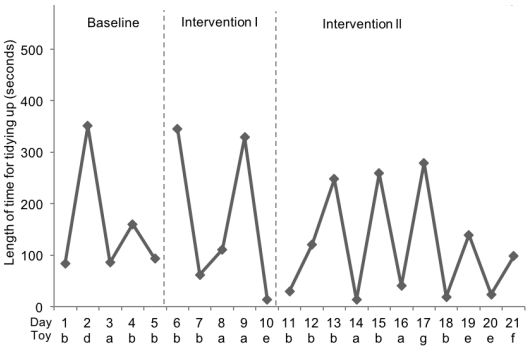


Figure 2a. Length of time required to complete the tidying task (Kei).

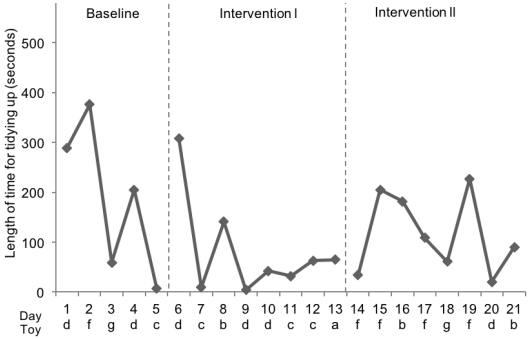


Figure 2b. Length of time required to complete the tidying task (Ichiro).

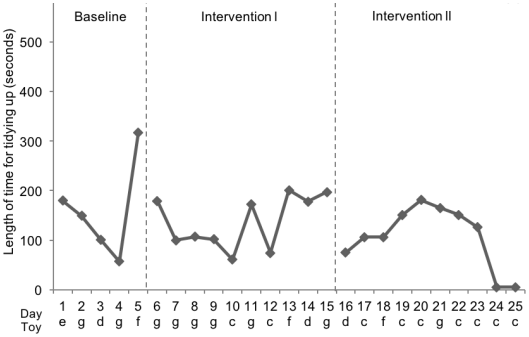


Figure 2c. Length of time required to complete the tidying task (Shizuka).

## Shizuka

Although Shizuka initiated the task quickly during Baseline and Intervention I, the latency increased in Intervention II (Figure 1c). In terms of the length of time she spent on the actual tidying task, however, she performed slightly better in Intervention II (Figure 2c). In the middle of the study, Shizuka began to follow an older peer, who was not a research participant, and she often copied what he did. If he touched the timer to extend the free play time, Shizuka touched the timer too. If he said "No" to tidying up his toys, she said "No." Shizuka followed directions and put her toy away if a care worker prompted her, but the latency period before initiating the tidying task increased in Intervention II, when she began to play more often with this peer. On Day 21, she was playing outside, and when the timer rang both Shizuka and her peer shouted, "I want to play more!"

Shizuka loved playing with bubbles in the first half of the study, and in Intervention II she enjoyed wearing princess play shoes. In addition to her frequent play with the older peer, this difference in toy and play preference increased the latency in Intervention II, as she particularly liked the princess play shoes and often refused to take them off!

# Discussion

The total time each participant took for transition was the sum of the latency (Figure 1) and the length of time taken for the tidying task (Figure 2). Compared with Baseline, the total time required for transition during Intervention I (song as prompt) decreased in the case of Ichiro and Shizuka. These results were similar to those of Register and Humpal's (2007) study.

## Kei

Although Kei did not respond to the sound of the timer, when he heard *Bye Bye Toy* in Intervention I, he looked around, saw that his peers were tidying up, and cried because he did not want to finish playing; then he started crying when he heard the timer. Therefore, although the latency

before the task increased after introduction of the songs, music functioned as an effective prompt and helped him to understand the time frame. Kei's response varied when he played with his preferred toys, puzzles or blocks, suggesting that the choice of toy did not influence his performance in the tidying task. He was participating more consistently toward the end of the study, and it might have improved if the study had continued for longer. Observation notes, made during and outside music activities, revealed that Kei seemed to have an interest in sounds. The care workers often used a sound book that played songs when a button was pressed, and he was able to sit and wait with the book. However, due to his very high learning needs and difficulty participating in group activities, within this behavioural framework additional rewards, such as food treats, might be considered.

## Ichiro

Ichiro's responses were influenced by his enjoyment of group activities, especially music activities provided by the researcher, and he took the researcher's arrival as a cue to stop playing and walk away from the toys, ready to transition to group work. However, he had difficulty putting the toys back into the toy box, and he wanted to go to the activity room before he had completed this task. In Ichiro's case, the group activity was also functioning as a reward for transition, and it was not difficult for him to finish playing. The focus was more on initiating the tidying task, which he tended to skip. Ichiro also tended to approach a peer and try to take him or her to the activity room. By reminding him that his peers would come along after they put their toys back, Ichiro gradually started learning the steps to the next activity – finishing play, putting a toy away, taking a seat, and waiting – partly because his peers began to respond to the songs. Eventually, he was able to initiate the task more smoothly in Intervention II. Ichiro sometimes sang *We Did It!* by himself, even after the group activities; this suggested that the song was one of his favourites and functioned as an effective reward.

## Shizuka

Compared with Kei and Ichiro, Shizuka had little difficulty following directions, so she readily completed the tidying task throughout the study. As Shizuka was relatively new to the facility, at the beginning of the study she rarely played with her peers, and only expressed her wants verbally to particular care workers. As she became used to the setting, she gradually started playing with her peers, although this brought another challenge, especially when she initiated the tidying task.

At the beginning of the study, Shizuka wanted to hold a care worker's hand wherever she went, even when walking to the toy box a few meters away. However, towards the end of the study she developed more independence, moving around without holding hands, even though her performance deteriorated slightly in terms of the time taken. This improvement might have reduced the time needed to tidy up, because she could then put toys away by herself without waiting for help. Shizuka quickly learned the songs and often sang along with the researcher. She even sang *Bye Bye Toy* to herself as she put the toy away during Intervention II – the phase in which care workers did not sing the song as a prompt. This could be another reason why she needed less time for tidying up in Intervention II.

## Summary

All three children showed improvements in the latency period or the time required for the tidying task in Interventions I and II, but the effect of music on each participant differed slightly. Using the song as a prompt supported Kei to understand the time frame and initiate the tidying task. In Intervention II, the song might not have functioned as a reward for Kei, but he recognised that the song symbolised the beginning of the next activity. Ichiro both initiated and completed the tidying task in response to a song as a reward. Shizuka required less time to initiate the task when the song was used as a prompt, and she completed the task more quickly with a song as reward.

# Limitations of the Study

## Sample Size

The sample size was limited because only four children regularly attended the day treatment centre more than three days a week. Research validity would also be increased by recruiting participants who attend more frequently, conducting a multi-site study, increasing the data collection period, and/or considering these factors in the analysis of a larger sample.

## Care Workers' Role and Training

This study did not include a structured evaluation of the care workers use of the songs, but they seemed uncomfortable singing *Bye Bye Toy*, and this seemed to be due to the rhythmic structure and inclusion of rests. The researcher included the rests in the song intentionally, as they provide a space for verbal praise; however, it was more difficult for the care workers to do this. Music therapists also use both their body and voice to attune to children (Archer, 2004) and other care workers may not have had this skill. Although CD recordings of both songs were left at the facility in this study, the care workers were not given a specific guidance and would have benefitted from training in how to implement the songs.

The study would also have been strengthened by analysis of the type of care worker supporting each child, and the number and type of prompts used – factors that are difficult to control in a naturalistic setting. This would require the use of video recording, which would have been difficult in this study because of the physical context (two rooms connected by a narrow hallway) and the likelihood that unfamiliar cameras would interrupt the children's play. It is also possible that some children preferred playing in one room or the other – this should be considered when recruiting participants for future studies, and the video could record in one room or the other.

## Song Structure

Song choice and style also require further consideration in future studies and professional practice. Although the researcher composed original songs on the basis of direct observations during music activity time and parent questionnaires, not all children learned the songs and sang along. The researchers believe this would increase task completion, although multi-tasking (singing and doing) might be a challenge for some children. Song writing would be enhanced through a systematic review of culturally relevant children's music and greater attention to individual musical preferences. Moreover, music therapists (particularly those working part-time) have limited time to provide hands-on training for parents, teachers, or other specialists, recommended above, so songs need to be easy to learn and sing. Original songs therefore need to take into account the needs of both the children and the adults working with them.

# Conclusions and Recommendations

As the author hypothesised, the song provided as a reward decreased the time taken for the tidying task in all participants although it was difficult for some participants to show a consistent response. The song as a prompt decreased the latency if the participants understood the steps in the transition. For one participant, the song as a reward was more effective and helpful to learn the steps. Therefore, depending on a child, when to implement music to produce the best benefits is different.

The results of this study suggest that children respond in different ways to the integration of an original song as prompt or reward in a daily activity. There were no significant differences between Interventions I and II, suggesting that music can be used as both a prompt and a reward in behavioural approaches teaching these children with developmental disabilities to put away their toys.

While music therapists may use a strategy with a group, with different individual goals, other staff may need more guidance and carefully

structured songs. However, the study has shown the potential for music therapists to act as consultants in supporting special educators to integrate music into existing behavioural frameworks. Applied use of music, based on existing frameworks, provides friendly introduction to music therapy. Further research is needed to validate this approach with a larger sample size.

## Acknowledgements

The authors wish to thank the children, families and staff at the treatment centre for participating in this research. Kumi Sato would also like to thank her supervisor, Professor Shigeki Sonoyama.

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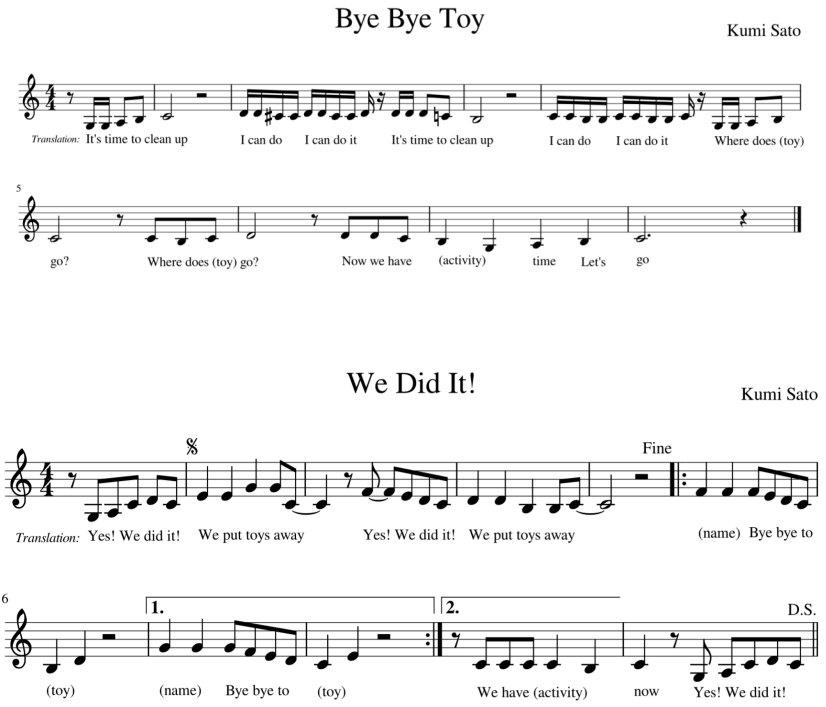
# Appendix A

Two original songs were composed for this study. Japanese lyrics were used during the study, but have been translated into English for this article.




## Suggested citation

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# Book Review

## Lathom-Radocy, W. (2017). *Peters' Music Therapy: An introduction* (3rd ed.). Springfield, IL: Charles C. Thomas.

REVIEWER:

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When *Peters' Music Therapy: An Introduction* (3rd edition) by Wanda Lathom-Radocy[1] was delivered to my office, with months to spare before submission of the review was required, I assumed that I would take it home and move through its 650 plus pages chronologically in the evenings and on weekends. However, later that week I was at my desk preparing a presentation for speech therapists, and found myself reaching for this book to see if it cited new research on music therapy and communication. What I found in Chapter 12, "Music Therapy for Individuals Who Have Communication Disorders or Impairments", was 30 pages that not only defined types of speech and language disorders, but also described therapeutic music experiences to develop the skills needed for communication, from breath control and articulation to fluency and inflection. The effectiveness of music therapy when working with individuals with communication disorders was expansively articulated and the chapter not only provided me with research to cite during my presentation, but gave me insights to share with some of the families with whom I work in my clinical practice.

Needless to say, *Peters' Music Therapy* stayed at my desk. I referenced it when investigating assessment tools which might lend themselves to multidisciplinary settings. I picked it up when preparing for a new client

[1] *Peters' Music Therapy: An Introduction* (3rd ed.) is a revision of Jacqueline Peters' *Music Therapy: An Introduction* (1987, 2002). The table of contents is very similar in the second and third editions.

consultation appointment in which the focus was bereavement, an area in which I had no experience. I sought out current research on working with children with cleft palates on receiving a parent enquiry, and suggested that a student music therapist read the Chapter 23, "Clinicians and Research". While *Peters' Music Therapy* was not able to provide answers to all of my queries, it proved to be an excellent desk reference in its thoroughness, clarity and organisation, and a great alternative to journal and book searches when in need of answers quickly.

Parts I and II of Lathom-Radocy's book focus on the history of music therapy, primarily in the United States, and the development of the training programmes and professional field in that country. While this information is focused quite regionally, the content in the chapters that open the third part of the book, which focuses on the general guidelines for the therapeutic use of music, would be more recognisable to music therapists around the world. However, it is this section of *Peters' Music Therapy* which made me question the target audience of this quite lengthy book. Between them, Chapter 5, "General Guidelines for the Therapeutic Use of Music, Part I: Theoretical Principles" and Chapter 6, "General Guidelines for the Therapeutic Use of Music, Part II: Practical Planning", cover, in just 50 pages, the basic principles that were taught in a year and a half of my undergraduate coursework. The information is presented too cursorily to provide true understanding of the theoretical and practical principles of music therapy for music therapy students and practitioners, but the almost 500 pages which follow and discuss music therapy for a wide variety of clinical populations would be far too intensive to consider including in an introductory course. In her preface, Lathom-Radocy describes the book's target audiences as being students in introductory courses, professionals in related disciplines, individuals considering music therapy training and members of the general public who are interested in music therapy, as well as "some practicing music therapists" (p. viii) who might be seeking an overview of research or considering working with a different population.

While I believe that students would be well served to reference chapters of this book when applicable to their academic and clinical work, I would argue that the book is actually *most* valuable as a resource for practising music therapists, since the majority of its chapters are dedicated to clinical practice. Chapters 7 to 21 each follow a similar outline in their discussions on music therapy for a variety of clinical populations: intellectual, learning and multiple disabilities; sensory, communication and orthopaedic impairments; autism; mental illnesses; medical and rehabilitation patients; the elderly and terminally ill; and the general population. These chapters provide definitions and common characteristics of each condition and then discuss where music therapists might work with these clients and, most helpfully, ideas for how to effectively use music in therapy as supported by a wealth of research and evidence-based clinical practice. For instance, Chapter 9, "Music Therapy for Hearing Impaired Individuals", contains sections titled "Music to Help Assess Auditory Functioning", "Music Therapy Strategies to Assist in Auditory Training", "Music Therapy Strategies to Improve and Reinforce Speech Production", "Music Therapy Strategies to Improve and Reinforce Language Development" and "Music Therapy Strategies to Improve and Reinforce Social Skills". The research supporting these strategies and interventions spans the past 40 or so years of the literature and references music therapy and related field publications from around the world.

Not only can a reference book, such as Lathom-Radocy's, serve as a clinical practice resource, but it can also provide us as clinicians with support for how we communicate about music therapy. I often thought during the first nine years of my career as a music therapist, at which time I worked in Upstate New York, that being a music therapist in my area was somewhat akin to living in a post-feminist or post-racial society in which the generation of music therapists before me had done all of the hard work in educating and explaining and I could just get on with being a music therapist. It took me quite a while, when beginning my current work in Aotearoa New Zealand, to understand that being able to effectively communicate about the less-known discipline of music therapy with people outside of my field was an essential part of

my work in this country, and that not only did I have to be able to communicate clearly and concisely, but that I needed to draw upon research and evidence-based practice relevant to the person or group whom I was speaking with. The people with whom I talk about music therapy in Aotearoa New Zealand have been extraordinarily responsive, open and curious, and by and large they want to understand the research and the science around the who, the why and the how of the work that we do. *Peters' Music Therapy* has been an excellent resource when discussing music therapy with those new to the field, and has also helped me to clarify to colleagues how I approach my own clinical practice and research interests through its final chapters, "Selected Approaches to Music Therapy and Clinicians and Research".

Lathom-Radocy strongly advocates for therapists not to adhere completely to one music therapy approach, orientation or musical technique, as well as not to try to tightly align music therapy work with other disciplines in an effort to increase professional stature, and so she allows for an open and inclusive look at our field. It is a thoughtful and substantial reference book, easily accessible and excellently organised, and one that will remain a resource for me as I consider and communicate about the work that we do as music therapists.

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**Suggested citation**

Ryckaert, J. (2017). [Review of the book *Peter's music therapy*, by W. Lathom-Radocy. *New Zealand Journal of Music Therapy, 15*, 117-120.

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# Book Review

## Wheeler, B. L., & Murphy, K. M. (Eds.). (2016). *Music Therapy Research* (3rd ed.). Dallas, TX: Barcelona Publishers.

REVIEWER:

Alison Talmage, MMusTher (Hons), MEd, PGCertHealSc (Adv Psychotherapy Practice), PGCertHealSc (Clinical Supervision), BA (Hons), NZ RMTh

Music therapy research is a complex, expanding field, encompassing a remarkable choice of methodologies and methods. Over the years, I gained much from the previous edition of this book, and I warmly welcome the ambitious scope of this 758-page third edition and the companion volume, *An Introduction to Music Therapy Research* (Wheeler & Murphy, 2016). This time Barbara Wheeler has collaborated with a co-editor (Kathleen Murphy) and there are significant contributions from Ken Bruscia and many distinguished, international authors. In a lively interview with Daphne Rickson, Wheeler has expressed a justifiable satisfaction in enthusing and educating the music therapy profession about research (Wheeler & Rickson, 2017).

I have explored these books slowly, taking time to delve into each section – admittedly with some chapters still remaining to be read! The research terminology has been updated, with a focus on the value of both "objectivist" and "interpretivist" approaches, rather than a quantitative/qualitative divide, and an extensive glossary is a helpful addition to both books. For students and other new researchers, *An Introduction to Music Therapy Research* is an accessible introductory text, containing 20 chapters of *Music Therapy Research* (3rd ed.), with additional chapters by Ken Bruscia providing an overview of objectivist and interpretivist research designs.

*Music Therapy Research* (3rd ed.) offers additional, in-depth chapters, and I will focus on this book in the remainder of the review. The book is well organised into nine sections ("units", each containing several chapters). Unit One ("Introduction") highlights historical perspectives and relationships between research, practice and theory, and Unit Two ("Preparations") the broad issues of research topics, literature reviews, ethics, multicultural contexts, interprofessional collaborations, and funding. I encourage readers to absorb and reflect on these "big picture" chapters before plunging into the detail specific approaches.

Of particular interest to me were the two chapters discussing the interrelationship of music therapy research, practice and theory – encompassing a balanced critique of the benefits and challenges of both objectivist and interpretivist research, the task of bridging practice and research, and the relevance of both external and grounded theories (Chapter 3 by Baker & Young; and Chapter 4, by Amir, LaGasse, & Crowe). Baker and Young emphasise that music therapy began as "a practice-based discipline thanks to the pioneering clinical work of practitioners" (p. 26). They encourage researchers to continue to honour the context and lived experience of practitioners and participants, and not only the preferred methods of current evidence-based practice (such as randomised controlled trials). As journal editor, I welcome this encouragement to value and publish different voices exploring and reflecting on our eclectic professional practice in Aotearoa New Zealand.

Merrill illustrates the history of music therapy research through the metaphor of a river, with its headwaters, tides, currents, confluence and broadening delta (Chapter 2). North America, Europe, Latin America and Asia all feature, along with an acknowledgement that language barriers sometimes limit international dissemination. I was disappointed not to see mention here of the University of Melbourne's National Music Therapy Research Unit (NaMTRU[1]) although Australia and New Zealand research feature elsewhere in the book. In this context, I note that the geographical spread of contributing authors has expanded considerably

[1] http://mcm.unimelb.edu.au/research/national-music-therapy-research-unit

in this edition; however, almost two-thirds of authors are from the United States (based on current location, which in some cases differs from nationality). Of the others, approximately one quarter are European, with some from Australia, Canada and Korea, and one from New Zealand (Sarah Hoskyns' chapter about thematic analysis). Additional international research vignettes are incorporated into many chapters – including New Zealand research, particularly in Stige and McFerran's overview of action research (Chapter 39).

I welcome Merrill's suggestion that research cultures in Asian countries might be well positioned to draw on both indigenous knowledge frameworks and contemporary western concepts – this resonates well in contemporary Aotearoa New Zealand, with our bicultural and multicultural context and values. Multicultural issues are further addressed by Kim and Elefant (Chapter 8):

> Engaging in research is ultimately a multicultural act that involves intra- and interpersonal levels of work including individuals and their community within cultural contexts. In this collaborative act, researchers need to come with the authentic intent of wanting to learn from the participants and their community. […] just as culture permeates through all dimensions of life, it inherently becomes impossible to ignore culture when conducting research. (p. 81)

Unit Three ("Foundations and Principles") clarifies the philosophies guiding "objectivist" and "interpretivist" research, with subsequent units and chapters expanding on these and describing specific approaches and research designs. James Hiller (2016) clearly defines and discusses ontology, epistemology, axiology and methodology, difficult concepts for some beginner researchers. He encourages researchers and authors to be explicit about their stance, and offers music therapy research examples to illustrate diverse paradigms (positivism, post-positivism, constructivism, social constructionism, phenomenology and hermeneutics) rather than favouring any particular stance.

Further individual chapters discuss specific methodological issues and research design within objectivist (Units Four and Six) and interpretivist approaches (Units Five and Seven). Unit Eight surveys "other types of research": objectivist and interpretivist approaches to microanalysis; mixed methods research; reviews and meta-analyses; historical research; and philosophical inquiry. Evaluation and publication are addressed in Unit Nine. It is beyond the scope of this review to do justice to each topics and authors

I highly recommend these books to students, researchers and tertiary educators. They contain a wealth of expertise, demystify complex concepts, and offer guidance across the spectrum of approaches. Both electronic and hard copy formats are available from the publisher: http://www.barcelonapublishers.com. The editors have ensured readability, while honouring individual authors' writing styles. It is exciting to anticipate the positive impact of these books, in terms of enabling creative, innovative, reflexive and culturally responsive research.

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# Book Review

## Lee. C. A. (2016). *Music at the Edge* (2nd ed.). Abingdon, England: Routledge.

REVIEWER:

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*Music at the Edge* (2nd ed.)[1], by Colin Lee, is a detailed and engaging account of thirty-three music therapy sessions between music therapist Colin Lee and Francis, a musician living with AIDS.

Lee is refreshingly honest throughout the book about his own personal fears and insecurities in working with Francis. Francis is a brilliant pianist with incredible improvisation skills. He also has a unique ability to articulate his own thoughts and feelings about each improvisation. Lee expresses his initial feelings of intimidation at working with someone so musically and verbally proficient. He also has a strong sense of excitement, as a composer and improviser, at having a client who is an accomplished musician and the potential this represents for their work together. Lee is able to be honest and open about his feelings of inferiority and insecurity that arise during sessions with Francis, which is both refreshing and inspiring. As Lee faces these feelings through reflections after sessions and in his own supervision session, he comes to realise that these music therapy sessions are providing him with opportunities to reconsider his perspective of what music therapy is, what it can be, and the place of improvisation within music therapy sessions. This is inspiration for Lee's evolving concept of Aesthetic Music Therapy.

[1] First published as: Lee, C. A. (1996). *Music at the edge: The music therapy experiences of a musician with AIDS.* London, England: Routledge.

Francis has very strong and clear ideas about what he expects from music therapy and a music therapist, often to the point of bluntness. “I expect your musical inventions to be of the highest order…” (p.45). Francis is unapologetic at expressing his need for a musically proficient music therapist who is able to meet his musical strength and abilities. Francis articulates his needs and what he would like from Lee in every session. Lee reflects on the pressure he feels to respond in the exact way that Francis needs, “My answer would have to be at least miraculous…” (p.48). His honesty about this makes him relatable and encourages music therapists to be open about their own limitations and boundaries.

The audio files that accompany the book are integral to witnessing and understanding the powerful work that takes place between Lee and Francis. Listening to these excerpts emphasises that Francis is a very gifted musician. The excerpts also provide us with a sense of what it was like in the music therapy room – an experience that words cannot adequately express. We are invited in, at the moment of musical creation, to witness the power of Francis’ music. The recordings are both beautiful in and of themselves, and also strongly evoke in the listener some of the feelings Lee himself feels – a sense of being stifled at times, or confronted with really strong and often overwhelming feelings of loss, sadness, grief.

Lee is a composer and improviser as well as a music therapist, and had always hoped to work with a musically talented client. He is able to meet Francis’ challenges with passion and anticipation – while also continuing to acknowledge how daunting it is working with him. Part way through their work together, Francis begins to play solos that take up the entire session and no longer needs Lee to be musically active in sessions. Lee is required to consider what he can offer as a listener, and it is interesting to hear his reflections about what he can offer if he is not a musical participant, and how disempowered he initially feels to give up this role.

Lee initially has a strong sense of discomfort in how much time Francis spends verbally reflecting on each improvisation. He comes to the

conclusion that “if words came directly from music they can be equally meaningful”. Francis’ ability to articulate himself at such a deep level following his improvisations indeed adds power to the music and gives Francis himself power to name his feelings and to say them out loud, when for so long he has felt unable to do so. Lee comes to highly value Francis’ abilities to reflect on music therapy sessions, particularly given the fact that often, “spending one’s life as a music therapist is a journey of intuition and faith” (p.73). Music therapy clients are often unable to provide articulate responses to their experiences within a session. In contrast, Francis’ “precise evaluations connecting musical structures and their connection to his emotional wellbeing often left [Lee] in awe” (p.60).

During one session, Francis asks that Lee improvise for him on his own. Lee again questions their roles and what implications this might have for their ongoing work together. However, he discovers that, “by improvising for clients, attempting a reflection of their feelings and mine, I found it possible to offer an emotional exchange that would allow for intense expressions of grief” (p.80). This again leads to a deepening of their therapeutic connection and illustrates another way that the flexibility of music therapy can meet the needs of clients.

As Lee becomes more comfortable and familiar with what is required of him in each session his responses are a source of comfort to Francis, who often needs reassurance that the music he creates is received as he wants it to be, and that it means something to someone else. A theme in the book is Francis’ deeply felt need to leave something behind – a legacy, something that was real, something that captured his pain and his passion and who he truly was. This is a common theme in palliative care music therapy, and clients can reach a deep state of peace when they feel they have passed something on that will live on beyond the time they have left.

The relationship that evolves between Lee and Francis, right up until Francis’ death, is central to the story. Towards the end of Francis’ life, it is no longer possible to maintain their therapeutic relationship. They decide to navigate the rest of the time Francis has left as friends. The

ethical implications of this decision are interesting to contemplate, but it seems clear in this instance that continuing their relationship is central to Francis' wellbeing. Further exploration into this seems necessary, in a general sense, particularly when working with clients who have life-limiting illnesses.

What most resonated with me in this book is how open Lee is about his personal responses to working with Francis. It shows how crucial the time spent reflecting before and after each session as well as regular supervision are to our continued effectiveness as music therapists. There are passages and ideas within *Music on the Edge* that will remain with the reader long after finishing it, perhaps particularly those who continue to navigate their relationships with clients who are nearing the end of their lives.

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**Suggested citation**

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# Book Review

## NiaNia, W., Bush, A. & Epston, D. (2017). *Collaborative and Indigenous Mental Health Therapy: Tātaihono – Stories of Māori Healing and Psychiatry.* New York, NY: Routledge.

REVIEWER:

Claire Molyneux, MA (Music Therapy), BA (Hons), PGCertHealSc (Clinical Supervision), NZ RMTh, HCPC (UK) Music Therapist

Anglia Ruskin University, Cambridge, UK.

This publication is a collaboration between Wiremu NiaNia, a Māori spiritual healer, Allister Bush, a child and adolescent psychiatrist (who worked together at Te Whare Mārie, the Māori mental health service at Capital Coast District Health Board), and David Epston, co-founder of narrative therapy[1]. The book embodies the principles of *Te Tiriti o Waitangi* (Treaty of Waitangi) – partnership, protection and participation – at many levels: in the engagement with the young people and their families, in the working partnership between NiaNia and Bush, and in the consultation and collaboration with the young people, their families and a group of senior psychiatrists during the writing process. "In each story we reflect on the meaning of what happened from at least three perspectives: that of the psychiatrist, that of the Māori healer, and that of the young person and their family" (p.14). The joy of this book is not only in the narratives that powerfully describe the healing processes for the young people and their families, but also in the way the authors have generously shared their experiences of collaboration and learnings when *wairuatanga* (spirituality) and cultural accountability are given a central place in the work.

[1] http://dulwichcentre.com.au/what-is-narrative-therapy

The stories in the book focus on the unique experiences of five individuals and document the ways in which spiritual and cultural problems were identified and subsequently addressed with culturally appropriate interventions. The stories are preceded by two informative chapters. First the authors introduce themselves, their backgrounds and influences, with NiaNia explaining the central concepts of *mauri*, *mana* and *tapu*, which "can help families make sense of *wairuatanga*" (p.3). Chapter 2, "Context", provides detailed contextual information that situates the Māori mental health service within the history of colonisation and the devastating effect this had on indigenous healing practices and beliefs in Aotearoa. This chapter goes on to describe the struggle to recover and reposition Māori knowledge within the mental health service, and acknowledges the leading role played by Mason Durie[2] in this process. Bush provides valuable context for his own journey towards understanding the ways that colonising processes continue to be perpetrated by Western-trained health professionals and therapists. The process of decolonisation, which calls for mutual respect and reciprocity among all partners, and a commitment "to be mindful of the extent to which Western therapeutic concepts tend to dominate indigenous paradigms and render them invisible" (p.36) is embodied in the work in this book.

The closing chapter, "*Tātaihono*", generously outlines the practical ways in which NiaNia and Bush have worked together to address cultural and spiritual problems, along with their reflections about the writing process itself. The careful reader can gain insight and understanding of the principles of cultural accountability, collaborative approaches, and ways to enquire and listen that open up different conversations. This chapter emphasises the importance of partnership and negotiation with the young person and their family in working towards a "shared understanding of the overall problem and situation" (p.155).

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[2] Sir Mason Durie (Rangitāne, Ngāti Kauwhata, Ngāti Raukawa) is Emeritus Professor of Māori Research and Development at Massey University and is known for his contributions to Māori health.

The narratives presented attend to the intersection between “psychiatry and culture” (p.13), challenge the dominant Western psychiatric lens, and show the ways in which the team at *Te Whare Mārie* open up the potential for different understandings, particularly when the presenting experiences and symptoms do not fit recognised diagnostic categories. For example, Chapter 6, “I Will Not Leave My Baby Behind”, describes the way in which a young girl's sleep disturbances, anxiety, and episodes of agitated behaviour were ameliorated following a single intervention by NiaNia, after a cultural problem was identified. Bush describes NiaNia's assessment as including “perceptions not only of the appearance, intentions, and communications from family members in the therapy room, but also of deceased ancestors whom he perceived as present in the room” (p.101). An understanding of intergenerational breaches or conflict in relationships was reached. NiaNia's intervention brought about reparation and healing which restored balance for the whole family across multiple generations.

Most of the narratives describe transformative experiences that occurred during a single intervention or consultation with NiaNia. However, the final narrative, “Into the World of Light”, describes work that took place over an extended period. It provides insight to the ways in which the needs of a young woman experiencing distressing voices and visions were addressed using “an integrated approach incorporating medical, psychological, and spiritual aspects” (p.104). This chapter goes on to highlight some of the literature and research emerging from the recovery movement, which aims to empower individuals accessing mental health services, and explores differing views about hearing voices. This interrogation of dominant discourses in psychiatry provides a helpful example which can encourage other professionals to question and be open to new understandings.

The narrative style of writing is accessible, and there is an easy conversational tone throughout. A warmth of relationship and respect for different knowings and expertise is evident, along with a determined process of inquiry and deconstruction of dominant attitudes and approaches in psychiatry. A spirit of partnership is central

to the book and demonstrates an inclusive and collaborative approach where young people and families are given opportunities to experience their own agency. The book explores the conversations required for the ongoing process of decolonisation, and is a welcome guide to the ways in which culturally collaborative and appropriate practice can be established and support beneficial outcomes. I highly recommend it as inspirational and informative reading for all music therapists, especially within the context of growing dialogue between New Zealand music therapists and Māori traditional healers and musicians (Rollo, 2013; Fletcher, DeAth Green, MacDonald & Hoskyns, 2014; Nunns, 2003; Hoskyns & Roestenburg, in press) which builds on earlier conversations (McIvor, 1988, 1998) and brings different understandings of the ways in which sound and song connect with the physical world, health and medicine.

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# Book Review

## Salhi, K. (Ed.) (2014). *Music, Culture and Identity in the Muslim World: Performance, Politics and Piety.* Abingdon, UK: Routledge.

REVIEWER:

Cheri Ang, MMusTher, NZ RMTh

Private Practice, Singapore

As music therapists come into contact with people from diverse backgrounds, it becomes increasingly important for us to seek an understanding of the socio-political situation faced by Muslims and the current trend in the Islamic music scene. According to a report by Pew Research Center (2015), Islam was (in 2010) the second the largest religious group after Christianity, with an estimated population of 1.6 billion Muslims worldwide. The same report predicted that Islam would grow faster than any other major religion.

I was excited to be writing this review because of my interest in Sufi philosophies and the Mevlana Dervish dances. I initially found this book a challenge to read because some chapters contained many Arabic and Persian terms unfamiliar to me – a glossary would have helped to make this book easier to read. In addition, there were significant typographical errors (consistent omission throughout the book of “ff”, “ffi” and “fl” in words such as off-line, office and conflict) that need to be corrected in future editions. Once these omissions were figured out, I found the book informative because it demonstrates the socio-political situation and on-going tensions and disagreements within Islamic communities about acceptable approaches to music and performance. It also provided insights into how these factors influence the practice of the musicians, the cultural scene and the sense of identity of young Muslims living in various countries, such as Turkey, Egypt, Afghanistan, Pakistan, India, the USA, UK, France and Germany.

This book begins with an introduction by the editor, Kamal Salhi, who explains his intentions to address the place of music, culture and identity of the worldwide Muslim population. The book comprises 11 chapters, all by different authors with notable credentials. Their backgrounds range from ethnomusicology, Islamic studies, sociology, music, to religious and cultural studies specializing in both Eastern and Western traditions. Overall, this book effectively demonstrates how social-political situations shape the development of Islamic music in the Muslim world. As this theme recurs throughout the book, one can benefit equally from reading individual chapters.

Chapter 1 explores the musical culture of Turkey through an extensive research into a prominent music practitioner, Mehmet Emin Ay, and interviews with local teachers in Turkey. This chapter studies the tension surrounding the legitimacy of performance and music in the Muslim world. Chapter 2 demonstrates the heterodoxy of Sufi musical performances in Egypt, and Chapter 3 examines how Sufi chanting can be a vehicle of empowerment for Moroccan Muslims, that extends to the wider Moroccan community. Chapter 4 provides insightful, personal accounts by a few Egyptian musicians who left a successful performance career to devote themselves to God. While some of them remain active through preaching, others returned to their profession and serve as role models to the public. Chapter 5 examines the role of dance in Afghanistan. Although it is not about music, it highlights many similar contradictions and conflicting views by the Muslim community about its legitimacy.

Chapter 6, one of the longest chapters, focuses on the Muharram rituals in Delhi, Karachi and Hyderabad in Pakistan, where the ritual drummers, musicians and co-participants in Muharram are being interviewed. This chapter involves an in-depth discussion around the manifested and hidden aspects of performances and how performers viewed their roles and interpreted the music. One can find some detailed descriptions of the musical repertoire, drumming rhythms and patterns employed.

In Chapter 7, the author highlights how issues of Islamophobia resulted in marginalised Muslim youths turning to the Internet as a means of expressing their political views. Digital media and *Taqwacore*, a transnational punk music scene have become a popular platform for Muslim youths in the USA and other western countries to form their own identities and engage meaningfully with others from the Muslim diaspora.

Chapter 8 analyses the use of *qawwali* music in Indian films and shows the influence of Muslim and Sufi traditions and music on Indian films. Chapter 9 investigates the history and programming of Bradford Mela, the United Kingdom's largest South Asian music and art festival, to show how fear of terrorism impacted the festival and contributed to the marginalization of young Pakistani Muslims or Mirpuris. Chapter 11 analyses the 2007 single *Mange du kebab* ("Eat kebabs")[1] by Lil'Maaz, who went from kebab shop waiter to online YouTube rap sensation in France. The stereotypes faced by Muslims in France and the socio-cultural significance of the video are discussed.

I found Chapter 10, by Maruta Herding, to be the most useful and easiest to read. Herding's ideas and arguments are clearly articulated and foreign words used are fully translated and defined. This chapter describes the development of the Islamic music scene in Germany, France and the United Kingdom within a socio-political context. The author names several influential Islamic rappers and provides readers with insights into their background and motivations. The types of songs and possible messages to their listener are clearly described. Most of these songs can be found on YouTube. Extracts of song lyrics in French and German are fully translated into English, providing readers with a better feel of the songs. The comparisons between countries and multi-dimensional analysis of Islamic music development in Western Europe help readers to gain a fuller understanding of the social and political context.

[1] https://www.youtube.com/watch?v=TCBSqYOZzPM

For music therapists, I would highly recommend reading Chapter 10, because it explains in a very clear and concise manner, the socio-political context and current Islamic music scene. In addition, Herding's suggestions of several hip-hop songs popular with Muslim youths in Germany, France and the United Kingdom might be useful for music therapists. Chapter 6 might interest some music therapists because it describes in detail a few drumming patterns used in Islamic *Muharram*[2] rituals in Pakistan and the role of the different musical instruments in different contexts.

To conclude, I do not recommend reading the entire book, but I encourage music therapists to begin with Chapter 10 by Maruta Herding, which is both accessible and highly informative. In my personal view, it is a well-written piece of work, which I have found inspirational.

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[2] *Muḥarram* is the first month of the Islamic calendar, a sacred month.

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# Book Review

## Cornelius, S. & Natvig, M. (2016). *Music: A Social Experience.* Abingdon, UK: Routledge.

REVIEWER:

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*Music: A Social Experience* offers an introduction to the social role of music throughout history and culture. It is primarily written as a course text for university students taking a paper in music appreciation. The authors are both American university music professors specialising in music history and music from different cultures, and have written other books on similar topics including *Teaching Music History* (Natvig, 2002) and *Music of the Civil War Era* (Cornelius, 2004). The authors aim to equip students with the skills to listen to and think critically about a variety of musical styles and promote cultural understanding through musical knowledge. Personally, as a music therapist working with families from a range of different cultural backgrounds and with social goals often a focus, I hoped this book would help inform my understanding of music's cultural and social role.

The book offers a basic introduction to the standard Western concert repertoire, then links it to a wider range of music from a range of cultures, genres and time periods. It is organised into four parts: (1) "Music Fundamentals" introduces the power of music and how we perceive music in its cultural and historical context; (2) "Music Identities" focuses on how music expresses individual and group identities and how music shapes social expectations of identity, and covers chapters on music's connection to ethnicities, gender and spirituality; (3) "Musical Intersections" explores how music crosses into the social realms of politics, conflict and love: and (4) "Musical

Narratives" highlights the musical genres of theatre, film, dance, and the concert experience.

I found the book easy to read and it provided numerous listening examples, complete with timed analytical comments which helped to illustrate the text. There were profiles on different musicians, composers and musical styles scattered throughout the book, written in a succinct and lively way. It was illustrated with photos and drawings which brought visual interest to the text. There were also questions, activities and assignments at the end of each section, which students might be interested in exploring. The main strength of the book was that it provided a good introductory exploration of different cultural musical styles and genres and how they link to Western music. Through reading it, I gained a better understanding of many cultural musical forms that I had previous little knowledge of, such as Japanese *shakuhach*i music, West African *jalolu* musicians, Balanese *gamelan*, the *Samā* ceremony of the Mevlei Sufi Order, and Bulgarian folk music, to name a few.

At times, I found the author's views quite subjective, especially within the chapter on gender, which did not allow for wider and more objective perspectives. As it is written for university students with an elementary understanding of music, the book includes extensive basic music theory and history. I thought the book could have been improved by adding a final concluding chapter, as I felt it ended rather abruptly after discussing different types of performance. There were also a few formatting issues – for example, the book was bound incorrectly, starting at chapter 8, and contained a few spelling and typing errors. Hopefully in future print runs they will correct the binding issue. A multimedia 4 CD set can be purchased separately, and contains over 60 recordings and other information. As an alternative, you can purchase an access code which allows you to access the resources online through Pearson's MySearchLab[1]. The book states that as well as the listening examples, the online resources include video examples, short texts on special topics and sample recordings and notation to illustrate basic

[1]https://www.pearsonhighered.com/mediaproducts/mysearchlab/index.html

concepts in music. These resources were not available for review, so I cannot discuss their quality.

This book would be useful for music therapy students and music therapists who want to work in a culture-centred way. It also has a role in helping us more fully understand music's social role throughout history and culture, which is important in our work as music therapists. It provides a context to experience and explore music's social and cultural impact in a variety of ways through text, illustrations, listening examples, questions, activities and assignments. It also offers good examples of how to analyse and describe musical works which can be helpful when analysing our own musical interactions within therapy sessions. I would recommend the book to anyone who is looking for an easy-to-read book and is interested in understanding a wider range of cultural musical styles and how music expresses and shapes identities.

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**Suggested citation**

Hearn, S. (2017). [Review of the book *Music: A social experience,* by K. Salhi.] *New Zealand Journal of Music Therapy, 15*, 139-141.

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# Publications Alert

This new section of the journal highlights recent publications (beyond the *NZJMT*) by New Zealand music therapists. Music therapists without a university affiliation have mentioned the challenge of keeping abreast of current research and literature. This digest is intended to partially address this gap, and we encourage readers to contact the authors directly, if there is any difficulty accessing their work.

The list is based on responses to an invitation circulated to all NZ Registered Music Therapists; any omissions brought to our attention will be included in the next issue of the journal. For publications in the *NZJMT*, please refer to the *NZJMT Index*, updated annually, available from www.musictherapy.org.nz/journal.

**Alison Talmage**
*NZJMT* Editor

## 2016

Fletcher, H. (2016). The whole is greater than the sum of its parts: Music therapy and collaboration in an infant, children and adolescent mental health service. In C. Miller (Ed.), *Arts therapists in multidisciplinary settings: Working together for better outcomes* (pp. 182-197). London, UK: Jessica Kingsley Publishers.

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Rickson, D.J., Castelino, A., Molyneux, C., Ridley, H., & Upjohn-Beatson, E. (2016). What evidence? Designing a mixed methods study to investigate music therapy with children who have autism spectrum disorder (ASD), in New Zealand. *The Arts in Psychotherapy, 50*, 119–125. https://doi.org/10.1016/j.aip.2016.07.002

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## 2017

Boom, K. & Hoskyns, S. (2017, July). Journey to musicking: Resourcing people to music outside the therapy room. Poster presentation for the 15th World Congress of Music Therapy, Tokyo, Japan.[1] Retrieved from http://www.wfmt.info/wp-content/uploads/2017/09/student-poster_Katie-Boom.pdf

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[1] First prizing winning student poster.

[2] This book includes a forward by Sarah Hoskyns, and writing by music therapists Carolyn Ayson, Ajay Castelino, Heather Fletcher, Nolan Hodgson, Libby Johns, Shari Storie, Alison Talmage and Marie Willis, and Roger Hicks, CeleBRation Choir member.

## Policy of the *NZJMT*

The purpose of the New Zealand Journal of Music Therapy is to extend the knowledge of music therapists, and develop their understanding of their own profession and of the context in which they work. It should also help to promote understanding of the use of music and the place of music therapy in the wider health professional community.
Articles may be accepted which arise from research, clinical and professional perspectives, case studies, interviews of interest, or from experience in music therapy or in related professions. Reviews may be accepted of books, software and DVDs. The journal will publish only original material, except where reprint rights have been sought for an article of particular relevance to New Zealand practice.

### Peer Review

All articles will be anonymously peer-reviewed by two or more reviewers, with at least one of them being a music therapist. The Editor shall select reviewers on an annual basis, according to the nature of articles submitted.

Contributors are responsible for obtaining copyright for figures, graphs, lengthy quotes, or illustrations that have been published elsewhere. Once an article has been accepted for publication, the author will be required to assign rights to Music Therapy New Zealand. An article will not be published unless the Editors have received a copyright waiver.

### Further Information

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| NZJMT Editor: | editor@musictherapy.org.nz |
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