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UNIFIED PHILOSOPHY FOR MUSIC THERAPY:

SOLVING THE IDENTITY CRISIS THROUGH

INTERDISCIPLINARY ANALYSIS

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UNIFIED PHILOSOPHY FOR MUSIC THERAPY:
SOLVING THE IDENTITY CRISIS THROUGH
INTERDISCIPLINARY ANALYSIS

A Dissertation Presented to the Graduate Faculty of the

Simmons School of Education and Human Development

Southern Methodist University

in

Partial Fulfillment of the Requirements

for the degree of

Doctor of Liberal Studies

by

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(B.M., Sam Houston State University, 1995)
(M.A., Texas Woman's University, 2001)

April 18, 2022

ACKNOWLEDGEMENTS

I wish to thank my dissertation advisor, Dr. Julie Scott for guiding me through this process; my second reader, Dr. Robert Krout for offering support and revisions frequently; and my external reviewer, Dr. Lauren DiMaio, for providing valuable feedback. I would also like to thank Dr. Barbara Wheeler for reviewing the results for trustworthiness, rigor, and quality; and the Department of Music Therapy in the Division of Music in Meadows School of the Arts at Southern Methodist University for supporting me during my education. I could not have done this without the support of Kevin Lindstrom, my husband, Kyle Lindstrom, my son, my parents, Dr. Jim Harris and Mrs. Johnnie Harris, and countless friends and family.

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Unified Philosophy for Music Therapy:
Solving The Identity Crisis Through
Interdisciplinary Analysis

Advisor: Dr. Julie Scott

Doctor of Liberal Studies conferred April 18, 2022

Dissertation completed April 18, 2022

The purpose of this dissertation was to investigate the feasibility of a unifying philosophy for music therapy and to offer an identity for the music therapy profession that is appropriate for the various ways in which music therapy is practiced throughout the world. A systematic review of published music therapy approaches informed this investigation. The central research questions for this dissertation were: (a) Is it possible to articulate a unifying philosophy of music therapy that is inclusive of the diverse ways music therapy is currently practiced; and if so, (b) What might be that resultant integrated philosophy of music therapy? If an integrated or unified philosophy of music therapy and identity for the profession is possible to define, it may have implications for music therapy education at the undergraduate and graduate levels. Using the unique interdisciplinary perspective of the Doctor of Liberal Studies (DLS) program at SMU, each major published approach, theory, and model of music therapy was analyzed to compare similarities and differences between them. Current research was examined to determine whether current music therapy practice supports the conclusions from the analysis. Each approach, theory, and model was analyzed to identify the complexity making it unique from other approaches, or the repetition making it similar to other approaches. Finally, an evaluation of whether a unifying philosophy of music therapy is possible, along with the implications for the profession regarding whether one is possible, was completed.

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LIST OF ABBREVIATIONS

Aesthetic Music Therapy (AeMT)

American Association for Music Therapy (AAMT)

American Music Therapy Association (AMTA)

Analytical Music Therapy (AMT)

Anthroposophical Music Therapy (AnMT)

Behavior (beh.)

Benenzon Model of Music Therapy (BMMT)

Bonny Method of Guided Imagery and Music (BMGIM)

Certification Board for Music Therapists (CBMT)

Colorado State University (CSU)

Community Music Therapy (CoMT)

Compassion-Focused Relational Music Therapy (CRMT)

Creative Music Therapy (CMT)

Cultural Intelligence (CIQ)

Developmental-Integrative Model in Music Therapy (D.I.M.T.)

Developmental Speech and Language through Music (DSLM)

Doctor of Liberal Studies (DLS)

Guided Imagery and Music (GIM)

International Society for Music in Medicine (ISMM)

Journal of Music Therapy (JMT)

Lysergic Acid Diethylamide (LSD)

Music Educators National Conference (MENC)

Music Education (MUED)

Music Teachers National Association's (MTNA)

Music Therapist – Board Certified (MT-BC)

Music Therapy (MT)

Music Therapy Perspectives (MTP)

Musical Sensory Orientation Training (MSOT)

National Association for Music Therapy (NAMT)

National Association of Schools of Music (NASM)

National Institute of Mental Health (NIMH)

New York University (NYU)

Neurologic Music Therapy (NMT)

Nordoff-Robbins Music Therapy (NRMT)

Nordoff-Robbins Music Therapy-Creative Music Therapy (NRMT-CMT)

North American Anthroposophic Music Therapy Association (NAAMTA)

Prefrontal Cortex (PFC)

Psychiatric Music Therapy (Psychiatric MT)

Randomized Control Trial (RCT)

Rational Scientific Mediating Model (R-SMM)

Receptive Creative Experience (RCE)

Registered Music Therapist (RMT)

Resource Oriented Music Therapy (ROMT)

Sam Houston State University (SHSU)

Social Capital Theory (SCT)

Southern Methodist University (SMU)

Texas Woman's University (TWU)

The Florida State University (FSU)

The Institute for Rehabilitation and Research (TIRR)

Therapeutic Function of Music Plan (TFM Plan)

Therapeutic Instrumental Music Performance (TIMP)

Therapeutic Music Experience (TME)

Therapeutic Music Training (TMT)

Transpersonal Music Therapy (TPMT)

United Kingdom (UK)

United States (US)

University of Kansas (KU)

Vice President (VP)

World Federation for Music Therapy (WFMT)

World War I (WWI)

I dedicate this dissertation to my students and colleagues,

who asked me tough questions about music therapy.

CHAPTER 1

INTRODUCTION

Music therapists are currently suffering from an identity crisis (Abrams, 2012; Aigen, 2014; Bruscia, 2014; Hanson Abromeit, 2015; Robb, 2012; Matney, 2019, 2020; Stige, 2002). This crisis is contributing to their struggle to gain credibility as a health profession (Ruud, 1988; Hanson Abromeit, 2015; Matney, 2019, 2020). Music therapy jobs that pay a living wage can be difficult to find and there are several instances of non-credentialed musicians or health professionals publishing about recreational uses of music for health-related gains using the term "music therapy" to describe their work (Ledger, 2016). An interdisciplinary analysis of music therapy may assist in solving the identity crisis of the music therapy profession.

Music therapy was established as a profession in the 1950s, and since then music therapists have disagreed about whether the foundation for music therapy is as an art or a science (Bruscia, 20014; Byers, 2016; Matney, 2020; Nöcker-Ribaupierre, 2016). This disagreement has caused an identity crisis with the development of music therapy, both internationally and in the United States (Byers, 2016).

Evidence for the development of music as therapy is often taken from vague references of the benefits of music in antiquity. These range from Plato's explanation of specific musical modes affecting emotions in particular ways and Pythagoras' music of the spheres, to David playing his harp to soothe Solomon's mood in the Old Testament of the Bible, to a specific musical form curing an unusual illness following a bite from a tarantula (Horden, 2000). Perhaps

because of the continued use of these references to explain the therapeutic nature of music, music therapists repeatedly have difficulty responding to the question, "What is music therapy?", and thus struggle with identity (Aigen, 2014; Ansdell, 2002; Bruscia, 2014). Further, music therapists work with an increasing and wide variety of clients and colleagues on various therapeutic and wellness goals in so many health care and community settings that there is growing disagreement about how to define music therapy.

Issues in Defining Music Therapy

Bruscia (2014) identified several issues with defining music therapy, which itself is a combination of two subject areas: music and therapy. According to Bruscia, since music therapy is both an art and a science, it is also a transdisciplinary field with diverse applications, goals, methods, and theoretical orientations. In addition, music therapy has a dual identity as a discipline and a profession (Bruscia, 2014).

The disagreement about defining music therapy has led to multiple, and sometimes conflicting, definitions of music therapy. For instance, the biomedical definition states that music therapy is, "the enhancement of human capabilities through the planned use of musical influences on brain functioning" (Taylor, 2010, p. 259). As another example, the humanistic definition of music therapy is, "the use of music to give people new possibilities of action" (Ruud, 2010, p. 130). A third, music-centered music therapy, is described as an approach that places music and musical experiences in a central role (Aigen, 2005).

There is also disagreement over the jurisdiction of music therapy (Byers, 2016). The music therapy field has never been able to agree on any one way to explain the therapeutic application of music in a way that would cover all intervention strategies as applied to all clients of all ages in all settings and still lend itself to scientific inquiry and verification (Aigen, 2005;

Bruscia, 2014; Byers, 2016; Taylor, 2010). An attempt at identifying a philosophy of music therapy, which would consist of a coherent belief system on which music therapy is based (Abrams, 2012; Aigen, 2014; Bruscia, 2014; Hanson Abromeit, 2015; Robb, 2012; Matney, 2019, 2020; Stige, 2002), has not occurred in the field. The prevailing unofficial music therapy philosophy seems to be that music has some sort of mystical power that cannot be defined because music therapists only need to understand how to use it to achieve desired outcomes (Michel & Pinson, 2005, p. 9; Taylor, 2010, p. 21). However, others in the healthcare arena have sought a more clearly defined explanation (Ledger, 2016). Without a consistent way to explain the outcomes, the developing profession attempted to gain credibility by aligning with various schools of psychology, regardless of how well grounded those approaches were (Ruud, 1980). This alignment with psychology schools led to many music therapists adopting a philosophical position that music therapy is a form of "music psychotherapy," although this approach did not garner widespread support throughout the profession (Byers, 2016). Like other labels borrowed from psychology, this term did not seem to apply to vast numbers of clients and areas of disability with which music therapists worked. Also, the use of the term "psychotherapy" could be viewed as attempting to practice outside the scope of music therapy education and training.

Development of Personal Philosophies of Music Therapy

Each music therapist typically defines a personal philosophy of music therapy, often as part of a course assignment in undergraduate degree programs or as part of the application process for clinical internships. I define my personal philosophy of music therapy as a belief that engaging in music is a fundamental and essential human behavior that is necessary for survival, and music therapists are specially trained to help all humans engage in music regardless of

ability, background, or accessibility. When I enquired via email, Taylor (2018) identified his personal philosophy of music therapy:

> My own philosophy of music therapy is based on the belief that music is a universal behavior pattern throughout the human species and thus carries out strong and necessary functions in the perpetuation of human biological and social life. My biomedical approach is a "theory" because it states specific functions of music that happen in the physical world and can be investigated and verified if found to be true. Although my theory is based almost entirely on the ability of music to affect brain functioning, it is named "biomedical" (not "neurological" or "cranial") in recognition of music's ability to affect other systems such as the endocrine and immune systems. … Although my theory does not provide an in-depth explanation of the essential use of music to form a relationship with a client, it does offer the desired explanation for the final outcomes as observed in clinical practice and it has the advantage of being applicable across the board. (D. B. Taylor, personal communication, November 30, 2018)

However, some music therapists disagree that the biomedical theory proposed by Taylor is sufficient to describe the effects of music therapy. Aigen (2005) identified the biomedical theory as "recontextualized" because it uses concepts from other disciplines (e.g., neuroscience) to explain music therapy. He admits that recontextualized theory is probably most useful for explaining music therapy to non-music therapists but claims that it is less useful for audiences of music therapists. Aigen (2005) stated that an indigenous theory that is original and specific to music therapy will help develop the profession. He proposed placing ideas about music at the core of music therapy theory.

Kenny (2002) questioned whether a unified theory is possible, since it would need to encompass many diverse populations and practices, stating:

> I believe that one of the biggest contemporary challenges for dot-connecting is between the "new behaviourists" [*sic*] in music therapy, who are hard-wired into strong evidence in neuroscience about how music can offer predictable results, and those of us who focus more on process than product, many of whom love the ambiguity and poetry of the creative process. (Kenny, 2002, para. 9)

Byers (2016) reviewed several sources to weigh the benefits and challenges with forming a unified theory, stating:

> It appears that supporters and detractors of unified theory development recognize both the importance of theory and the difficulty of dealing with a profession that is vast and diverse and accept the need for respect and inclusion. The field's vastness has led some to advocate for inclusive acceptance of diversity with focus being placed on individual work rather than on the profession as a whole…. It is almost as if the profession has been frozen by a need to respect others' opinions, something that can also be seen in the lack of critical analysis in the field. (Byers, 2016, pp. 107–108.)

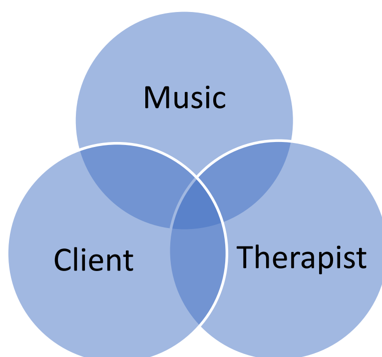
The author concludes that her review of the history of music therapy suggests the jurisdictional area that is common to all models of music therapy: the music-client-therapist relationship. The underlying assumption to this claim is that the quality of the interaction is different from nonmusical interactions (Byers, 2016).

Envisioning the relationships of music-client-therapist as three overlapping circles (see Figure 1), Byers (2016) states there are three levels of interaction. The first level is made up of the individual circles and the interaction of the elements within the circle. For example, the

"client" circle encompasses the culture, self-knowledge, and life experiences of the client. The second level consists of the interactions between music-client, client-therapist, and therapist-music. These interactions refer to each relationship and how each person understands the relationship with one another or with the music. The third level is at the center of the overlapping circles: the music-client-therapist interaction. This is where each component influences and is influenced by the other, and it is this unique interaction that distinguishes music therapy from other professions (Byers, 2016).

Figure 1

A Representation of the Music-Client-Therapist Relationship Described by Byers (2016, p. 116)



Since there are various approaches to the clinical practice of music therapy, and if the field is to remain a unified profession, the challenge is to integrate them under one philosophical identity. Members of the American Music Therapy Association (AMTA), the professional music therapy association in the United States, chose to merge in 1998 from two existing organizations that were formed in part because of the philosophical differences regarding music therapy education and treatment approaches (Aigen & Hunter, 2018). This unification occurred because leaders of the two associations determined that it would benefit the profession, the members of

each association, and the clients served by music therapists (Aigen & Hunter, 2018). They believed a unified philosophy would bring the values of the profession more in alignment with inclusion and diversity, rather than exclusion and uniformity (Aigen & Hunter, 2018).

Division Within the Music Therapy Profession

The field of music therapy is currently divided, roughly, between those who define music therapy as an art or humanity, and those who define it as a natural or social science (Aigen, 2014; Bruscia, 2014). Michel described this dichotomy as a "two-edged sword," where music therapy consists of the board-certified music therapist using either the power of music as a sound stimulus or the social functions of music to provide treatment (Michel & Pinson, 2005). For the purposes of this paper, I will label these two factions as "Music Therapy as Art" and "Music Therapy as Science." These labels are generalizations that I am using to make the point clear. Most music therapists that align more closely with one side are likely open to other ways of practicing music therapy but have selected the approach(es) that work best for the context in which they are working. There are some music therapists who may believe their faction is the correct way to practice music therapy and other ways of practicing music therapy are wrong; however, I believe music therapists that hold these beliefs rigidly are few. That being said, the number of publications that seem to promote a particular way of practicing music therapy as more legitimate than others indicate that there are music therapists who identify solely as art- or science-based music therapists, and that this causes confusion within the profession.

For clarity, I will explain how I am defining the two factions. The Music Therapy as Art faction are process-oriented, experience-oriented, and prefer qualitative research and clinical approaches. The Music Therapy as Science faction are product- and outcome-oriented and prefer quantitative research and clinical approaches. Currently, music therapy practitioners in the

United States from both factions who complete an academic program accredited by AMTA are eligible for the same credential following successful completion of the board certification exam: MT-BC. These academic programs have various philosophies of music therapy, yet there is one common board certification exam for which graduates from each program are eligible. In my experience in talking with music therapists at various conferences, many music therapists tend to practice within both so-called factions, while others align more with one side or the other.

Those in the Music Therapy as Art faction tend to practice from what they call a "music-centered" approach, in which the act of making music or engaging actively in music for the sake of music is the primary goal of therapy (Aigen, 2005). They define problems that clients may have, such as motor difficulties one might experience after a stroke, as musical problems—specifically, problems of rhythm. In a music therapy session, they might encourage the client to experience rhythm by singing or playing instruments, improvising alongside the client to support the musical experience of the client. Music-centered music therapists believe that their approach is the true way to provide music therapy and that to practice any other approach is reductionist at best, and detrimental to the client's well-being at worst. They argue that the best evidence for the efficacy of music therapy is the personal experience of the client (Aigen, 2005; Aigen & Hunter, 2018; Bruscia, 2014; Byers, 2016; Crowe, 2004; Darrow, 2004; Kenny, 1982; Kenny, 2002; Peters, 2000; Ruud, 2010).

Music therapists who subscribe to the Music Therapy as Science approach believe that music therapy affects human behavior in ways that are observable and measurable. For example, biomedical music therapists believe that music influences the neural connections and hormone responses in the brain to elicit the desired outcomes in the client. A biomedical music therapist might treat the motor difficulties of a client who had a stroke through rhythm as well, but with

the goal of using the music to stimulate the motor cortex and the muscles in the affected motor area. The client engages in repetitive movement, strengthening the muscle and the neural connections that stimulate those muscles. The musical outcome may appear similar, with the client playing instruments or singing in a specific way, guided by the music therapist through improvising music that supports the specific musical behavior. However, the approach to the treatment and the outcomes measured are different from the music-centered approach. Scientific music therapists may believe that their approach is the more valid way to practice music therapy and that to practice any other way is "fluff" at best and malpractice at worst. They argue that the best evidence of music therapy is similar to the evidence-based medicine/evidence-based practice protocols, with randomized control trials being the "gold standard" (Aigen & Hunter, 2018; Bruscia, 2014; Byers, 2016; Crowe, 2004; Darrow, 2004; Peters, 2000; Taylor, 2010).

How the Division Developed

The division between the two factions developed in part because music therapists practice in diverse ways. In an attempt to understand the diversity in the practice of music therapy, Byers (2016) reviewed the history of the music therapy profession and what influenced its development, concluding that the profession developed with two primary beliefs: 1) Music is a natural human activity, and 2) music affects and changes people.

Music therapy developed differently than other creative arts therapies, such as dance, drama, and art therapy. In the United States, the profession of music therapy was heavily influenced by two other professions: medicine and music education. While most creative arts therapies were developed by artists, music therapy was developed by physicians in veterans' hospitals in the United States (Byers, 2016). Music therapy evolved as a specialization of occupational therapy, appearing very similar to music education, but with different intended

outcomes. This influence of multiple professions on the development of music therapy (e.g., medicine, music education, psychology, occupational therapy) contributed to the current diversity of practice. For example, some music therapists work in medical settings, such as rehabilitation of neurological disorders, while others work in educational settings with children, with the goal of improving academic skills. Music therapists also work in long-term care settings with older adults or in psychiatric settings with clients suffering from mental health issues, with the goal of improving quality of life (Byers, 2016).

Influence of E. Thayer Gaston. While music has been used for healing since antiquity, and degree programs for the education of music therapists were established as early as 1944 in the United States, music therapy was not a formal profession with standards of practice and a code of ethics defined by members until 1950 (Byers, 2016). During the Great Depression in the mid-1930s, the United States federal government instituted a work program that provided funds to hire and train musicians to play in prisons, hospitals, and psychiatric facilities. These first music therapists were music educators and professional musicians who worked with people with mental health needs. In the United States, this opportunity to provide music therapy was primarily through the Army Rehabilitation Program, which attempted to return wounded soldiers either to active duty or to civilian life in the best physical and mental condition possible (Byers, 2016).

These music therapists soon identified a need for specialized training and research, which led to the development of undergraduate and graduate degree programs for music therapists in the 1940s. In 1946, E. Thayer Gaston, who was influential in the development of music therapy as a profession, developed graduate courses at the University of Kansas entitled “Psychological Foundations of Music” and “The Influence of Music on Behavior” and later added advanced

courses on the same topics that focused on experimental research methods. He also began building a psychology of music laboratory to provide equipment and resources for student research projects. Students could earn a Master of Music Education majoring in functional music, with a clinical music therapy internship added a few years later (Johnson, 1973).

In 1945, music therapy and "functional music" received additional attention. Gaston (1945) wrote about functional music as the means to master emotion regulation (Johnson, 1973). Gaston served on the Music Teachers National Association's (MTNA) Committee on Music Therapy and the Music Educators National Conference (MENC) special committee on functional music and began developing a laboratory for music psychology research (Johnson, 1973). The MTNA Committee on Music Therapy identified a need for an organization to "eliminate quackery and charlatanism" in the field of music therapy (Underwood, 1947, p. 319). Regional conferences on functional music were convened in 1948, where the lack of research in music therapy was named as the primary problem facing hospital musicians (Johnson, 1973). Gaston also hosted a conference for hospital musicians at the University of Kansas, inviting only doctors and hospital musicians to participate, which Gaston hoped would be the beginning of an organization for people working in functional music. However, the time for an organization had not yet arrived (Johnson, 1973).

The University of Kansas approved a master's degree in music therapy in 1948 under Gaston's direction that included research competencies. Students also completed six months of clinical training supervised by hospital musicians and physicians. In addition, Gaston gained approval for doctoral degrees (Ph.D. and Ed.D.) in music education that required classes in statistics. These programs had enough flexibility to allow an emphasis in functional music, which became the first doctoral program for music therapy. Gaston established clinical training

standards and developed internships in psychiatric, geriatric, and medical facilities (Johnson, 1973).

Establishing a Professional Association. Following the recommendations from the functional music and music therapy committees, the National Association for Music Therapy (NAMT) was formed in 1950, and Gaston was elected to the only standing committee at that time, the Committee on Research. Most of the research presented at the association's second annual conference was completed by Gaston's students from the University of Kansas. He became president of NAMT in 1953 and worked to establish national clinical training and education standards for music therapists. He emphasized that acceptance by the medical profession was more important to the success of music therapy as a profession than good public relations (Johnson, 1973).

Gaston continued to serve NAMT in various positions and in 1956 was appointed chair of the Certification Committee, which established the first professional credential for music therapists, Registered Music Therapist (RMT). Gaston's advocacy of music therapy was recognized with an award of the first honorary life membership of NAMT in 1959, due to his contributions to the association and to the profession through his relationships with other professional associations (Johnson, 1973).

Toward the end of his career, Gaston began writing about music therapy concepts in music education journals. He wrote an article for the publication *American Music Teacher* entitled "Music in Therapy" about music as nonverbal communication and its use in creating connections between humans in all cultures (Gaston, 1960). In an article entitled, "Aesthetic Experience in Music," Gaston concluded that children develop best in a rich sensory

environment and that culturally aesthetic music is essential for healthy development (Gaston, 1963).

Gaston presented a paper at the 1964 national conference of the NAMT, reporting on a grant to carry out a cooperative research project to compile a comprehensive collection of music therapy research. He also reported on a grant he received from the National Institute of Mental Health (NIMH) to develop the best training program possible with advanced clinical training for music therapy to train competent researchers and music therapy scholars (Gaston, 1964b).

By 1964, NAMT began publishing the *Journal of Music Therapy* (*JMT*). Gaston's contributions to the music therapy journal consisted primarily of papers presented at NAMT conferences and one co-authored study. Gaston's presentation from the 1963 national conference was the first article in the first volume of the *JMT*, entitled "The Aesthetic Experience and Biological Man." This paper stressed the need for music therapists to have an interdisciplinary education that included psychology, sociology, and ethnology, and to study aesthetics as a science instead of a philosophy. He expounded upon the evolution of humans, which led to the creation of aesthetic expression that is evident in all cultures and societies, indicating a biological need for complex sensory stimulation, specifically through music. Music organizes sound and transmits cultural identity while enhancing group cohesion. He emphasized that since music and aesthetics are human behaviors they can be observed and studied scientifically (Gaston, 1964a). A banquet program address he gave at the 1965 NAMT conference was published the following year, in which he presented a "demonstration program." Musical selections were played by way of demonstrating how music is nonverbal communication through which associations, attachments, signals, and meanings are communicated, based on the experience and culture of each individual listener (Gaston, 1966).

Gaston's ideas on human evolution and functional music, and the implications for music education, seemed to mature by 1968 when he wrote, "The Evolution of Aesthetic Need" for *The American Music Teacher.* He explained that music has both a biological and cultural basis, while refuting the mystical nature of music, stating, "Because music is human behavior, it can be studied scientifically. The scientific method must be that of the behavioral sciences" (Gaston, 1968a, p. 16). He argued that music is an organization of sounds which creates human connection and cooperation, supporting adaptation to the environment, because it is a source of social cohesion derived from tender emotions (Gaston, 1968a).

Later that same year, Gaston published a paper expressing his belief that, because of human evolution and the need for social cohesion, music education should focus on training students to use music for mental health throughout life (e.g., functional music), not just for success at contests and concerts in high school. He encouraged an interdisciplinary training for music educators so that they could incorporate philosophy and behavioral sciences into music education practices. He supported a scientific approach to music education research and teaching methods (Gaston, 1968b).

Eventually, the NIMH grant resulted in what was perhaps the most influential publication on the field of music therapy: *Music in Therapy*, edited by Gaston and published in 1968. This was the first textbook for music therapy based on scientific research, rather than personal observations and mythology. The purpose of the book was to "bring more comprehension of man and music and to describe the processes in music therapy" (Gaston, 1968c, p. 7). Gaston wrote the first chapter, "Man and Music," explaining that music is human behavior and describing the evolutionary development of humans. This chapter was a culmination of his research on human need for aesthetic expression and experience (Gaston, 1968c).

After 15 to 20 years of the existence of music therapy degree programs, a decade following the formation of the professional association, and the profession's foundation in the Army's Reconditioning Program and medical settings, research was an established and integral part of music therapy. Behavioral psychology dominated music therapy practice in the 1960s as observable and measurable outcomes became valued in psychiatric and medical settings. This aligned with Gaston's philosophy of research in music therapy. Though perceived as a rigid approach that ignores the therapeutic relationship and emotional responses to music, these are actually central to the behavioral music therapy process. The therapist may use music creatively, but the focus of the work is on the non-music-based outcome, rather than the creative process of making music (Byers, 2016).

Developing philosophical beliefs. Gaston (1968c) outlined the first philosophical beliefs about music therapy, arguing that music is a form of human behavior and can be used to elicit and change behaviors by a therapist. He suggested that an interdisciplinary approach was necessary to fully understand the nature and meaning of music. For Gaston, music therapy was both a science and an art, where both roles complement, rather than exclude each other. Further, since music is experienced through the senses, Gaston proposed that it influences human social behavior and brain function, resulting in the intellectual and aesthetic enrichment of human lives. Gaston concluded that music is integral to human survival as it helps one adjust and adapt to the environment. Therefore, music therapy is a discipline built upon behavioral science, incorporating the social, behavioral, and aesthetic roles of music, which is essential to the human condition (Gaston, 1968c).

Sears (1968) outlined another philosophical position presented in the 1960s in a chapter titled "Processes in Music Therapy." On the premise that a system of classification was

necessary for building the scientific foundation of music therapy, he defined three roles for music in music therapy: to provide structure, to affect the individual, and to promote social interaction. Sears (1968) believed that the therapeutic relationship and the ability of the therapist to shape the environment were important to success in music therapy.

Disagreement With Gaston. As influential as his contributions were, Gaston was not beloved by everyone. Letters from former students indicated that he was a difficult professor and thesis advisor, with several references to Gaston throwing his eyeglasses in despair over a student's efforts (Johnson, 1973). Gaston's efforts to create a comprehensive music therapy curriculum with the NIMH grant contributed greatly to the field but did not yield the results for which he had hoped. Only thirty of the targeted number of fifty students were admitted to the program, and only twenty-four students actually completed the program. One of the factors Gaston listed as the reason for the low completion rate was that the majority of music therapists were young women who did not have an interest in graduate education (Johnson, 1973). His conclusions about women appear to be wrong, given that the majority of music therapists in the United States identify as female (AMTA, 2020). Gaston also stated that word had circulated about how difficult the training program was, which decreased the number of applicants (Johnson, 1973).

Clifford Madsen was a student of Dr. Don Michel (Michel, a student of Gaston), who established the first music therapy internship before initiating the music therapy program at The Florida State University (FSU) in 1954. Madsen, who is currently the Coordinator of Music Education/Music Therapy/Contemporary Media at FSU and contributed significantly to the development of music therapy research and practice (e.g., Madsen, 1974, 1978). Madsen (1965), claimed that music therapists only need to know how to use music to produce desired results, and

therefore are merely technicians, rather than therapists. This claim refuted the educational standards promoted by Gaston. Madsen (1965) stated that the lack of scientific research to inform when and how to use music relegated the music therapist to doing the "best he can with existing knowledge" (p. 83). This article was published with an editorial note indicating it did not reflect the views of NAMT, its education committee, nor the university from which Madsen completed his doctoral degree, and that he was asked to present his views as a challenge to think creatively regarding the educational standards for music therapists (p. 83). Gaston vehemently opposed these views and was already devoting considerable time and resources to collecting the extant body of music therapy research (Gaston, 1966).

A Second Professional Association. Due to differences in philosophy, education, and approach to music therapy practice, evidence of discord among the music therapy community eventually culminated in the formation of a second music therapy association, established in 1971. An example of the philosophical difference is that New York University did not want to apply for approval by the National Association of Schools of Music (NASM), the accrediting body for music therapy programs approved by the NAMT (Robbins, 2005). The American Association for Music Therapy (AAMT) published its own research journal, *Music Therapy*, with more clinical case studies and qualitative research (Peters, 2000). The AAMT appeared to have a humanistic orientation and established a competency-based education system. Its members opposed the NAMT, which appeared to have a behavioral orientation and used a course-based education system (Aigen & Hunter, 2018). In reality, neither organization claimed adherence to any particular philosophy, so as not to privilege one philosophy over another (Aigen & Hunter, 2018). The NAMT was perceived by the AAMT members as being exclusive and desiring uniformity in the profession, while the AAMT offered flexibility and espoused

progressive values of inclusion and diversity. There were also significant cultural differences between the membership of the two organizations, with the AAMT members primarily living in northeastern United States, particularly Philadelphia and New York, while the NAMT members lived across the nation (Aigen & Hunter, 2018).

Establishing the Certification Board for Music Therapy. In the 1980s, proving the cost-effectiveness of music therapy became more important as deinstitutionalization and third-party (i.e., insurance) reimbursement became more prevalent (Byers, 2016). The NAMT moved its office from Lawrence, Kansas to Washington, DC in 1980 to advocate more effectively for the profession through government relations (Byers, 2016). In 1985, the Certification Board for Music Therapists (CBMT) was established as an independent music therapy credentialing organization (Byers, 2016).

Reunification of the Professional Associations

By the 1990s, music therapy became an established profession globally, with many international programs begun by music therapists trained in the United States (Byers, 2016). Since advocacy of the profession became challenging with multiple voices, leaders of the AAMT and the NAMT began discussing the possibility of unification in 1994 to combine resources and advocate for the profession with one voice. In 1998, the two associations merged into the American Music Therapy Association (AMTA), drawing on the strengths of each association (Aigen & Hunter, 2018). However, decisions about education and training of music therapists and defining the scope of practice for music therapy came much later and are still being debated today (AMTA & CBMT, 2015; Commission on the Education and Clinical Training of 21st Century Music Therapists, American Music Therapy Association: Board of Directors, 2018).

Stance of the Researcher

Due to the fact that the music therapy profession in the United States is in the midst of obtaining state recognition for the MT-BC, in addition to redefining the education and clinical training standards for the 21st century; and due to the fact that unification of the professional associations happened over 20 years ago, I believe that it is time for music therapists to develop a unifying philosophy. Music therapists are still defining music therapy and arguing over the best approach to clinical practice, education, and research; therefore, the time has come to decide on a professional identity that includes the various ways music therapists practice.

I am a cis-gendered, heterosexual white female music therapist in the United States with 25 years of clinical experience and 10 years of academic teaching experience. I believe that the Doctor of Liberal Studies (DLS) program at Southern Methodist University (SMU) has given me unique tools and perspectives to analyze the state of the profession and discipline through an interdisciplinary lens that is not available in traditional Ph.D. programs. In addition, my background, training, and clinical work gives me a unique perspective on the state of the profession and discipline. I will situate myself through an explanation of my education and training, acknowledging potential biases.

Throughout high school, playing bassoon in both the band and the orchestra provided me with friends and social connections and gave me a sense of belonging. Plus, members of the ensembles all worked together to reach a common goal: making excellent music. It also led me to my career as a music therapist. I selected Sam Houston State University (SHSU) because I wanted to be a photojournalist for National Geographic so that I could travel the world. I auditioned for a bassoon scholarship because I wanted to keep music in my life. When I auditioned, they suggested I speak with Dr. Mary Ann Nolteriek, the Director of Music Therapy

at SHSU, so I did. As she described music therapy, it seemed like the perfect match for me as it melded my love for music and my belief that music can help people, as well as matching my talents more closely than photography.

The music therapy program at SHSU was accredited by NAMT and the primary textbooks included some written by music therapists who may considered to be from the Music Therapy as Art camp (Edith Boxill, Ruth Bright, Florence Tyson, and Clive Robbins), as well as those who may be considered to be from the Music Therapy as Science camp (E. Thayer Gaston, William Sears, and Clifford Madsen).

While I no longer play the bassoon, it propelled me into a career that has had an impact on many people in ways I never imagined. I read Gaston's (1968, pp. 7-29) chapter on music as an evolutionary necessity for human survival, and Sear's (1968, pp. 30-44) chapter on the processes in music that influence human behavior within structure, in self-organization, and in relating to others. These chapters excited me because they seemed to offer some concrete evidence that music therapy was essential for human well-being and I wanted to read every text book on music therapy that existed at the time—which were few in the early 1990s. I kept wondering when I would learn the secrets of how music influenced human brain functioning and started exploring medical music therapy, because I thought that was where the "real" music therapy scientists were working. I became the first music therapy intern at The Institute for Rehabilitation and Research (TIRR) in Houston, Texas under the supervision of Kiran Murty Montague in October of 1994 and fumbled my way through learning how to work with occupational, physical, and speech therapists, as well as physicians and neuropsychologists.

After graduating in the summer of 1995, I dreamed of a fulltime job in a hospital where I could conduct research studies and prove to the world how important music therapy is to human

well-being. I worked part time for a year at TIRR and supplemented with some private clients and contracts. I begrudgingly learned how to operate a private practice with many trials and errors, mostly because I treated it as a temporary condition until I got my "big break" at a hospital. Friends of mine were getting fulltime jobs working for a company providing psychiatric services to long-term care settings, so I followed them to that company looking for stability and income. While working as a team with a psychologist and a licensed professional counselor, I started learning about certifications and licensing of other disciplines and understanding my own scope of practice. I also learned that working with vulnerable people could be rewarding and that I could be a person who respected and supported their human dignity at a time when respect and dignity are often declining.

Then, the Attorney General of Texas issued an opinion that would affect how the company employing music therapists billed for those services. Thus, its nine music therapists found themselves unemployed. This job loss was devastating to me at the time, and I moved back home to work out what to do next. I thought about leaving the field so that I could make some money and get that stability I craved but felt strongly that music therapy was my calling in life. I still resisted thinking of myself as a private practice music therapist and pieced together several contracts at pediatric hospitals, school districts, and psychiatric facilities, while hoping that one of the hospitals would soon see my value and offer me my dream job.

I still felt like there was more to music therapy that I needed to learn – because someone must have the secrets to how music therapy influences the brain. I decided that in order to have more credibility in medical settings, I needed additional education. I began working on a master's degree in music therapy at Texas Woman's University (TWU) in Denton, Texas with Dr. Nancy Hadsell, who encouraged my desire to take courses on cognitive science and learning

theory, as well as neuroanatomy and physiology, as electives. I also completed Neurologic Music Therapy (NMT) training and read *The Biomedical Foundations of Music in Therapy* (Taylor, 1997), submitting a book review on it to the *Journal of Music Therapy* (Harris, 2000).

Upon my graduation from TWU in 2001, I realized that the reason no one told me the secret for how music therapy affects the brain was that the information was just emerging. The closest book to having the secret, in my opinion, was Taylor (1997), which proposed that music therapists could take what is known about brain functioning and interpret what is seen in music therapy sessions through that filter. Being a biomedical music therapist means looking at neuroscience research and interpreting it with music therapy expertise to understand how music therapy affects human brain functioning.

I completed the NMT Fellowship training in 2005, where I learned how to defend my clinical decisions using a neurological basis. In 2008 and 2009, Louise Montello's Performance Wellness trainings helped me to understand the sympathetic and parasympathetic nervous systems and the effects of stress more clearly, and I began to work on my own stress management, as well as help others. I worked for a wellness company and presented on wellness models and how to apply it in music therapy and in self-care. I attended a HealthRHYTHMS® training and learned that it was possible to speak about neuroscience in an accessible way from Dr. Barry Bittman. In 2010, Taylor published a second edition of his book, this time with pictures of neurological structures. I read that and continued to refresh my knowledge of the neurological impact of music therapy.

In 2011, I began providing clinical supervision for the music therapy program at SMU. My wide range of clinical experience fit in well with the practicum curriculum at SMU, which included a sequence of working with individuals with intellectual and developmental disabilities

in the SMU Music Therapy Clinic. Further, I supervised students leading groups for older adults in senior living communities, followed by a psychiatric setting and a medical setting. The practicum sequence concluded with two elective placements based on the students' interests. I supervised students at each level of practicum throughout my time as a clinical supervisor, drawing upon my experience in home health, hospitals, psychiatric units, and long-term care settings.

For the majority of my clinical work, I considered myself solidly in the Music Therapy as Science faction. For me, the scientific explanations of music therapy provided the best explanations for how music therapy worked and why music therapy should be available in all settings for all clients. However, when I was working with some clients, I noticed that methods like NMT were not always the best fit. I tried justifying my clinical choices using biomedical explanations, such as music engagement for relationship development or enjoyment stimulated oxytocin or dopamine, which in turn helped the client access internal resources for health and wellbeing.

In 2016, the retirement of both SMU music therapy professors brought me into the music therapy classroom as Visiting Lecturer in Music Therapy and Acting Chair of the Music Therapy Department to provide some continuity for the program as a search for the Chair, followed by the search for the Lecturer position, occurred. In preparation for applying for the more permanent Lecturer position, I took advantage of the tuition benefit and began the Doctor of Liberal Studies (DLS) program, with the intention to study music therapy as my focal area.

When I applied for the program, my intention was to "prove" that the biomedical theory of music as therapy was the best choice for explaining music therapy and proving its value. Within the DLS program, I studied what it means to be human through the lenses of human

evolution; philosophy, religion, and psychology; human rights; creativity; science; and culture. I narrowed my focus on music therapy through courses on educational and executive coaching, history and philosophy of music education and music therapy, and research in music education and music therapy, and independent studies in neuroplasticity, music psychology, and music and emotions. During the philosophy, religion, and psychology course, I realized that what I needed to focus on was a unifying philosophy of music therapy, so I shifted my focus to being open to the Music as Art approaches.

Throughout my DLS coursework, some recurring themes emerged: humans prefer clear dichotomies (e.g., either/or, up/down, black/white), but frequently live somewhere on the spectrum within the range of possibilities between the dichotomies. Humans evolved to categorize experiences in order to survive (e.g., good/bad, safe/dangerous) and to conserve energy (e.g., physical exertion, cognitive load). Human creativity developed as a way to survive while conserving energy, through technological developments, artistic expressions, and collective learning. I believe this human need for categorization and definition is the root of the disagreement about the identity of music therapy.

My educational and clinical background, working in diverse settings with many populations, and my continuous attempts to explain the necessity of music therapy for human well-being, in addition to the liberal studies approach I took to study music therapy, place me in a unique position to explore this unified philosophy of music therapy within the greater context of human development. Also, my path of service to the professional association and as an educator of music therapists helps me understand music therapy as a discipline and a profession in a way that promotes an exploration of all sides of music therapy practice.

Professional Identity Crisis

Throughout the DLS program, I realized that humans tend to categorize ideas, situations, groups, and objects into binary and opposite dichotomies as a way to make sense of the world around them. Rather than living in clear categorical dichotomies, humans are complex beings living in complex social groups. Humans thrive on complexity, continuing to create complex ideas and stories to maintain interest and survive as a community and as a species. Yet humans also need repetition so that they can predict what will happen and survive on a daily basis (Bellah, 2011; Donald, 1991; Gaston, 1968c; Kleinman, 2015; Mithen, 1996; Pasiali, 2012; Snowden, et al, 2015). So much of human survival and daily life involves repetitive actions: waking up, finding food, picking up after oneself, working, playing, sleeping. This repetition can become stale unless it is made more interesting through added complexity. Music is a complex stimulus that engages more areas of the brain than any other stimulus (Taylor, 2010). Music also contains repetitions: the steady beat, harmonic progressions, melodic motifs, and form. As such, it aids in organizing complexity. Music is used in rituals and ceremonies in every culture to transform these complexities and repetitions into a rich and meaningful communal event (Crowe, 2004; Davis & Gfeller, 2008). The identity crisis in the music therapy profession arises from the complexity of its primary therapeutic modality (music) and the clients with whom music therapists work (humans), as well as through the cultural differences between the music therapists who practice as artists and those who practice as scientists.

Although many books and articles about music therapy approaches and theory development have been published (e.g., Bruscia, 2014; Byers, 2016; Kenny, 1989), there is still a disagreement about the identity of music therapy; still a conflict about evidenced-based practice

and the best way to research the effects of music therapy; and still no development of music therapy theory. Bruscia (2014) proposed an integral practice of music therapy:

> Integral practice is the therapist's continual adjustment of his own way of thinking about and working with a client, to continually meet the emerging needs presented by the client as therapeutic priorities. An integral therapist stays reflexive at the macro and micro level and thinks the way the client needs him to think, not the way of thinking the therapist has already adopted; similarly, an integral therapist works the way the client needs him to work, not the way the therapist has already decided to work. An integral practitioner stays vigilant and open to responding to whatever client needs unfold as they unfold, creating a continual give-and-take of therapist and client following and leading each other. Likewise, an integral therapist can follow a protocol or model faithfully; modify the protocol to meet emerging client needs; use other relevant protocols if and when necessary; and establish a unique way of working with a client without using protocols. (p. 260)

Bruscia (2014) concludes that music therapy is too diverse and complex to be defined within a single theory and that clients can only be served in a safe and ethical way if music therapists must be reflective and have the professional competence and status to practice integrally.

Additionally, music therapy is currently being confused with other forms of music in healthcare, like music entertainment and music listening programs, so music therapists must determine what differentiates music therapy from other uses of music, as discipline and a profession (AMTA, 2014; Robb, et al., 2011). Additionally, in order for third-party payors (i.e., insurance) to recognize music therapy as a health care field, the diversity of ways to practice music therapy must be identifiable as one field to those outside the profession. Presenting music

therapy as one field that has diverse approaches is a daunting challenge, but it seems necessary for the ethical practice of music therapy (Bruscia, 2014; Taylor, 2010).

The field of music therapy is still trying to define its identity, as evidenced by the recent establishment of the Commission on the Education and Clinical Training of 21st Century Music Therapists (American Music Therapy Association: Board of Directors, 2018) and that music therapists are striving for statutory regulation and recognition as a health profession across the world (Barcellos, 2001; CBMT, 2022a; Ikuno, 2005; Kigunda, 2003; Li, et al, 2015; Nöcker-Ribaupierre, 2016; Singh, 2021). If music therapy is still struggling to be recognized as a health profession, it is clear that music therapists are still struggling with their own identity as a profession, discipline, and practice. In order to discover the identity of music therapy, there should be a synthesis, evaluation, and comparison of the various texts that have already been written attempting to establish the identity. Each model of music therapy that is currently being used must be examined for similarities and differences to determine whether a common ground may be established that can lead to a unifying philosophy of music therapy. Once these comparisons have been made, the field can proceed to decide what the education of music therapists should look like, including whether some approaches, populations, or strategies are more appropriate for entry level education and others are more appropriate for advanced practice. If music therapists cannot determine a professional identity, how can they explain music therapy to others or continue to educate and train music therapists?

Purpose Statement

The field of music therapy is currently divided, and there are multiple conflicting definitions of music therapy. The purpose of this dissertation is to investigate the feasibility of a unifying philosophy for music therapy and to offer an identity for the music therapy profession

that is appropriate for the various ways in which music therapy is practiced throughout the world. A review of published music therapy approaches will inform this investigation. The central research question for this dissertation is, “Is it possible to articulate a unifying philosophy of music therapy that is inclusive of the diverse ways music therapy is currently practiced, and if so, what is an integrated philosophy of music therapy?”

Using the unique interdisciplinary perspective of liberal studies, I will investigate the identity of music therapy through a comprehensive review of the historical development of the profession, followed by an examination of each major published approach to music therapy, in order to compare similarities and differences between approaches. There have been several attempts to summarize multiple approaches, but they either purposefully exclude some approaches, or new approaches have been developed since their publication (Aigen, 2014; Bruscia, 2014; Crowe, 2004; Gaston, 1968c; Kenny, 1982, 1989; Taylor, 2010). Therefore, an evaluation and comparison of the previous attempts to develop a unifying theory or philosophy of music therapy is included. After synthesizing these sources with the historical development of music therapy, current research was examined to determine whether current music therapy practice supports the conclusions from the synthesis. Each approach was analyzed to identify the complexity that makes it unique from other approaches, or the repetition that makes it similar to other approaches. Finally, an evaluation of whether a unifying philosophy of music therapy is possible, along with the implications for the profession whether one is possible or not, is discussed. The analysis will conclude with recommendations for education and training, professional development, and a comprehensive research agenda.

The thesis is that a unified philosophy of music therapy which encompasses the diversity of approaches to the practice of music therapy is essential for the continued and positive

development of the profession. The antithesis is that a unified philosophy of music therapy is impossible because of the diversity of approaches to the practice of music therapy; therefore, the profession must develop along different paths. To inform the debate between the two positions, an extensive review of the existing music therapy approaches and theories was conducted. A systematic analysis compared each approach and theory to determine whether a unified philosophy of music therapy is possible. This research explores what it means to be human by engaging diverse cultures and ways of practicing music therapy to find common ground on which the profession may develop through an analysis of the complexity and repetition within each approach.

CHAPTER 2

REVIEW OF LITERATURE

Philosophy consists of ontology, epistemology, axiology, and aesthetics; in other words, what is real, what exists, how it is known, why it matters, and how these areas interact with each other (Matney, 2019). Through development of concepts and a historical examination of theory and practice, music therapists may question the nature of music, ways of understanding the promotion of health, and the values that inform that understanding (Matney, 2019). Many authors have explored the issues and difficulties relating to a unified music therapy philosophy. The following is a review of the literature that will 1) determine the origin and definitions of music therapy philosophy; 2) outline the key theories, concepts, and ideas related to music therapy philosophy; 3) summarize the major debates, arguments, and issues surrounding music therapy philosophy; 4) explain the key questions and problems that have been addressed; and 5) illuminate the important issues that have been insufficiently addressed in music therapy philosophy.

Origins and Definitions

The origins of music therapy philosophy come from collections of writings on the foundations of music therapy theory. Gaston (1968c) and Sears (1968) wrote the first two chapters, respectively, in the first published music therapy textbook. Those chapters influenced the direction of music therapy research and clinical work and identified a need for the development of the theoretical function of music in therapy. Nearly half a century later, Hanson-

Abromeit (2015) proposed a method for systematically describing the therapeutic function of music.

From 1950 to 1962, NAMT published papers presented at conferences in *Music Therapy: Book of Proceedings of the National Association of Music Therapy.* Recently, Bruscia (2018) selected papers from those proceedings that related to music therapy theory and provided commentary to explain the context of each paper and its author, as well as opinions about the relevance of the paper to current music therapy theory and practice. In 1973, Jellison analyzed the NAMT publications from 1952 through 1972 that included the book of proceedings and the *Journal of Music Therapy*. This analysis included 152 articles that were classified as philosophical.

Origins of Music Therapy Philosophy

In the forward to the first textbook published about music therapy, Gaston (1968d) identified three principles that form the foundation of music therapy: 1) establishing of interpersonal relationships, 2) manifesting self-esteem through self-actualization, and 3) using rhythm to energize and organize human activity. He explained that the basic understanding of music therapy must be multidisciplinary:

> An adequate understanding of the nature of man and his behavior is incomplete without some knowledge of his development. To apprehend music as an essential form of human behavior is to make more secure the foundations of music in therapy. Music therapy has long needed such a platform for its theoretical constructs, one that would be in accord with biological as well as psychological concepts. It has needed knowledge derived from a multidisciplinary approach. Music therapy is closely related to the behavioral sciences. As is the case in all sciences, music therapy strives to bring about organization,

classification, and description until a system emerges, a system that is behavioral, logical, and psychological. To bring more comprehension of man and music to describe processes in music therapy are the major purposes of this book. (Gaston, 1968c, p. 6)

Behavioral sciences include any of the various disciplines dealing with the subject of human actions, usually including the fields of sociology, social and cultural anthropology, psychology, and behavioral aspects of biology, economics, geography, law, psychiatry, and political science. This term is often used synonymously with social sciences and frequently includes similar disciplines. While Gaston (1968c) believed that studying overt behaviors is the most feasible "because little is known of what happens inside man when he is engaged musically" (p. 7), he also believed that excluding other sources of knowledge was incomplete: "No single scientific approach will explain man or his behavior" (p. 8). Gaston appeared to support a multidisciplinary understanding of music therapy and recommended research from several approaches to fully explain music therapy. However, he seemed to prefer empirical research as the starting point for determining the most effective methods for music therapy (Gaston, 1968c).

In the chapter entitled, "Processes in Music Therapy," Sears (1968) stated that the development of the theoretical function of music in therapy was necessary to promote better communication among music therapists and colleagues. The theoretical function of music in therapy could be developed through the organization, classification, and description of the processes in music until a system emerged that was behavioral, logical, and psychological that was consistent with pertinent and accepted psychological theories. Sears (1968) explained, "Music therapy offers the individuals the experiencing of events in certain ways and the processes attempt to define those ways of experiencing" (p. 32). The identification of those

processes was an attempt to integrate into one system the best knowledge and thought available at the time concerning the function of music in therapy. Sears (1968) expressed the hope that the processes would be tested, modified, improved, and expanded.

Subsequent chapters in the 1968 text were intended to provide clinical examples that referred to specific processes identified by Sears, but those processes overlapped in many examples (Gaston, 1968d). Additionally, the outline format of the processes caused conflation of subconstructs within the process with a separate process (Sears, 1968, 2007). This format apparently led to assumptions regarding a hierarchy within the processes that describe a behavioral model of music therapy (Aigen, 2014; Sears 2007).

In a revision of this chapter, presented at the National Association for Music Therapy 30th annual conference, Dallas, TX, October 30–31, 1979, Sears clarified that the processes in music therapy were not intended to be hierarchical or linear. He imagined a three-dimensional model similar to the double helix shape of DNA with the therapist at center of three circles that represented structure, self-organization, and social relations occurring within time-ordered behavior. The processes were intended to describe current music therapy practice and were not connected to specific philosophy or treatment concept (Sears, 2007).

Hanson-Abromeit (2015) proposed a method for defining and articulating the therapeutic function of music in a systematic manner using a reflective and interpretive process called the Therapeutic Function of Music Plan (TFM Plan). The author identified four ways in which this process will benefit music therapy: 1) creating a framework in which the therapeutic effect of music on behavior could be explained, 2) generating a way to consistently apply musical characteristics so that the musical response can be more consistently connected to a therapeutic response, 3) supporting predictable outcomes based on specific applications of music, and 4)

fostering an understanding of music as a therapeutic medium so that music therapy is recognized a specialized profession (Hanson-Abromeit, 2015, p. 30).

In 2018, Bruscia gathered a collection of papers presented at conferences from 1950-1962 published in the *Music Therapy: Book of Proceedings of the National Association for Music Therapy*. The articles selected related to theory, rather than research, practice, or client population, and were considered "theoretically significant" (p. xii). Bruscia (2018) helped clarify and contextualize each article that was written by professionals who were instrumental in the development of music therapy but were not necessarily music therapists. These authors reflect the interdisciplinary origins of music therapy. Some of the theoretically significant conclusions in each paper included: music therapy is both art and science and is more effective when the therapist first matches the client's mood then modulates to a desired mood state (Altshuler in Bruscia, 2018, pp. 7–21); and music is nonverbal communication and a social equalizer (Dreikurs in Bruscia, 2018, pp. 35–43). The first general theory of music therapy, proposed by Fultz (in Bruscia, 2018, pp. 59–63), asserted that music therapy improves interpersonal relationships and the communication competencies required to form and maintain relationships. In another paper, Gaston (in Bruscia, 2018, pp. 107–114) used interdisciplinary explanations of emotional responses to music using research from sociology, neurophysiology, and endocrinology.

Hahn (in Bruscia, 2018, pp. 118–124), a music education professor, proposed that more research needed to be conducted regarding personality, culture, psychoacoustic responses, and associations to music; while Klink (in Bruscia, 2018, pp. 130–135), a chaplain at Topeka State Hospital (which was also the location of the first music therapy clinical internship), identified the similarities between music and religion by conceiving of the session as a ritual and the music as

a sacred space. Kohut (in Bruscia, 2018, pp. 142–147), a psychiatrist and psychoanalyst, defined personality as functions of the Id, Ego, and Super-ego, and stated that music affects the whole personality. Therefore, change in one area of the personality affects change in all areas of the personality. Music is catharsis for the Id, play for the Ego, and has rules and aesthetics that appeal to Super-ego, while also serving as a means of relieving guilt and shame.

Not all the authors included in Bruscia's collection of early theoretical writings on music therapy were in support of the profession. Masserman (in Bruscia, 2018, pp. 160–170) did not actually believe that music therapy was useful but recognized that music promotes social connection and is universal and pervasive in society. Although Masserman claimed there is no scientific proof that music therapy works, he also stated that music therapy has the potential for harm, if misused. The remaining authors proposed that culture plays a large role in the effectiveness of music therapy (Meyer in Bruscia, 2018, pp. 175–182), that sound is vibration started by movement, and music is a human expression that organizes sounds in time (Ostwald in Bruscia, 2018, pp. 189–206).

The final author included in Bruscia's (2018) collection was Wayne Ruppenthal, the first graduate from the Master of Music Education in Functional Music program begun by Gaston. Ruppenthal disagreed with Gaston about how music therapy worked. While Gaston believed music was inherently therapeutic, Ruppenthal believed Gaston did not have the clinical experience to support that view. Ruppenthal felt that the human dimensions of music therapy were equally important. Three characteristics that made music therapeutic, according to Ruppenthal, were that music is a structured reality, a nonthreatening experience of reality, and a means of connection with others (Ruppenthal in Bruscia, 2018, pp. 211–216). In the commentary preceding Ruppenthal's paper, Bruscia questioned how structure is defined as reality and

whether music experiences are always nonthreatening; however, he stated he could not argue with Ruppenthal's point that music is a means of connecting with others.

Another author who studied NAMT publications to draw conclusions about music therapy philosophy was Jellison (1973), who analyzed the publications of NAMT from 1952 through 1972 to determine the frequency and general mode of inquiry of music therapy research. Articles were classified as philosophical, historical, descriptive, or experimental. An analysis of 485 articles yielded that 152 of them were classified as philosophical and showed a significant decline in philosophical research published from 33 articles in 1952 to 13 in 1972. Jellison (1973) concluded that:

> While philosophical research is imperative to the identification of needs and concerns in music therapy and is imperative to the identification of possible directions for the advancement of therapeutic practice, a decrease in articles of this mode of inquiry does not necessarily indicate a process of decline in valuable ideas and theories. It would only appear that philosophy has indeed identified areas and directions and the demand now is for precise examination of those ideas and theories. (p. 7)

Philosophical Foundations of Music Therapy Defined

Jellison (1973) defined articles about music therapy philosophy as those "dealing with analysis, criticism, and/or speculation of ideas or theories in relation to music therapy" (p. 3). Based on the origins of music therapy philosophy explored in the previous section, philosophical concepts that inform music therapy may be identified as multidisciplinary (Bruscia, 2018; Byers, 2016; Gaston, 1968c); based on a music-client-therapist relationship (Aigen, 2014; Byers, 2016; Gaston 1968d); and those that assert music is helpful to humans and can be used systematically to achieve goals (Aigen, 2014; Gaston, 1968d; Hanson-Abromeit, 2015; Sears, 1968/2007).

Philosophical foundations also relate to values. In the epilogue to his book, Aigen (2014) recounted four conversations with influential music therapists: Barbara Hesser, Florence Tyson, Clive Robbins, and Kenneth Bruscia. For Aigen, these conversations illustrated four values of music therapy: “the central importance of music, prioritizing a commitment to people over a conceptual system, letting the music do the work, and the inherent value of diversity” (p. 247).

Multidisciplinary aspects of music therapy are evident by the origins of music therapy from music educators, physicians, psychologists, and occupational therapists (Bruscia, 2018; Byers, 2016). Gaston (1968c) emphasized the need for a multidisciplinary education for music therapists, and his identification of music therapy as a behavioral science implies influences from anthropology, sociology, psychology, zoology, and the physical sciences. Gaston (1968c) stated, “No single scientific approach will explain man or his behavior,” (p. 8), and asserted that music therapists need a basic understanding of other approaches to the meaning and means of musicking, including aesthetics. By understanding music therapy first through behavioral sciences, then through other sciences, and finally through philosophy, the field, according to Gaston (1968c), would be better informed. The early writers on music therapy theory, however, were not music therapy clinicians, but music educators, psychologists, psychiatrists, and neurologists (Bruscia, 2018).

Several authors appear to agree that the foundations of music therapy philosophy include music, clients, therapists, and the relationships between the three. Gaston (1968d) identified the three foundational principles of music therapy as relationships, self-actualization, and rhythm as an energizer and organizer. These principles share similarities with the music-client-therapist relationship proposed by Byers (2016) to be the jurisdiction of the music therapy profession. Similar principles are also reflected in the values of music therapy identified by Aigen (2014):

music, people, and diversity. Whereas Gaston (1968d) emphasized interpersonal relationships, Aigen (2014) emphasized the priority of people over adherence to conceptual systems. Byers (2016) emphasized the relationship between the client and therapist, as well as each individual's relationship with music and the relationship between the client and therapist in the music.

Byers (2016) identified a core belief among music therapists, which is that music is helpful to humans and can be used systematically to achieve goals. This philosophical concept is also evident in two of the values identified by Aigen (2014): the central importance of music and letting the music do the work. Gaston (1968d) focused on the aspect of rhythm to energize and organize human behavior, but Hanson-Abromeit (2015) provided a method to define the therapeutic function of all the elements of music, not just rhythm. Sears (1968, 2007) supported a systematic analysis of the processes in music therapy to determine its effectiveness. Additionally, the foundational principle that a client's self-esteem is manifested through self-actualization implies the nature of music therapy to help clients achieve goals (Gaston, 1968d).

Key Philosophical Theories, Concepts, and Ideas

Gaston (1968c) believed that increasing knowledge of the nature of human beings was essential for music therapists. He stated that a combination of behavioral and psychological techniques is needed to increase knowledge of brain processes and that keeping the nature of the psyche a mystery is incompatible with trying to understand human nature (p. 8). Gaston pushed for multidisciplinary study and research in music therapy, because he asserted that an integrated knowledge of genetics, biochemistry, neurology, embryology, psychology, sociology, and physical sciences (acoustics) is necessary to understand both humans and art. Additionally, Gaston believed that a music therapist must be a good musician, who needs education in science, math, and liberal arts because humans are connected to everything. Further, Gaston (1968c)

believed that music therapists must understand the evolution of human beings beginning with the origin of the universe in order to understand humans.

Because biological and cultural evolutions are part of the same process, music has both a biological and cultural basis (Lumsden & Wilson, 1985). Both complex societies and complex human brain functioning are highly interactive and highly dependent on each other (Hari, et al., 2015). Personality is a result of expanding organization, and the key to the process of life is organization (Gaston, 1968c; Schneck, 2015). Human sensory systems crave input through sights, sounds, shapes, textures, and rhythms (Gaston, 1968c; Schneck, 2015). Aesthetics involves enriching and elaborating on human sensory and motor ranges of experience (Gaston, 1968c; Marković, 2012); therefore, Gaston (1968c) concluded, "Music is an essential and necessary function of man" (p. 15).

Just after NAMT and AAMT merged as the American Music Therapy Association (AMTA) in 1998, Michel (2000) assessed the progress on the goals of the association that were identified in 1960: advancement of research, distribution of helpful information, establishing education standards, and development of effective music therapy protocols for treatment of medical problems. Michel's (2000) assessment determined that these goals were still relevant to the newly formed AMTA. Concluding with a vision for the future of music therapy, Michel (2000) predicted that if these goals are realized, professional music therapists would be: trained and qualified clinical practitioners, in great demand in all health care fields, recognized as therapeutic generalists providing treatment for a wide variety of clients through the medium of music, work in preventive and wellness as well as clinical and educational areas, conduct research and contribute to professional journals, use scientifically-based protocols, and act ethically.

Philosophical ideas about music therapy are often personally specific. Michel and Pinson (2005) shared their respective philosophies of music therapy and identified common ideas: music is an effective therapeutic tool, music is a means of communication, the contribution of the therapist is important, and the nature of music therapy is "universal" (p. 9). Madsen (1974) wrote, "The philosophical issues about which we get the most excited are generally those issues which represent the widest chasms of disunity regarding appropriate 'methods' of investigation" (p. 171). He suggested that rather than trying to agree, proponents of specific research methodologies should disagree in order to "strive toward unity without sacrificing scientific integrity" (p. 171). Madsen maintained that statistics, behaviors, and phenomenology are different modes of inquiry, and that all three should be evaluated based on their own purposes, as well as respected for the various perspectives they provide to scientific truth.

Madsen, Cotter, and Madsen (1968) confronted the perception that a behavioral approach to music therapy negates the complexity of human behavior with dehumanizing techniques. The authors countered the misunderstandings by explaining that the word "behavior" includes emotions, ideas, and cognition, in addition to motor responses, but that music therapy must be subjected to scientific examination before being incorporated into more extensive applications.

Integral Theory

Bruscia (2014) concluded that Ken Wilber's theory of integral thinking, a way of thinking freely and creatively to solve a problem, is necessary for music therapists to ethically practice and serve their clients. Integral thinking requires accepting the diversity of music therapy, integrating old and new practices, and finding commonalities. This way of thinking also means that music therapists recognize differences as options, respect ideas of others, and be reflexive. Additionally, integral thinking in music therapy consists of changing the locus and

focus of awareness to understand the point of view of the client, and determining what would be most helpful to address, while looking at both the micro and macro perspectives (Bruscia, 2014).

Complexity Science

Crowe (2004) stated that music therapy is based on these basic points: Music is a powerful tool for healing, and music is source of human knowledge and understanding. She defined music therapy as the systematic use of music by a trained professional to achieve individual therapeutic goals for a wide variety of clients. Further, Crowe believed that music therapy is a process-based intervention that combines the art of music and the interpersonal interaction of therapy that is verified by science, and a process of engaging in music-making but sounds/vibrations also affect human functioning. Using complexity science, Crowe formulated a philosophy of music therapy that explains its effectiveness. Complexity science is the science of complex systems in motion.

The soul is that which is most unique and genuine in each individual. Crowe (2004) stated that theories from multiple disciplines are necessary to explain the complexity of human functioning. She reviewed the cultural origins of music and history of modern music therapy, along with current state of music therapy, to arrive at the conclusion that music therapy is a behavioral science. The author identified it as a well-established professional discipline, which developed within and as part of the scientific, biomedical model. She concluded that music therapy must take into account the physical effect of sounds and music on human functioning, in addition to the experience of music and human interactions with it, proposing a theory of music therapy called “music and soulmaking.”

Crowe (2004) described complexity science as a new scientific paradigm and stated that music and soulmaking, which is based on principles of complexity science, is a new scientific

theory of music therapy that is inclusive of all approaches and processes. Soulmaking is defined as the ongoing process of health in mind, emotion, body, and spirit, and health is the process by which humans maintain the ability to function optimally in face of change, trauma, and challenge. However, this theory is not yet widely referenced in other music therapy publications, probably because the works Crowe used to support some of her arguments are frequently considered to be pseudoscience. The works Crowe cites that fall under scrutiny include those of authors such as Deepak Chopra, Don Campbell, and Alfred Tomatis, as well as other practices that are not generally studied scientifically, such as Sound Healing and Traditional Chinese Medicine.

There are two notable exceptions that may indicate increasing acceptance of Crowe's work. Aigen (2014) referenced Crowe's theory, identifying the following elements of complexity science-based music therapy: mindfulness, intuition, decreased emphasis on a musically prescriptive approach, holistic understanding of the person, and greater attention to musical factors (p. 224). Matney (2020) also referenced complexity theory in relation to multiplicity, noting that Crowe promoted a new understanding of predictability in music therapy by including the concepts of emergent properties, novel interactions, chaos, and fractals.

Phenomenological Theory

Kenny (1982) defined music therapy as:

> "a process and a form which combines the healing aspects of music with the issues of human need for the benefit of the individual and hence society. The music therapist serves as a resource person and guide, providing musical experiences which direct clients toward health and well-being." (p. 7)

Kenny (1982) identified the proper conditions for creativity as flexibility; having the tools for self-expression in an expressive situation; and spontaneously playing with patterns, shapes, sounds, colors, ideas, and relationships. For Kenny, the problem with a scientific study of music therapy is that the experience of music therapy is not entirely predictable or controllable. The parts of the music therapy experience that are unpredictable may be described as "magic," which makes music and the arts necessary for survival (Kenny, 1982).

According to Kenny (1982), an overuse of the medical model led to the negation of spirituality and a dearth of creativity and the ability to use paradox. The author stated there are processes in music that can be used for healing that are often ignored in most clinical orientations. The assumptions for Kenny's healing processes include:

1) Music contains magic.

2) Music is an aesthetic experience and therefore conducive to patterning.

3) Music can introduce and develop creative processes. (Kenny, 1982, p. 138)

According to Kenny (1982), humans can sense connections between themselves, their environment, and their culture, which brings them together through the sharing of patterns. Further, identifying and using music provides a unification and a connection:

> "Music carries messages which speak of our intimate involvement in the human condition and connects us to the historical stream of human existence and all of nature. For music is the expression which focuses on the continuity of life. This is the Mythic Artery" (Kenny, 1982, p. 57).

As the mythic artery, music functions as a healing agent in three ways:

1) A work of art and music usually focuses on one outstanding theme or message, allowing humans to deal with one emotion at a time, making it bigger so it can be understood or seen more clearly;
2) An artistic expression is an objectification so humans can experience feelings symbolically that they are not currently feeling; and
3) Music and art can help humans learn that they are not alone in their feelings (Kenny, 1982).

The role of therapist is to guide the journey, to guard and support the participants, and to aid them in identifying meaningful themes. The materials of the arts touch the human spirit and inspire the creation of the art of the people (Kenny, 1982).

In 1989, Kenny developed a holographic model to describe the experience in music therapy that applies to any population or technique. Using phenomenology—a descriptive research method—to search for patterns within an experience, Kenny (1989) determined that the field of music therapy provides a human service that is generally concerned with the human condition as an interplay with society and culture. The author described music therapy as a process-oriented art and science with four essential elements: conditions—strengths and limitations, cultural context, and identity; fields—environments, containers for change, and supportive contexts; relationships—between humans and music within a context for growth and change; and self-organization. Further, Kenny believed that music provides a safe field for change, growth, and recovery. Kenny (1989) described theory as the foundation for practice and philosophy as the foundation for theory. Philosophy asks questions of meaning and directs experience and how it is understood: "Our philosophy is the source and therefore the cause of

many of our actions in our work. It informs our decisions" (Kenny, 1989, p. 47). For Kenny, the connection of philosophy to direct clinical experience is fundamental.

Music Centered Music Therapy

Aigen (2005) proposed that music therapy is best understood through indigenous theory—that which comes from within the discipline of music therapy—rather than borrowing from theories outside of music therapy, like psychology. The author distinguished a music-centered theory of music therapy as a general theory, rather than a foundational theory. According to Aigen (2005), a general theory of music therapy is constructed from the analysis of current clinical music therapy practice and by studying what music therapists do to explain how it works. A foundational theory of music therapy is constructed from an understanding of broader human functioning and interpreting how music therapy works based on the effects of music on human functioning. For Aigen (2005), music-centered thinking reflects existing music therapy practice: "*…in music-centered music therapy, the mechanisms of music therapy process are located in the forces, experiences, processes, and structures of music"* [italics original] (p. 51).

Aigen (2005) identified one problem with music-centered theory: "The music-centered perspective cannot be represented simply, as there is no official doctrine or set of beliefs and practices that define the approach" (p. 51). Music-centered approaches emphasize the clinical value of musical experiences and music-centered practitioners need to be able to articulate this value and explain clearly why this way of working is therapeutic. Aigen (2005) proposed, "A broad music-centered theory should be able to accommodate different ways of conceptualizing and implementing music therapy" (p. 241). Aigen pointed to two music-based theories that could inform music therapy philosophy. The first was a schema theory, which is an approach to human

understanding that relates to metaphors and a way to experience and talk about music. The second was Zuckerkandl's dynamic theory of tone, a theory that examines the nature of music to see what it reveals about the nature of humans and reality. Aigen (2005) described how these music-based theories inform music therapy philosophy: "And recognizing the reality of musical force, motion, and space allows us to utilize them in an explanatory capacity in music therapy theory" (p. 235). However, not all approaches rely on metaphors or on the nature of music to explain the effects of music therapy on human beings.

Biomedical Theory

Taylor (1997, 2010) acknowledged that music therapy is not widely accepted as a profession because there is neither a consensus of a philosophical approach to music as therapy, nor a theoretical basis in which to understand how music therapy works. The author explained how the effects of music on the human brain are possible to observe and explain in biomedical terms without discounting the work of music therapists who subscribe to various theoretical approaches, including behavioral, sociological, psychoanalytical, cognitive, guided imagery and music (GIM), improvisational, neurologic music therapy (NMT), phenomenological, and quantum theory. Taylor did not include complexity science or Nordoff-Robbins Music Therapy (NRMT), another music-centered approach, in his description of how biomedical concepts are compatible with various approaches. Crowe (2004) acknowledged that the biomedical model adapts slowly, even though many disciplines of science now apply the principles of complexity science, including biology, human consciousness, economics, cultural development, human functioning, and health.

The primary rationale for using the biomedical theory to explain the various methods of music therapy is that each approach addresses brain activity to change the client's ability to

function (Taylor, 2010). Emphasizing that biomedical music therapy is not a specific set of techniques or an intervention model, Taylor clarified that the biomedical theory of music as therapy provided a foundation for research, education, and clinical practice in which to explain the effectiveness of music therapy.

Major Debates Surrounding Music Therapy Philosophy

There are several major debates surrounding music therapy philosophy including two notable symposiums attempting to address this debate. Additional debates regarding music therapy jurisdiction, education and training, theories, and research have occurred in publications. Another debate occurred regarding whether music therapy is an art, a science, or a humanity.

Symposia

The First International Symposium on Music Therapy Training was held in Herdecke, Germany in October 1978 (Wheeler, 2003). The symposium was followed by two meetings of a group that formed at the Herdecke symposium to discuss the Theory of Music Therapy. This group was chaired by William Sears and met two additional times in 1979 at the University at Aalborg in Denmark and at SMU in Dallas, TX (Wheeler, 2003). The second international symposium was "Music in the Life of Man," which was organized by Barbara Hesser in 1982. From this symposium, a group of people who gathered by invitation of Hesser spent five days in a retreat center in Phoenicia, New York. The Phoenicia Gathering was a small international retreat of humanistic and transpersonal music therapists that took place from 1985 -1992 from which the idea for the Bonny Foundation, an Institute for Music-Centered Therapies came into being (Hesser, 2014).

First International Symposium on Music Therapy Training. Educators and clinicians from 12 countries were invited to participate in the First International Symposium on Music

Therapy Training in Herdecke, Germany. The primary purpose of this symposium was to stimulate international cooperation in music therapy education. Representing the United States at this symposium were three music therapists affiliated with NAMT, three affiliated with AAMT, and those who were not affiliated with either association. The primary outcome of this symposium was improved communication between music therapists worldwide and direction for future international cooperation in the music therapy field (Wheeler, 2003). Both the development of the World Federation for Music Therapy (WFMT) and the unification of AAMT and NAMT trace their origins to the relationships developed at this symposium (Wheeler, 2003).

World Symposium on Music Therapy, "Music in the Life of Man." During the 1982 symposium organized by Barbara Hesser and held in Phoenicia, NY, 31 music therapists from around the world were invited to New York University to participate in discussions with the intent to formulate a theory of music therapy and the principles underlying the theory. Four groups discussed topics identified on the first day of the symposium: Illness and Wellness in Musical Experience, Encountering Self in Musical Experiences, Experience of Time and Rhythm in Music Therapy, and Appropriate/Acceptable Approaches to Studying Musical Experiences. These discussion groups offered recommendations for further discussions, including:

- Is meeting the client where he is a basic philosophy of music therapy?
- What are the social and cultural aspects of music therapy?
- What is the neuro-psychological basis for music therapy?
- What is aesthetics in music therapy?
- What is the role of the musical personality of the client and the creative process?
- How can music therapists connect and integrate the human experience with basic principles and philosophies of music therapy to not get lost in methodology?

- How do different music therapy techniques compare using one case study?
- How is the personality of the music therapist an integral factor in the music therapy process?
- What is the difference between musical experience and musical experience as therapy?
- How do music therapists maintain a balance between humanness and intellectualism, reflecting holism?
- How does verbalizing after music experiences occur and what does it influence?
- How can music therapists incorporate a diversified approach to music therapy research? (Forinash & Kenny, 2015)

The recommendations from this symposium have been widely discussed within the areas of jurisdiction (Byers, 2016; Ruud, 1980; Taylor, 2010); education and training (Aigen, 2014; Bruscia, 2014; Kenny, 1982); theory (Aigen 2005, 2014; Bruscia, 2014; Ruud, 1980; Taylor, 2010; Thaut, 2005); research (Aigen, 1991; Geist, 2016); and whether music therapy is an art, humanity, or science (Bruscia, 2014; Matney, 2020).

Jurisdiction

Byers (2016) defined jurisdiction as referring to the boundaries of profession defined by how the profession diagnoses a problem, treats the problem, and creates a connection between diagnosis and treatment through academic knowledge and is influenced by society's understanding of the problem and the academic knowledge. The author advocated for music therapists to define themselves, rather than letting other disciplines determine the jurisdiction of music therapy. Byers contended that the diversity within the profession may contribute to this dilemma:

"It is almost as if the profession has been frozen by a need to respect others' opinions, something that can also be seen as a lack of critical analysis in the field. Respect and a desire to be inclusive should not cause one to fear critiquing ideas and delineating parameters of the profession. An honest evaluation of the field and the identification of some grounding principles are needed if the profession is to continue to develop as a single entity. If the profession does not define music therapy, others will." (p. 108)

Using Abbott's system of professions theory, Byers (2016) defined a profession as "a group of workers who apply a common abstract knowledge base and who are structurally organized through a system of education and qualifications" (p. 109). Abbott's theory considers a profession at three levels: the actual organization of the profession, a differentiation within professions, and how larger social forces affect the individual profession (Byers, 2016). Byers indicated that conventionally, music therapy jurisdiction was considered to be the use of music to improve human life. She identified four threats to this jurisdiction: the subordination of the profession to other therapeutic areas of jurisdiction, a weak jurisdictional control over the "use of music," the field's wide scope of practice, and the profession's global organizational development. Music therapy is musically and therapeutically demanding, and music therapists are often paid less than other health care professionals, so this view of music therapy jurisdiction is not sustainable, according to Byers. The field of music therapy, therefore, must find a way to be unified in diversity by developing a foundational jurisdiction that solves a problem which society values and is unique to music therapy. Byers maintained that an "unarguable" jurisdictional area is the music-client-therapist relationship, and that this relationship is unique to music therapy, even though the balance of the components may vary clinically, depending on the model of practice. This idea is similar to the foundational principles identified by Gaston where

relationships are represented by Byers' client-therapist relationship, *self-actualization* refers to the client, and *rhythm as an energizer and organizer* is indicated for music.

Ruud (1980) concluded that the relationship between humans and music is what distinguishes music therapy from other disciplines. However, the author did not believe that music therapy could establish theories and procedures that were separate from those of psychology or philosophy.

Taylor (2010) submitted that the human brain is the true domain of music therapy:

> "This clear conclusion is based on the inescapable fact that literally all of the work that music therapists do is ultimately aimed at changing some type of behavior, which can only occur with changes in the functions of specific biological structures of the human body, all of which are determined either directly or indirectly by the brain." (p. 49)

Aigen (2014) refuted this fact, stating that choosing a medical model is unethical because one chooses this model for pragmatic or epistemological reasons. Ethical music therapists choose creative, improvisational, context-, and relationship-based work because these approaches provide the best possible care (Aigen, 2014, p. 22). According to Aigen (2014), medical and psychodynamic models view music as compensatory strategy or medium, while social and music-based models view music as a value-added medium. Byers would refute the idea of the brain as a domain of music therapy because other professions (neurologists, psychologists, etc.) would have a more dominant claim on the brain as a jurisdiction. Taylor (2010), on the other hand, provided arguments and clinical examples illustrating how music therapy enhances "human capabilities through the planned use of musical influences on brain functioning" (p. 259).

Education and Training

Aigen (2014) claimed that the *Study of Music Therapy* is the only book in music therapy that gathers all the major issues that are currently being debated in the field. Comparing himself to Bruno Nettl, who explored positions and issues in ethnomusicology and offered his own perspectives in a “non-polemical” way, Aigen used a multidisciplinary approach to examine defining issues of music therapy as a scholarly discipline, rather than as an area of clinical practice. The author acknowledged that his values in music therapy align with improvisational, social, creative, music-based approaches and do not align with medically oriented, scientific, behavioral, or psychodynamic approaches. He stated that the diversity of field is a strength but that social progress requires a unified voice. Music therapy is a health profession implemented by trained therapists, has applications in a variety of contexts, and is predominantly modeled after the medical profession (Aigen, 2014). While music therapists assert that the profession of music therapy originated as a health profession after World War II, historians and anthropologists, contend that music therapy originated as a healing art practiced by shamans and mystic or religious healers (Aigen, 2014).

A common definition of music therapy is “the use of music to achieve non-musical ends” (Aigen, 2014, p. 15). Aigen (2014) identified four problems with this definition:

- There is no reason for music therapy if there is an alternative means for achieving the same goals;
- It does not reflect how music therapists actually practice, especially music-centered and community-focused music therapists;
- It restricts the focus to rehabilitations goals and disconnects from social, cultural, or psychological contexts; and

- It isolates music therapy from related disciplines that do not define themselves in similar ways (e.g., speech therapy is not the use of speech to address non-speech goals).

Music therapy has developed to a state where models and approaches are so differentiated and to the point where the spectrum of practice is so broad, that global descriptions of music therapy are impossible, making the idea of a unified identity difficult (Aigen, 2014). However, Aigen claimed that diversity is healthy, because it enables music therapists to meet the needs of diverse clients in a rapidly changing world. Further, he held that the interests of clients are best served by a diversity of clinical approaches, and that a tolerant attitude supports this diversity. This, according to Aigen (2014), requires that elements of any one theoretical perspective are not emphasized in academic or professional standards; that different approaches are not considered more effective, more advanced, or work at a more fundamental level; and therefore, that enhanced respect for all perspectives will benefit clients.

While the concept of therapy is a Western concept, the goal of therapy is to help clients adopt more functional ways of being in the world. Myth and ritual can help in this process of change. Music therapy as ritual has a strong connection to a shaman, who connects people to hidden sources of insight and growth (Aigen, 2014).

Aigen (2014) confronted what he called Gaston's paradox: Gaston (1968c) claimed that music is valuable because it is more than just a biological necessity, but also claimed that music is valuable because it provides biological advantages. Music is essential to what it means to be human. The origins and rationale for music lie within a biological consideration. If the brain is the fundamental focus of music therapy, then explanations based on psychological, sociological, or musicological foundations are not legitimate. Neurological explanations, according to Aigen

(2014), cannot account for psychosocial or psychological outcomes. Social science should, therefore, not be eliminated as a viable explanation of music therapy, since this would constitute a reductive approach that is limiting and flawed (Aigen, 2014). However, it appears that Aigen misunderstood Gaston (1968c), who stated that music therapy is multidisciplinary, so one mode of exploring music therapy would be incomplete.

Aigen (2014) summarized the development of music therapy theory in three stages. Stage one occurred in the 1940s through the 1960s when clinical psychology theories were imported into music therapy, first as psychoanalytic theories, followed by behavioral theories, which coincided with the predominant theory in psychological fields at the time. Stage two occurred in 1965 to 1981, when treatment models were developed in clinical practice by individuals, such as Nordoff-Robbins Music Therapy (NRMT, developed by Paul Nordoff and Clive Robbins), Analytical Music Therapy (AMT, developed by Mary Priestly), Guided Imagery and Music (GIM, developed by Helen Bonny, often referred to as the Bonny Method, or BMGIM), and the Benenzon Model of Music Therapy (BMMT, developed primarily in Latin countries by Rolando Benenzon). Stage three began in 1982 with the publication of Kenny (1982) and continues into the present, although the next publication in this stage over a decade later by Taylor, (1997, 2010). The theories developed in stage three were identified by Aigen as indigenous, in which the social sciences, arts disciplines, biological sciences, and broad-based theories were developed that are relevant to multiple models (see Aigen, 2005; Crowe, 2004; Garred, 2006; Hadley, 2006; Kenny 1982, 1987; Lee, 2003; Pavlicevic & Andsell, 2004; Rolsvjord, 2009; Ruud, 2010, 2020; Smeijsters, 2005; Stige, 2002; Taylor, 1997, 2010; and Thaut 2000, 2005).

The Neurologic Music Therapy (NMT) approach provides training in neurological processes and research related to how music affects those processes, with specific techniques to

address neurological disorders that have a standardized label to increase clarity when communicating with medical, educational, and rehabilitation professionals (Thaut, 2005). Aigen (2014) criticized NMT as an advanced practice because the training occurs over a few days instead of years like Guided Imagery in Music (GIM), Analytical Music Therapy (AMT), or Nordoff Robbins Music Therapy (NRMT). To Aigen, NMT appears to be more a technology of applications rather than a combination of musical, creative, and intuitive skills. However, NMT is intended for board certified music therapists, who have already developed those skills.

Aigen's (2014) writing indicates a clear bias against behavioral, neuroscientific, and medical models of music therapy. The author referenced the 1997 edition of Taylor, rather than the 2010 edition. Aigen proposed that most music-centered music therapists are working eclectically and pragmatically but did not extend the same assumption to biomedical music therapists. Aigen stated erroneously that the therapist-client relationship is not a necessary component in a medical model. Although the therapist-client relationship may not be emphasized in the same way as other approaches, it is still essential (Hojat, 2007). Aigen also stated that music is not a biological adaptation because an adaptation is a solution to a problem, a reaction, but creation is fashioning something that did not exist before. Therefore, music is not reducible to solving a problem related to material survival. Survival, according to Aigen (2014) does not explain the lengths to which people with profound disabilities go to engage in music therapy. However, if people with profound disabilities are going to extreme lengths to engage in music therapy, perhaps it is because they do need music to survive, which meets the criteria for a biological adaptation.

Kenny (1982) wrote, "It is clear that music therapy is an interdisciplinary field" (p. 125), indicating that music therapy training must include courses in music, psychology, philosophy,

religious studies, art, drama, anthropology, sociology, ethnomusicology, and more. A music therapy candidate, according to Kenny, must be a mature person with a liberal arts background and some life and work experience. This implies a belief on Kenny's part that music therapists should be trained at the master's degree level and should have respect for their own personality resources and the resources of the client. Additionally, Kenny (1982) focused more on personality characteristics that music therapists should cultivate, such as respecting the processes inherent in music, structure, silence, time, space, and history, more than on the education and training. Music therapists must have confidence, both in themselves and in others, as well as confidence in the process of growth. They must exhibit flexibility, adaptability, empathy, strength, knowledge, humility, enthusiasm, humor, and warmth. Successful music therapists must also have a sense of balance, good intentions, objectivity, and musical sensitivity—ability to explore sound and silence freely, while encouraging participants to do the same (Kenny, 1982).

Integral thinking leads to integral practice, in which the therapist adjusts ways of working with clients to meet the emerging needs and therapeutic priorities of the clients. Bruscia (2014) claimed that the bachelor level of education and training is inadequate for music therapists to practice in this way. Music therapy educators and researchers would require master's and doctoral level degrees, while music therapists with a master's level or extensive clinical experience combined with advanced training could work at the primary and intensive levels, as well as providing clinical supervision. Clinicians with a bachelor's degree are qualified to practice at the augmentative and intensive levels, and to provide supervision of practicum students and other individuals using music at an auxiliary level.

Theories

Music-centered vs. Biomedical. Taylor (2010) originally proposed biomedical foundations of music as therapy in 1997 and stated that the implication that defining music therapy through observable influences of music reduces the therapeutic experience is only viable as a philosophical basis if music therapists were only explaining the effectiveness to musicians. In order to be compensated as medical professionals, Taylor (2010) argued that music therapists need "to delineate a clear and pervasive basis for music as therapy and to articulate it to other medical professionals in language that is technically familiar, grounded in medically acceptable research, and theoretically sound" (p. 29). The author contended that because the effects of music on human functioning can be explained by understanding brain functioning, music therapists must include the brain in any explanation of music therapy (Taylor, 2010).

Aigen (2005) countered this argument:

> And while there is no musicing without a brain, this does not imply that an understanding of the neurological correlates of musical experiences and phenomena will shed any light on the mechanisms of music therapy processes across a wide spectrum of practice…. [N]eurological information cannot provide insight into the nature of clinical processes when one is concerned with human motivations, intentions, and experiences" (pp. 163–164).

According to Aigen (2014), if the brain is the fundamental focus of music therapy, then explanations based on psychological, sociological, or musicological foundations are not legitimate.

Conversely, Thaut (2005) pointed to brain research as justification for the use of music therapy, writing: "Traditionally, music in therapy has been based mostly on social science

models in which the cultural role of music is interpreted as an effective facilitator for therapeutic concepts of well-being" (p. 61). In the mid-1990s, as brain imaging became more accessible, evidence emerged indicating that engaging in music changes the brain and that music stimulates complex sensorimotor, affective, and cognitive processes in the brain that can generalize to nonmusical therapeutic applications. Thaut (2005) proposed the Rational Scientific Mediating Model (R-SMM) as a perceptual neuroscience model for understanding music therapy, shifting away from an interpretive social science model. In the R-SMM, music is a mediating stimulus between current brain function and the desired therapeutic response.

Aigen (2014) refuted this paradigm for understanding music therapy, arguing that Thaut's claim of the existence of a dedicated neurological structure for music conflicts with his claim that music was not evolutionarily selected for survival. According to Aigen, if music represents human aspirations beyond mere survival, one cannot also use biological considerations to explain the presence of music in human culture. Additionally, if music is an exercise for optimal brain functioning that is required for other tasks, this implies that music enhances survival. Aigen criticized the need for having a neurological understanding of how music is processed or produced to understand music therapy. For Aigen, neuroscience cannot account for the psychosocial or psychological effects of music.

Indigenous vs. Psychological. Aigen (2014) argued that medical and psychodynamic approaches to music therapy view music as a compensatory strategy or medium, whereas social- and music-based approaches view music as a value-added medium. He cited the work of Florence Tyson and Mary Priestley, music therapists who applied psychoanalytic methods to their work, stating, "Although they both employed aspects of traditional psychoanalytic thinking in their theories and methods, they also both worked eclectically and pragmatically" (p. 40).

Ruud (1980) analyzed, critiqued, and compared psychological theories, which relate to music therapy theories, to determine which one best fits music therapy. It appears his concern is that one theory will emerge as the primary theory and subsume all the others. He concluded that music therapy is closely related to psychology and philosophy theories; however, one theory would give an incomplete understanding of both humans and music. The unique feature of music therapy, according to Ruud, is the relationship between humans and music. Music therapy must stay open to each perspective and collaborate within perspectives. Ruud held that experimental research was developed for physics and does not work to study biology—especially human biology. Ruud suggested that phenomenological research is more appropriate for the study of humans than experimental research.

Research

In a 2016 study, Geist found that music therapists tend to use their own experience and training as the primary source of knowledge to inform their clinical practice, rather than published research findings. In an earlier study, Aigen (1991) concluded that social pressures have dictated the positivistic research that dominates music therapy. The author found that there was a schism between research and clinical practice that was created when social pressures demanded behavioral, quantitative research, during a time when prominent music therapists Florence Tyson, Helen Bonny, Paul Nordoff and Clive Robbins, and Mary Priestly were developing methods based on transpersonal and psychodynamic theories (Aigen, 1991). Those methods, he claimed, were not represented in music therapy research.

Aigen (1991) identified three periods of research paradigms in music therapy. The first begin in 1950 and was loosely based on psychodynamic theories; the second beginning around 1968 and continuing through 1978 focused on behaviorism; and the third period emerged in the

late 1970s when music therapists began publishing articles and essays voicing their dissatisfaction with purely quantitative research (Aigen, 1991). The author argued that clinicians practiced within humanistic, psychoanalytic, and transpersonal approaches, while researchers primarily affiliated with universities were advocating behavioral approaches (Aigen, 1991).

Aigen (1991) contended that, because of the essential nature of the music-therapist-client relationship, the music therapist's subjective reactions could not be separated from research of clinical work. The author's primary complaint was against experimental research and the inability to control for variables within a music therapy context. He stated that outcome research is impossible before first determining the essential characteristics and underlying processes of music therapy. Attempting to control for the therapeutic relationship, the expressive variability of the music, or the client's motivation renders the experiment irrelevant. Research, argued Aigen, needs to relate directly to clinical work.

Art, Science, or Humanity

Some authors claim that music therapy should be considered an art (Aigen, 2005; Bunt & Stige, 2014; Kenny, 1982). Others state that music therapy aligns more closely with science (Taylor, 2010; Thaut, 2005). Still other authors claim that music therapy is better conceived as a humanity (Abrams, 2018; Ruud, 2010). Bruscia (2014), however, identified music therapy as an art, a science, and a humanity:

> As an art, it is concerned with subjectivity, individuality, creativity, and beauty. As a science, it is concerned with objectivity, universality, replicability, and truth. As one of the humanities, it is concerned with interpersonal processes on all levels, including community, society, and culture. (p. 11)

Viewing music therapy in only one way, as only an art, only a science, or only a humanity, leads to exclusions (Bruscia, 2014). Matney (2020) explained these three components as intermingling and informing one another. Rather than being oppositional, they are multiple aspects of the same thing.

Prior Attempts to Rectify Differences in Music Therapy

Defining Music Therapy

Recall that Bruscia (2014) identified the difficulty with defining music therapy: “A central challenge in being in a field such as music therapy is to find and articulate our identity in being in a field such as music therapy is to find and articulate our identity as best we can” (p. 6). He believed music therapy is too broad and complex to be defined by a single philosophy (Bruscia, 2014, p. 21). Bruscia delineated several components that must be included in a definition of music therapy: music as a means (tool), a medium (process), and an end (product/outcome). The definition should also indicate whether it refers to music therapy as a practice, a discipline (theory, research, practice), or a profession. Additionally, it must be broad enough to include many characteristics and qualities deemed significant by music therapists, clearly identify the agents and their relationships, and outline the qualifications of a music therapist. The terms used for beneficiaries of music therapy should be defined (e.g., client, client) and it must include cultural, linguistic, and sociopolitical factors. The definition should also identify the role of the therapist and the music; indicate the desired outcome, domain, or area of concern; and account for the wide range of clientele served by music therapy (Bruscia, 2014, pp. 33–34). Bruscia (2014) proposed this working definition:

> “*Music therapy is a reflexive process wherein the therapist helps the client to optimize the client’s health, using various facets of music experience and the relationships formed*

through them as the impetus for change. As defined here, music therapy is the professional practice component of the discipline, which informs and is informed by theory and research." [italics original] (p. 36)

Bruscia (2014) did not propose this definition for use by lay audiences, meaning that it is a theoretical definition intended for examination and discussion among music therapists. However, music therapists must be able to describe music therapy for lay audiences if a definition is to be useful for communication with related professions and clients.

Bruscia (2014) analyzed each component phrase of the working definition in great detail to establish a common understanding of each word and phrase, while acknowledging the complexity and diversity of understanding language. He then defined the areas and levels of practice of music therapy. Areas of practice, or the primary clinical focus, include didactic, medical, healing, psychotherapeutic, recreational, and ecological. Levels of practice—the breadth, depth, and significance of therapy—include auxiliary, augmentative, intensive, and primary. The auxiliary level is outside the scope of music therapy since they include the use of music in any capacity in which additional training is not required. The augmentative level is used to enhance other treatment modalities and accommodates goals set by other disciplines. The intensive level involves a significant role of music therapy in addressing the priority health needs of the client. At the primary level, music therapy meets the main therapeutic needs of the client, making pervasive changes in the client's health and life. According to Bruscia (2014), music therapists trained at the bachelor level can practice at the augmentative level, while advanced training is needed to practice at the intensive or primary levels. Music therapy training is not needed to practice at the auxiliary level (Bruscia, 2014). One difficulty with Bruscia's text is that

he did not include several definitions of music therapy in his analysis, such as Crowe (2004), Gaston (1968c), Michel and Pinson (2005), Taylor (2010), and Thaut (2005).

Diversity in Music Therapy

Music therapists work with various client populations, in various work settings, on various client goals, with the option of a holistic or a narrow focus on goals. Additionally, music therapists have the option of treating individuals or groups, in confidential or public settings, with distinct time or indistinct time and place limits, using discussion or music only, within a single approach or an eclectic approach (Byers, 2016). Diversity in the music therapy profession came from the formation of field by professionals from other disciplines, such as psychotherapy, occupational therapy, music education, and the medical field (Byers, 2016, p. 97). Models of practice evolved in response to changing client needs which can cause difficulty when discussing different concepts but using the same terms.

Ansdell (in Byers, 2016) identified problems with a unified theory of music therapy. The first problem is the constraints of language: It is difficult to talk about music, so it is difficult to talk about the music therapy process. Second, a unified theory must be based on either essentialist or constructionist thought, where essentialist theory is an attempt to identify Truth and constructionist theory does not identify an essential Truth, but rather a representation of something real. Third, the profession must consider the definition of the self or person, as well as the definition of therapy (Ansdell in Byers, 2016, p. 106).

Sundar (in Byers, 2016) identified four general areas of diversity in music therapy: diversity in the field, diversity in variables which affect therapeutic outcomes, diversity in contexts, and diversity in who is performing music. The field uses different applications, procedures, theories, practices, and research. Therapeutic outcomes may be affected by diverse

cultures, traditions, and beliefs. Music therapy occurs within various societal, cultural, historical, traditional, and professional contexts. Sometimes the music therapist is the artist and sometimes the client is the artist (Sundar in Byers, 2016, p. 106).

Multiplicity

Matney (2020) introduced the multiplicity concept to address the problems of diversity in music therapy. The multiplicity concept, as explained by Gilles Deleuze, shows relationships of difference between and within, the extensive and intensive, and the actual and the virtual, as an explanation of the practical world. Applying Deleuze's multiplicity concept to Bruscia's integrative music therapy, Matney presented a re-vision of music therapy to understand multiple outcomes due to the complexity of music therapy and the clients' engagement with new contexts over time. This way of thinking opens the field of music therapy to the potential of nonlinear thinking that welcomes new critiques and new types of inclusivity (Matney, 2020).

Professional Identity

Professional identity crises due to a lack of an underlying, unifying philosophy is not unique to music therapy. Occupational therapists have also experienced an identity crisis through clinicians' lack of understanding of the underlying philosophy of occupational therapy. Ikiugu (2001) analyzed the history and development of occupational therapy to determine whether a common philosophy could be discerned. Occupational therapy was developed as a profession in 1917 by six individuals from multiple disciplines: a teacher, a social worker, two architects, a physician, and a nurse (Ikiugu, 2001). Through a systematic analysis of published occupational therapy literature, of published articles on the philosophy of pragmatism, and of themes from a lecture series of scholarly leaders in occupational therapy, Ikiugu (2001) compared themes underlying the core principles, values, and assumptions from each source. The author concluded

that pragmatism was a viable philosophy for occupational therapy that would resolve the identity crisis. Ikiugu (2001) also recommended course topics for the education of occupational therapists that would help them be able to articulate the philosophy of the field.

Music education has also navigated an identity crisis due to competing philosophical ideas. McCarthy and Goble (2002) described the evolution of music education philosophy through functional, aesthetic, sociological, cognitive, and praxial foundations. The authors concluded that the current diversity in culture and music in the United States makes the identification of a unifying philosophy of music education challenging. However, they acknowledged the initial unification of the discipline within aesthetic philosophy provided stability, professionalism, and validation for music education.

Wheeler (2006) asserted that Reimer's aesthetic philosophy is rooted in Platonic or rationalist ideals, while Elliot's praxial philosophy is based on Aristotelian or empirical perspectives. Wheeler (2006) believed these two philosophies to be dialectic, or two ideas that appear to be in opposition, but are actually interdependent. The author proposed a synergistic philosophy of music education that integrates the aesthetic and praxial philosophies of music education by focusing on the nature of human relationships—teaching the individual, not the music. He concluded that most music educators utilize a synergistic philosophy in order to teach the students in the most effective way for those students, with a combination of music education for the education of feelings, and music education as an intentional human activity.

Snell (1980) analyzed the Orff Schulwerk approach to determine whether a coherent philosophy existed primarily by studying published works about the approach. Within the analysis, the author demonstrated a relationship between the current Orff Schulwerk music

education practices and the underlying philosophy, using the conclusions to make recommendations and identify implications for American elementary schools.

Itoh (2003) attempted to connect music philosophy and music therapy through an analysis of David Elliot's praxial philosophy of music education as it applies to music therapy. Although unable to identify how to scientifically study aesthetics within a praxial framework, the author concluded that aesthetics in a praxial framework emphasized the consciousness of the therapist, which places the value on subjective experiences.

Using a grounded theory design, Christian (2015) examined the feasibility of using a resource-oriented approach to clinical music therapy in medical settings. The author concluded that this approach is feasible in medical settings, since music therapists working in this setting tend to use one or more of the components of a resource-oriented approach, although they may not be formally aware of this approach. However, the nature of medical settings may prevent one from practicing within this approach with every client in every situation.

Important Issues That Have Not Been Addressed

There are two main issues that have not been fully addressed in music therapy literature. The first is that music therapists do not agree on the public image of their professional identity. Some music therapists are essential health care workers, while others are alternative health practitioners. The origins of music therapy indicate a dispute over whether it is a science or an art (Aigen, 2014). Did music therapy begin in 1950 when a professional association with standards for education and training was formed, or does music therapy have shamanistic origins?

Music therapy is a global profession. Ruud (2016) identified the difficulty of establishing a unifying philosophy or theory of music therapy in a global context:

> "In this global community also, some music therapists do not want to reduce these numerous ways of life interpretations to a single model or philosophy. The field of music therapy thus has to live in a situation where different models of explanation, different theories or ways of describing music therapy practices live side by side. As a consequence of this situation, the followers of a contextual model of music therapy theory will not search for a single or general theory of how music and music therapy may affect us. As a result, theories could also become more local and based upon specific cases, rather than general explanations" (p. 136).

The second issue that has not been fully addressed in music therapy literature is the multitude of approaches. Dileo (2016) offered a summary of recommendations for the future of music therapy that might be seen as relevant strategies to advance the discipline of music therapy in the future: (a) theories that embrace the diversity of practice in music therapy are needed; (b) the biopsychosocial theory may provide an appropriate framework for understanding client needs and for developing music therapy practice with various populations; and (c) integrative theoretical models are relevant and useful, as well as hybrid theories and theories that crossover concepts from one model to another. There needs to be a multifactorial understanding of how music therapy works (Dileo, 2016, p. 158).

Music therapy philosophy originates from the multidisciplinary foundations of the profession and relate to the music-client-therapist relationship. There is disagreement on whether music therapy should be considered a social science, a behavioral science, or a neuroscience; an art, a science, or a humanity; and studied quantitatively or qualitatively. Several authors have proposed theories to reconcile the differences in music therapy philosophy but are not inclusive of all the approaches. Debates continue about the jurisdiction of music therapy, the education and

training of music therapists, and the theory on which practice and research of music therapy is based. Music therapists have yet to determine whether their professional identity is an essential health care worker or as an alternative health practitioner. Additionally, there are a multitude of approaches in music therapy that have not been analyzed to determine whether a unified philosophy of music therapy is possible.

Purpose of the Study

The purpose of this study is to investigate the feasibility of a unifying a philosophy of music therapy through an interdisciplinary analysis of existing models, approaches, and theories that is as inclusive of the diversity in music therapy practice, not to create a new model, approach, or theory. There are many models, approaches, and theories in music therapy, but they have never been analyzed through an interdisciplinary lens to determine whether a unified music therapy philosophy is possible.

This study will attempt to answer the following questions:

1. Is it possible to articulate a unifying philosophy of music therapy that is inclusive of the diverse ways music therapy is currently practiced?
2. What might be that resultant integrated philosophy of music therapy?

CHAPTER 3

METHOD

The purpose of this dissertation was to investigate the feasibility of a unifying philosophy for music therapy and to offer an identity for the music therapy profession that is appropriate for the various ways in which music therapy is practiced throughout the world. A systematic review of published music therapy approaches informed this investigation. The central research questions for this dissertation were: (a) Is it possible to articulate a unifying philosophy of music therapy that is inclusive of the diverse ways music therapy is currently practiced; and if so, (b) What might be that resultant integrated philosophy of music therapy? If an integrated or unified philosophy of music therapy and identity for the profession is possible to define, it may have implications for music therapy education at the undergraduate and graduate levels. Using the unique interdisciplinary perspective of the Doctor of Liberal Studies (DLS) program at SMU, each major published approach, theory, and model of music therapy was analyzed to compare similarities and differences between them. Current research was examined to determine whether current music therapy practice supports the conclusions from the analysis. Each approach, theory, and model was analyzed to identify the complexity making it unique from other approaches, or the repetition making it similar to other approaches. Finally, an evaluation of whether a unifying philosophy of music therapy is possible, along with the implications for the profession regarding whether one is possible, was completed. The analysis concluded with

recommendations for education and training, professional development, and a comprehensive research agenda.

Research Design Overview

This study used dialectical reasoning to draw inferences by discussing the possibility of a unified philosophy of music therapy. Dialectical reasoning is the ability to view issues from multiple perspectives and to arrive at the most economical and reasonable reconciliation of seemingly contradictory information. This philosophical research approach "draws inferences by discussing or debating opposite ideas (thesis and antithesis)" (Phillips, 2007, p. 69). The definition by Peng and Nisbett (1999) informed the analysis used to draw inferences:

> Even in science, the concept of a complex system reflects the reality of the world we are living in, a reality that is multilayered, unpredictable, and contradictory. Therefore, a dialectical approach may enable people to tolerate and even appreciate contradiction, consequently maintaining a view of the big picture. On the other hand, the dialectical approach may be accompanied by a tendency to accept too much at face value, failing to generate counterarguments for a statement and trying to reconcile opposing views, even when one viewpoint is inferior in terms of the evidence supporting it. (p. 751)

Therefore, this study attempted to maintain a view of the big picture, while generating counterarguments and identifying evidence to support each viewpoint.

The thesis was that a unified philosophy of music therapy, which encompasses the diversity of approaches to the practice of music therapy, is essential for the continued and positive development of the profession. The antithesis was that a unified philosophy of music therapy is impossible because of the diversity of approaches to the practice of music therapy; therefore, the profession must develop along different paths. To inform the debate between the

two positions, an extensive, comprehensive review of the existing music therapy approaches and theories was conducted. A systematic analysis compared and contrasted each approach and theory to determine whether a unified philosophy of music therapy is possible. This research explored what it means to be human by engaging diverse cultures and ways of practicing music therapy to find common ground on which the profession may develop through an analysis of the complexity and repetition within each approach.

Rationale

Music therapy is frequently confused with other forms of music in healthcare, such as music entertainment and music listening programs. If they are to remain a relevant healthcare profession, music therapists must determine what differentiates music therapy from other uses of music. Third-party payors are more likely to recognize music therapy as a healthcare field, but in order to reach that goal, the diversity of ways to practice music therapy must be identifiable as one field to those outside the profession.

For the purposes of this study, an evaluation, synthesis, and comparison of the existing literature on the various models, approaches, and theories of music therapy was conducted in an attempt to understand the current debate regarding the identity of music therapy as a profession, discipline, and practice. Each model of music therapy that is currently being used was compared for similarities and differences that would determine whether a common ground could be established that can lead to a unifying philosophy of music therapy. Following these comparisons, recommendations for how the field determines what the education of music therapists should look like could be made, including whether some approaches, populations, or strategies are more appropriate for entry level education and others are more appropriate for advanced practice.

Researcher Description

Each year, the American Music Therapy Association (AMTA) completes a workforce survey. In 2020, 2,015 music therapists responded to the survey, which is approximately 20% of credentialed music therapists in the United States. I am a white female music therapist, which places me within the dominant culture for music therapy (see Table 1). I am 48 years old, which falls within 14.7% of the survey respondents (AMTA, 2020). My education, training, and career took place in various cities within the State of Texas in the United States. I have been a board-certified music therapist for 25 years and have worked as a clinical music therapist, primarily as a self-employed sole practitioner for 20 years. I have bachelor's and master's degrees in music therapy. In 2011, I began providing clinical supervision for practicum students, first as university staff, then as adjunct faculty, for a private university in the southwestern region of the United States. Currently, I am a full-time lecturer in the music therapy department in the Division of Music in the Meadows School of the Arts at Southern Methodist University (SMU) in Dallas, Texas. Table 1 shows how the researcher compares to music therapists in the United States.

Table 1

Researcher Demographics Compared to Music Therapists in the United States

Music therapists in the U.S.	% respondents
Female	86%
48 years old	14.7%
Self-employed	10%
Live in Southwestern Region	7%
In profession 21-25 years	10%
Obtained bachelor's degrees	47%
Obtained master's degrees	44%

My experience with music therapy philosophy includes reading Gaston, Sears, Bruscia, Aigen, Kenny, Crowe, and other authors who wrote about music therapy philosophy (see Chapter 2). I have attended conference sessions about music therapy philosophy, such as "Philosophy Slams" with Barbara Crowe, and included study of it in most of my doctoral courses. My values include helping people, continuing music education throughout one's lifespan, disability rights, and mental health. I have been trained in university programs that focus on behavioral, biomedical, and humanistic approaches to music therapy. However, I have challenged myself to understand approaches that are different from those more familiar to me, especially psychodynamic, music-centered, and Nordoff-Robbins approaches.

In the DLS program at SMU, course content focused on considering what it means to be human from several perspectives, including human biological and cultural evolution; philosophy, religion, and psychology; creativity; human rights; science; and cultural intelligence. Because music therapy is an interdisciplinary profession, the DLS method of interdisciplinary study provided an excellent foundation through which to analyze the profession of music therapy. The multitude of music therapy approaches, models, and theories have never been analyzed through these interdisciplinary lenses to determine whether a unified philosophy of music therapy is possible.

As a cis-gendered, heterosexual white female music therapist, I recognize that Queer and BIPOC voices need to be amplified within the development of music therapy philosophy, and that I cannot adequately do that within the limitations of this study. While I will not attempt to include those voices in this particular study, I will endeavor to amplify and create space for the voices of music therapists who identify with underrepresented groups.

Selection of Music Therapy Approaches

Several authors referenced in the previous chapter have cited music therapy approaches and models (Aigen, 2014; Byers, 2016; Edwards, 2016). Additional approaches and models have been published that were not included in those sources (Ruud, 2020; Sekeles, 1996; Tyson, 1981). There may be many approaches used by music therapists that are not published or are published but not available in English. Since I needed to limit the scope of this project to one that I could conceivably complete in a reasonable amount of time, only sources that have been published or translated into English were examined for this analysis. Additionally, I also limited the journals from which publications were selected to *Approaches: An Interdisciplinary Journal of Music Therapy, Journal of Music Therapy, Music Therapy Perspectives,* the *Nordic Journal of Music Therapy,* and *Voices: A World Forum for Music Therapy.* There may be publications that are unable to be accessed through the university library or the author's personal collection of books that related to music therapy approaches, published in other countries, or not available in English; however, the scope of this study was limited to those the author could access, in English, within a reasonable amount of time to complete this project.

Other approaches, like Queer theory or those significant to non-dominant cultures, were not included here because I could not find sources that described them in enough detail where I felt competent to include them. I believe those theories and approaches are best discussed and examined by music therapists who identify as belonging to those cultures; therefore, I did not include them in this study.

To determine the initial approaches and methods included in the study, the music therapy approaches, theories, and models were selected from those included in the Approaches and Models section of the *Oxford Handbook of Music Therapy* (Edwards, 2016); those identified as

contemporary theoretical frameworks and listed in the development of music therapy theory in *The Study of Music Therapy: Current Issues and Concepts* (Aigen, 2014); as well as those listed in *A History of the Music Therapy Profession: Diverse Concepts and Practices* (Byers, 2016). The primary sources for each of the approaches, theories, and models referenced in each text were retrieved from the author's personal library, the SMU library, or through interlibrary loan. The term "primary source" indicates the source from which the information for each approach was taken, rather than an indication of giving credit to the author for creating the approach. Whenever possible, I attempted to use the original source where the approach was first described or written by the music therapist who developed the approach and deserves such credit. If the source was unable to be retrieved, articles or book chapters that explained the approach, theory, or model were located within these music therapy texts, *Journal of Music Therapy, Music Therapy Perspectives,* the *Nordic Journal of Music Therapy,* or *Voices: A World Forum for Music Therapy.* For example, Hadley (2003) may not be considered a primary source describing the development of psychodynamic music therapy. However, the author's chapter on psychodynamic music therapy provided a historical overview of the development of the approach and defined psychodynamic therapy generally, as well as its different types (i.e., drive psychology, ego psychology, object relations, self psychology, and Jungian theory) and constructs (i.e., defenses, transference, and countertransference). Therefore, the chapter was considered useful for the purposes of understanding psychodynamic music therapy distinctly from other approaches that use similar concepts, like Psychiatric Music Therapy (Tyson, 1981), Analytical Music Therapy (Priestley, 1994), Free Improvisation Therapy (Alvin & Warwick, 1991) or Guided Imagery and Music (Bonny, 2010). In some cases, two or more sources were used for one approach when the approach may have been developed by one author (e.g.,

Priestley, 1994) and expanded on or updated by another author who was clearly influenced by the original author (e.g., Eschen, 2002).

Additionally, the table of contents of every issue of *Approaches: An Interdisciplinary Journal of Music Therapy* published as of October 27, 2020, was reviewed, and articles that identified a model, theory, or approach were included in the analysis. Ruud (2020) was included in the analysis since it introduced another approach to music therapy not previously published, and Tyson (1981) was included because the author is referenced frequently in music therapy literature, although not included in the texts from which the sources were originally identified. From these, 33 approaches were identified for analysis, listed alphabetically in Table 2. Since these approaches, theories, and models represent the most frequently referenced and the most recently identified in music therapy literature, these sources were considered an adequate number for this analysis.

Table 2

Sources Included in Analysis

Approach, theory, or model	Primary source
Aesthetic Music Therapy	Lee, 2003
Analogy-Based Music Therapy	Smeijsters, 2005
Analytical Music Therapy	Priestley, 1994 & Eschen (ed), 2002
Anthroposophical Music Therapy	Intveen & Edwards, 2012
Behavioral Music Therapy	Madsen et al., 1968
Benenzon Music Therapy	Benenzon, 1981, 1997
Biomedical Music Therapy	Taylor, 2010
Community Music Therapy	Pavlicevic & Ansdell, 2004
Compassion-Focused Relational Music Therapy	Binnie, 2019
Complexity Science Music Therapy	Crowe, 2004
Culture-Centered Music Therapy	Stige, 2002
Dalcroze Eurhythmics in Music Therapy	Articles from *Approaches* Special Issue on Dalcroze-Eurhythmics in Music Therapy, 2016
Developmental-Integrative Model in Music Therapy	Sekeles, 1996
Dialogical Perspective of Music Therapy	Garred, 2006
Feminist Perspectives in Music Therapy	Hadley (ed.), 2006
Free Improvisation Therapy	Alvin & Warwick, 1991
Guided Imagery and Music	Summer, 2002 (ed.) & Bonny, 2010
Humanities Oriented Music Therapy	Ruud, 2010
Humanistic Music Therapy	Articles from *Music Therapy Perspectives* Special Issue on Humanistic MT, 2018
Music Centered Music Therapy	Aigen, 2005
Neurologic Music Therapy	Thaut, 2005
Nordoff Robbins Music Therapy	Robbins, 2005
Orff Music Therapy	Articles from *Approaches* Special issue on Orff Music Therapy, 2013
Psychiatric Music Therapy	Tyson, 1981
Psychodynamic	Hadley, 2003, Metzner 2016
Quantum Therapy	Eagle, 1991
Resource Oriented Music Therapy	Schwabe, 2005
Social Capital Theory	Proctor, 2011
Sociology	Ruud, 2020
The Field of Play	Kenny, 1989
Therapeutic Music Training	Jones, 2020
Transpersonal Music Therapy	Crowe, 2017
Vocal Psychotherapy	Austin, 2016

Data Collection

Procedures

The data collected for this study were notes, themes, or quotes from the sources in response to the analysis questions. Each source was analyzed using the following questions, which were informed by the topics of the foundational courses in the DLS program at SMU:

- What is the historical context of the approach, model, or theory?
- What is the philosophical context that informs the approach, model, or theory?
- How does creativity influence the approach, model, or theory?
- How do human rights influence the approach, model, or theory?
- What is the scientific method of the approach, model, or theory?
- What is the cultural context of the approach, model, or theory?

The selected books and articles were read in alphabetical order by name of the approach, apart from feminist music therapy, which was a book obtained through interlibrary loan and was read immediately upon receipt to return it by the due date, and humanistic music therapy, which was originally thought to be equivalent to humanities, but later determined to be a different approach. A second source on Analytical Music Therapy was read because it was referenced in several other sources as an important description of the contemporary development of that approach (Eschen, 2002).

As each book or article was read, detailed notes were taken in a lab journal notating main ideas, items of personal interest, and anything pertaining to the research questions. When the reading sparked a connection to other concepts, a question, or an idea, the researcher wrote those thoughts and questions down and labeled them as a Personal Reflection. Notes on each source were taken using a different color of ink so that notes could be easily distinguished from each

source, and a list was kept at the front of the lab journal with the name, author, publication year, country in which the author(s) published or worked, as well as the preferred research method (i.e., quantitative, qualitative) and implementation method (i.e., improvisation, listening) for each approach (Appendix A).

Once each source was completed, the notes from the lab journals were reviewed and sorted into a table listing: the name and definition or description of the approach; the author, publication date, and background of the author; the historical context; the philosophical context; the influence of or references to creativity; the influence of or references to human rights; the scientific method or preferred research method; and the cultural context (see Appendix B).

Several of the books or articles indicated possible methods for data analysis. Hadley (2006) inspired the notation of the personal context (country of origin, professional practice areas) for each author. Ansdell (2002) stimulated ideas about analyzing each source based on a series of questions about who, what, when, where, why, and how music therapy happens in particular situations. Garred (2006) inspired using one case study and analyzing it through the perspective of each approach in a dialogical manner, an idea that was also suggested in one of the conclusions of the 1982 Symposium on "Music in the Life of Man" (Forinash & Kenny, 2015).

Recording and Data Transformation

As each source was reviewed, data were recorded in three lab journals notating responses to the analysis questions and other significant information for understanding the approach, theory, or model. Data were collected from the 33 sources over a period of 10 months. A reflexive research diary, or lab journal, was maintained, in which the researcher made regular entries during the research process. In these entries, the researcher recorded detailed descriptions

of the main ideas in each source, connections to other sources, and reflections upon music therapy in terms of the researcher's own values and interests (see Appendix A). These notes were transcribed into a table so that each approach, theory, and model could be compared and contrasted side-by-side (see Appendix B).

Analysis

Data-Analytic Strategies

Analysis of the data consisted of four phases. In Phase 1, the personal context of each author of the primary sources were listed. Then, the data tabulated in Appendix A were reviewed to find themes. Phrases were categorized by similarities and labeled by topic. Phase 2 consisted of using the themes identified in Phase 1 to respond to the questions posed in Ansdell (2002). For each approach, the researcher responded to the following questions (see Appendix C):

- **identities and roles:** Who *am* I as a music therapist? What am I expected to *do* as one?
- **sites and boundaries:** *Where* do I work as a music therapist? Where are the limits to this work? What are the limits on what I do there?
- **aims and means:** What am I trying to do as a music therapist and *why*? How do I go about achieving these aims?
- **assumptions and attitudes:** On what theoretical assumptions are all of the above questions based? How do these ideas affect my attitude to both people and music? (Ansdell, 2002, pp. 21-22)

This table was sorted chronologically to provide an overview of the development of thinking in music therapy. Information from Appendix B was reorganized to respond to the questions above for each approach, theory, and model of music therapy.

In Phase 3, the information from Appendix C was used to interpret a single music therapy case study according to each approach, theory, or model of music therapy (Appendix D). A case study published in Garred (2006, pp. 89-91) was selected because it is accessible to other researchers; it provided enough detail with which to analyze it from the various perspectives of music therapy; and it could be used more objectively than a case from the researcher's personal music therapy experiences.

In Phase 4, the personal reflections and connections were transcribed in Appendix E with the context from their position within the lab journals.

Methodological Integrity

During the 1982 symposium organized by Barbara Hesser, discussions were held with the intent to formulate a theory of music therapy and the principles underlying the theory. The results of these discussions were inconclusive; however, those that participated in the discussions wrote many of the sources reviewed in this dissertation and inspired most of the research in music therapy philosophy to date. These discussion groups offered recommendations for further discussions. Some of these recommendations were encompassed within the original research questions for this study (historical context, human rights influences, etc.) and informed the data analysis methods. The social and cultural aspects of each approach were identified in the historical and cultural categories. The aesthetics in music therapy and musical personality of the client were addressed in the creativity category. Connecting and integrating the human experience with basic principles and philosophies of music therapy was reflected in each category, as this was a main theme of the DLS program.

Trustworthiness, Rigor, & Quality

Qualitative research may be defined as “any kind of research that produces findings not arrived at by means of statistical procedures or other quantification” (Strauss and Corbin, 1990, p. 17). Triangulation is a strategy used to evaluate findings or to improve the reliability and validity of research (Golafshani, 2003). While reliability and validity are essential for quantitative research, the terms, according to Golafshani (2003), are inadequate for determining credibility of qualitative research. Rather, Golafshani (2003) asserts that credibility in qualitative research “depends on the ability and effort of the researcher” (p. 600). Therefore, terminology such as credibility, transferability, and trustworthiness—terms that encompass both reliability and validity, instead of separately—are more fitting for evaluating qualitative research, (Golafshani, 2003).

Golafshani (2003) stated, “To improve the analysis and understanding of construction of others, triangulation is a step taken by researchers to involve several investigators or peer researchers’ interpretation of the data at a different time or location” (p. 604). To check for trustworthiness, rigor, and quality, the findings of this study were submitted to a well-respected music therapist who practiced in different parts of the United States with different approaches from the researcher for triangulation. This doctoral-level music therapist has approximately 50 years’ experience as a music therapist and educator from the Mid-Atlantic and Southeastern Regions of AMTA and has published and presented extensively throughout the world about various music therapy topics. This reviewer provided a plethora of useful feedback that helped to refine the research process and findings (see Appendix F). She concluded, “In summary, I find Janice Lindstrom’s method – her rationale and the steps that she followed – to be logical and to

lead to a very satisfactory conclusion – it *is* possible to develop a unified philosophy of music therapy" (Barbara Wheeler, personal communication, March 14, 2022).

In addition, since the case study was selected from one of the sources (Garred, 2006, p. 89-91), the researcher's interpretation of how to work with the client within a Dialogical perspective in music therapy was compared with the description of Garred's work with the client within the Dialogical perspective, in the manner of member checking.

CHAPTER 4

FINDINGS

Several terms have been used to describe the different ways that music therapists practice. A report by McFerran, Chan, Tague, Stachyra, and Mercadal-Brotons, (2022), explored and mapped the different approaches that are currently part of the profession of music therapy across the globe. As a part of their process, the authors defined the terms orientation, approach, method, and model, as they relate to music therapy, and determined that the decision about categorizing the various music therapy practices could be made by the respective experts and pioneers for each one. While each term has a different definition, determining which term applies to each approach is beyond the scope of this study. For simplicity, I will use the word "approaches" to mean approaches, theories, orientations, methods, or models.

Findings From the Lab Journals

To analyze and ascertain the results of this study, I began by reading each source and took extensive notes in lab journals (Appendix A). After I completed reading each source, I reviewed the notes and sorted them into categories matching the subject matter of each of the six foundational courses in the DLS program (Historical Context, Philosophical Context, Creativity Influences, Human Rights Influences, Scientific Method, and Cultural Context – see Appendix B). I notated the country of origin, music therapy training, and professional practice areas of each author to establish the personal context of each source. To compare the approaches, I reviewed

the table looking for common words used to describe music therapy then counted the number of approaches that included each of those words.

Personal Context

To establish the personal context of each source, as suggested by Hadley (2003), I identified the country of origin or primary practice location of the author, gender, and, where available, the music therapy training and professional practice areas of each author (see Table 3). While I do not know the gender identification of each author, I have categorized them as male or female according to how they have been represented in the primary sources used for this study.

There were 37 countries represented in total, with the most being from the United States (13), the United Kingdom (8), and Norway (8). NRMT was developed in the most countries (28). Fifteen sources were written by male music therapists, 15 were written by female music therapists, and three sources were either coauthored by a male and a female or were an edited book or journal with both male and female authors of the chapters or articles. Nine authors were trained in or influenced by NRMT, four authors were trained by Gaston, and four approaches were developed or written about by individuals who were not trained as music therapists. The articles for one of those journals (*Approaches* Special Issue on Dalcroze-Eurythmics in Music Therapy and Special Music Education) were written by music educators or neuroscientists who were not music therapists. These findings indicate diversity and multidisciplinary aspects within the practice of music therapy and the widespread influence of NRMT in the field of music therapy.

Table 3

Personal Context of Primary Source Authors

Approach, model, or theory	Source	Gender	Country of origin	Music therapy training and/or practice area
Aesthetic Music Therapy (AeMT)	Lee, 2003	Male	United Kingdom	Composer, NRMT. Worked with AIDS, Down syndrome, autism, hospice, bereavement. Taught for many years at Wilfrid Laurier University in Canada.
Analogy-Based	Smeijsters, 2005	Male	Netherlands	Faculty member
Analytical Music Therapy (AMT)	Priestley, 1994	Female	United Kingdom	Clinician, violinist, psychoanalyst, lived 1925-2017
	Also: Eschen (ed) (2002)	Male	Germany	lived 1928-2013, spent last years in Vienna
Anthroposophical Music Therapy (AnMT)	Intveen & Edwards, 2012	Females		MTs who are not trained in AnMT but interested in the approach. Intveen's PhD thesis was on Anthroposophical Music Therapy
Behavioral Music Therapy	Madsen et al., 1968	Both	United States	Madsen spent his long career as music education faculty member at Florida State University and taught generations of music therapy students; studies music therapy with Donald Michel but never became a Registered Music Therapist
Benenzon Music Therapy (BMMT)	Benenzon, 1981	Male	Buenos Aires	Distinguished psychiatrist and accomplished musician.

Approach, model, or theory	Source	Gender	Country of origin	Music therapy training and/or practice area
Biomedical Music Therapy	Taylor, 2010	Male	United States	Studied with Gaston. MT professor
Community Music Therapy (CoMT)	Pavlicevic & Ansdell, 2004—edited book with 17 authors; Stige is one author and is very important in CoMT	Both	17 authors from UK, Norway, Israel, South Africa, Ukraine	Mostly trained in NRMT in London; Pavlicevic co-instituted the music therapy program at the University of Pretoria in South Africa; she worked during her last years at the Nordoff-Robbins Centre in London; Ansdell has held several positions at the Nordoff-Robbins Centre in London.
Compassion-focused Relational Music Therapy (CRMT)	Binnie, 2019	Female	United Kingdom	MT research associate at University of Bristol. Psychospiritual palliative care. Hospice-based MT
Complexity Science	Crowe, 2004	Female	United States	Director of MT at Arizona State University since 1981. Past President of NAMT.
Culture-Centered Music Therapy	Stige, 2002	Male	Norway	Professor in music therapy at the University of Bergen and Head of Research at GAMUT - The Grieg Academy Centre for Music Therapy Research (University of Bergen and Uni Research Health). Co-Editor-in-Chief of Voices: A World Forum for Music Therapy.

Approach, model, or theory	Source	Gender	Country of origin	Music therapy training and/or practice area
Dalcroze-Eurhythmics in Music Therapy	*Approaches* 2016	Both	Authors from various countries: UK, Germany, Spain, Denmark, Poland, Mexico, Finland, Switzerland, Austria.	Many not MTs. Music educators and Neuroscientists.
Developmental-integrative model (D.I.M.T.)	Sekeles, 1996	Female	Israel	1936-2018; founded and headed the first music therapy training program in Israel in the Music Therapy Department at David Yellin Academic College in Jerusalem, and served as its director until her retirement (1980-2002)
Dialogical Perspective	Garred, 2006	Male	Norway	NRMT, BMGIM; currently at University of Stavenger, Norway
Feminist Perspectives	Hadley, 2006 (Ed)	Females	Multiple authors from Belgium, Canada, UK, Norway, US, Australia, Korea, Taiwan, Germany, Ireland	Authors with experience in BMGIM, Sociology, CoMT, Psychoanalysis, NRMT, AMT, Free Improvisation, Medical MT, MT Educators
Free Improvisation Therapy	Alvin, 1978/Alvin & Warwick 1991	Females	United Kingdom	Cellist, founder of British Society for MT, Alvin lived 1897-1982

Approach, model, or theory	Source	Gender	Country of origin	Music therapy training and/or practice area
Guided Imagery and Music (GIM/BMGIM)	Bonny/Summer (ed), 2002	Females	United States	Maryland Psychiatric Research Center. Violinist. Trained (MT equivalency) with Gaston. Lived 1921-2010
Humanism	MTP 2018, Abrams – guest editor.	Male	United States	MT Professors
	Hadley and Thomas – critical theory.	Females	United States	
	Andsdell and Stige – posthumanism	Males	Norway	
Humanities oriented	Ruud, 2010	Male	Norway	BMGIM; Psychologist; Professor, Department of Musicology, University of Oslo
Music-Centered Music Therapy	Aigen, 2005	Male	United States	NRMT, Associate Prof., New York University; President of the Nordoff-Robbins Music Therapy Foundation and the International Trust for NRMT; AAMT president instrumental in unification
Neurologic Music Therapy (NMT)	Thaut, 2008	Male	Germany/United States/Canada	Professor of music and neuroscience at Colorado State University; now Professor at University of Toronto; Founder/developer of Neurologic Music Therapy; Fulbright scholar, Advisory Board of World Federation of Neurologic Rehabilitation
Nordoff-Robbins Music Therapy-Creative Music Therapy (NRMT-CMT)	Robbins, 2005	Male	Work developed in UK, US, many other countries	Robbins lived 1927-2011 - Developed Nordoff-Robbins approach with Paul Nordoff. Nordoff lived 1909-1977 and was a composer and pianist. Work spanned 60 years, MT pioneers

Approach, model, or theory	Source	Gender	Country of origin	Music therapy training and/or practice area
Orff Music Therapy	Founded by Gertrude Orff Voigt, 2013, plus other articles from the Special Issue 5 of Approaches	Female Both	Germany	Began developing Orff MT in 1970 for children with developmental delays.
Psychiatric Music Therapy	Tyson, 1981	Female	United States	Pioneer in CoMT and application of psychodynamic principles to MT. RMT since 1958. Founder and Director of Creative Arts Rehabilitation Center in NYC. Active in NAMT – MAR. Lived 1919-2001
Psychodynamic	Hadley, 2003; Metzner, 2016	Based on Freud – Male	Europe and United States	Concepts developed in late 1960s, first publications of psychodynamic MT in 1970s.
Quantum Therapy	Eagle, 1991	Male	United States	Student of Gaston. Professor of MT at SMU
Resource-Oriented Music Therapy (ROMT)	Schwabe, 2005	Male	East Germany	Neurologic-psychologic hospital 1960-1980. 1981-1992 Lecturer on educational psychology. 1992 founded Academy of Applied Music Therapy. Schwabe first published this article in German in 2000. Without knowing of this reference until 2005, when it was published in English, Rolvsjord (2009) developed a similar concept of Resource-Oriented Music Therapy, but Schwabe's approach differs from Rolvsjord's approach "in relation to the understanding of resource orientation as an implicit

Approach, model, or theory	Source	Gender	Country of origin	Music therapy training and/or practice area
				and common factor in music therapy" (Rolvsjord, 2009, p. 8)
Social Capital Theory (SCT)	Proctor, 2011	Male	United Kingdom	NRMT
Sociology	Ruud, 2020	Male	Norway	Emeritus status, reflections on music therapy (See above)
The Field of Play	Kenny, 1989	Female	First Nations; United States, Canada	Influenced by Bonny, Nordoff and Robbins. MT educator in Quebec and US; Co-founded music therapy program at Capilano College/University in Vancouver, BC; Professor at Antioch University. Lived 1946-2017
Therapeutic Music Training (TMT)	Jones, 2020	Female	Canada	PhD in Neuroscience and music, NMT Fellow, Con Brio Music Therapy, Piano
Transpersonal (TPMT)	Crowe, 2017	Female	United States	NRMT, BMGIM, Professor at Arizona State University
Vocal Psychotherapy	Austin, 2016	Female	United States	Private practice; Adjunct faculty at New York University

Identification of Common Words or Themes

As I examined Table B1 in Appendix B, I began to identify words that were used more than once. These words became the "themes" of the study. The themes were color-coded using the Replace All feature in Microsoft Word. Each approach that used the word or a form of the word at least once in the table was marked, then the number of approaches for each theme was tabulated. There were 33 selected approaches with 13 common words or themes selected to describe music therapy. Next, I examined the lab journals to determine how many approaches relate in some way to each theme. Table 4 shows the number of approaches that relate to each word or theme. Improvisation was featured in 23 of 33 approaches. Seventeen approaches included brain functioning and musicing in their descriptions. Spiritual concerns and community were addressed in 15 approaches. Behavior, NRMT-CMT and psychoanalysis influenced 14 approaches. Psyche (13) and Culture (12) were also featured in several approaches. Music Centered, movement, and complex were found in 11 approaches. These findings suggest that improvisation, brain function, musicing, spiritual concerns, and community are important in music therapy approaches. They also suggest that NRMT-CMT has widespread influence over many music therapy approaches used in many countries.

Table 4

Number of Approaches Using Common Words or Themes

Theme	Number of approaches
Improvisational	23
Brain	17
Musicing	17
Community	15
Spiritual	15
Behavior	14
NRMT-CMT	14
Psychoanalysis	14
Psyche	13
Culture	12
Music Centered	11
Movement	11
Complex	11

I used Table B2 in Appendix B to tabulate the number of themes coded within each approach. Table 5 indicates the number of themes each approach was coded for. Dalcroze-Eurythmics included the most (10) themes, and Quantum Therapy included the fewest (1). These findings suggest that some approaches may be more similar to or encompass work from other approaches, while others are narrower in scope.

Table 5

Themes Coded for Each Approach

Approach	Number of themes	Themes
Dalcroze-Eurhythmics in Music Therapy	10	Improvisational, NRMT, Spiritual, Psyche, Movement, Behavior, Community, Brain, Musicing, Complex
Analytical Music Therapy	9	Improvisational, Music Centered, Spiritual, Psyche, Psychoanalysis, Movement, Behavior, Brain, Musicing
Complexity Science Music Therapy	9	Improvisational, Spiritual, Movement, Behavior, Community, Brain, Culture, Musicing, Complex
Developmental-Integrative Model in Music Therapy	9	Improvisational, NRMT, Spiritual, Psychoanalysis, Movement, Brain, Culture, Musicing, Complex
Feminist Perspectives in Music Therapy	9	Improvisational, NRMT, Spiritual, Psyche, Psychoanalysis, Community, Brain, Culture, Complex
Culture-Centered Music Therapy	8	NRMT, Music Centered, Spiritual, Psychoanalysis, Community, Brain, Culture, Musicing
Dialogical Perspective of Music Therapy	8	Improvisational, NRMT, Music Centered, Spiritual, Psychoanalysis, Community, Culture, Musicing
Aesthetic Music Therapy	7	Improvisational, NRMT, Music Centered, Spiritual, Psyche, Musicing, Complex
Community Music Therapy	7	Improvisational, NRMT, Music Centered, Psychoanalysis, Community, Culture, Musicing
Transpersonal Music Therapy	7	Improvisational, NRMT, Spiritual, Psyche, Brain, Musicing, Complex
Analogy-Based Music Therapy	6	Improvisational, Spiritual, Psyche, Psychoanalysis, Behavior, Musicing
Benenzon Music Therapy	6	Psyche, Psychoanalysis, Movement, Community, Brain, Complex

Approach	Number of themes	Themes
Compassion-Focused Relational Music Therapy	6	Improvisational, Spiritual, Psyche, Psychoanalysis, Community, Culture
Psychodynamic Music Therapy	6	Improvisational, NRMT, Psyche, Psychoanalysis, Behavior, Brain
Music-Centered Music Therapy	6	Improvisational, NRMT, Music Centered, Community, Culture, Musicing
Anthroposophical Music Therapy	5	NRMT, Music Centered, Spiritual, Movement, Brain
Behavioral Music Therapy	5	Improvisational, Movement, Behavior, Brain, Complex
Biomedical Music Therapy	5	Improvisational, Behavior, Brain, Culture, Musicing
Free Improvisation Therapy	5	Improvisational, Music Centered, Psychoanalysis, Movement, Behavior
Guided Imagery and Music	5	Music Centered, Spiritual, Psyche, Psychoanalysis, Brain, Complex
Humanistic Music Therapy	5	Improvisational, NRMT, Music Centered, Community, Culture
Neurologic Music Therapy	5	Improvisational, Movement, Behavior, Brain, Complex
Nordoff-Robbins Music Therapy-Creative Music Therapy	5	Improvisational, NRMT, Music Centered, Psyche, Musicing
Resource-Oriented Music Therapy	5	Improvisational, Psyche, Behavior, Community, Culture
Sociology	5	Spiritual, Behavior, Community, Brain, Musicing
Humanities Oriented Music Therapy	4	Community, Brain, Culture, Musicing

Approach	Number of themes	Themes
Orff Music Therapy	4	Improvisational, Movement, Behavior, Musicing
Psychiatric Music Therapy	4	Psychoanalysis, Behavior, Community, Brain
Social Capital Theory	3	NRMT, Community, Musicing
The Field of Play	3	Improvisational, NRMT, Spiritual
Therapeutic Music Training	3	Movement, Behavior, Brain
Vocal Psychotherapy	3	Improvisational, Psyche, Psychoanalysis
Quantum Therapy	1	Complex

Chronological Order of Development or Publication of Approaches

Sorting the approaches chronologically based on publication date or on the date of origin of the approach as stated in the publication provided some information about when each music therapy approach developed (see Table 6). Nordoff-Robbins Music Therapy (NRMT-CMT) and Anthroposophical Music Therapy (AnMT) began in Europe in the late 1950s and early 1960s. Behavioral Music Therapy and Psychodynamic Music Therapy became prominent in the United States by the late 1960s. Dalcroze Eurhythmics in Music Therapy, Alvin's Free Improvisation Therapy, Guided Imagery in Music Therapy (BMGIM), and Humanistic Music Therapy began in the 1970s; with Orff Music Therapy, Benenzon Music Therapy, Tyson's Psychiatric Music Therapy, Quantum Therapy, and Kenny's Field of Play proposed in the 1980s. In the 1990s, Analytical Music Therapy (AMT), the Developmental-Integrative Model, and Biomedical Music Therapy were established, and at the turn of the century, 10 approaches were published: Culture-Centered Music Therapy, Aesthetic Music Therapy (AeMT), Community Music Therapy (CoMT), Complexity Science, Analogy-based Music Therapy, Music-Centered Music Therapy,

Neurologic Music Therapy (NMT), Resource-Oriented Music Therapy (ROMT), the Dialogical Perspective, and Feminist Perspectives. Seven approaches were published in the last decade: Humanities Oriented, Social Capital Theory, Transpersonal Music Therapy (TPMT), Vocal Psychotherapy, Compassion-Focused Relational Music Therapy, Sociological Music Therapy, and Therapeutic Music Training (TMT). These findings indicate that music therapists have been seeking and developing theories to support their work for decades.

Table 6

Chronological Order of Approaches

Approach	Development or publication date
Nordoff-Robbins Music Therapy-Creative Music Therapy	1958
Anthroposophical Music Therapy	1963
Behavioral Music Therapy	1968
Psychodynamic	1968
Humanistic Music Therapy	1970
Dalcroze-Eurhythmics in Music Therapy	1970
Guided Imagery and Music	1970
Free Improvisation Therapy	1978
Orff Music Therapy	1980
Benenzon Music Therapy	1981
Psychiatric Music Therapy	1981
Quantum Therapy	1981
The Field of Play	1989
Analytical Music Therapy	1994
Developmental-Integrative Model	1996
Biomedical Music Therapy	1997
Culture-Centered Music Therapy	2002
Aesthetic Music Therapy	2003
Community Music Therapy	2004
Complexity Science	2004
Analogy-based	2005
Music-Centered Music Therapy	2005
Neurologic Music Therapy	2005
Resource-Oriented Music Therapy	2005
Dialogical Perspective	2006
Feminist Perspectives	2006
Humanities oriented	2010
Social Capital Theory	2011
Transpersonal	2012
Vocal Psychotherapy	2016
Compassion-Focused Relational Music Therapy	2019
Sociological	2020
Therapeutic Music Training	2020

Stimulating Fruitful Dialogue and Debate

Using the similarities and differences identified in Appendix B, as well as the lab journals (Appendix A), the next phase of analysis began (Appendix C). Ansdell (2002) used themes to compare the key practices and theoretical assumptions of what he referred to as the "consensus model" of music therapy with those of Community Music Therapy. A similar analysis was used in this study to provide a point of comparison through which dialogue and debate between each approach may be stimulated. Ansdell (2002) posed questions regarding what the music therapist is expected to do in each approach, as well as where one works with each approach, what the music therapist is trying to do within each approach, and the theoretical assumptions on which each approach is based. Responding to these questions assisted in clarifying each approach so that a case example illustrating how each approach might work with one client could be designed.

Analysis of Approaches Using Ansdell (2002)

The approaches were first sorted chronologically (see Table 6), then I read through the notes from Appendix B and the lab journals for each approach in turn to identify identity and roles of music therapy, sites and boundaries, aims and means, and assumptions and attitudes. "Identity and roles" were determined through statements from the notes describing the music therapist, what qualities the therapist should have, or ways the music therapist worked. "Sites and boundaries" were defined either by descriptions of where the work takes place or where the author worked if they based the approach on their own work. For "aims and means," I looked for phrases identifying the primary goals or focus of the approach and how those goals were addressed. To identify "assumptions and attitudes," I looked at philosophical backgrounds, historical origins, and beliefs or specifically identified assumptions.

Common to every approach was the role of the music therapist to engage the client in music. Two items were different for each approach: the means for engagement and the explanation for what the music therapist does. Ten approaches were intended for practice within specific sites or had more specific boundaries for where or with whom they were best suited. The remaining 24 approaches seemed to fit within most settings or with most clients.

Although many goals for each approach seemed to overlap several domains, the aims and means for each approach were reduced to general goals that represented the primary focus: engaging in music or music-making (three approaches), peak experiences and identity integration (10 approaches), emotional competency or change (seven approaches), neurological engagement or change (four approaches), targeting the psyche (two approaches), and health and well-being (three approaches). The aims and means for four approaches did not fit clearly in any of those six categories: Behavioral Music Therapy goals are centered solely on behavior change; Feminist Music Therapy encompasses goals focused on human rights; Social Capital Theory is designed to generate social capital; and Compassion-Focused Relational Music Therapy promotes a positive relational legacy with dying clients (see Table 7). These findings indicate that the role of the music therapist and the aims of therapy are similar in many of the approaches. The role of the music therapist in each approach is to engage the client in musical experiences, while the aims of music therapy approaches include engaging in music and music-making, stimulating peak experiences and identity integration, developing emotional competency or change, promoting neurological engagement or change, targeting the psyche, and improving health and well-being. The assumptions and attitudes for each approach were unique. One could argue that several attitudes are similar across many approaches, but the foundational assumptions for each

approach are quite different. Additionally, the means for achieving the goals of music therapy vary widely, as do the sites and boundaries in which music therapy is practiced.

Table 7

Aims of Approaches

Aim	Approach
Engaging in music/music-making	NRMT, CoMT, Music Centered
Peak experiences and identity integration	AeMT, AMT, BMGIM, Free-Improvisation, Humanistic, Orff, The Field of Play, TPMT, Sociological, Vocal Psychotherapy
Emotional competency or change	AnMT, Benenzon, Psychiatric, D.I.M.T., Dialogical, ROMT, Humanities oriented
Neurological engagement or change	Dalcroze-Eurhythmics, Biomedical, NMT, TMT
Targeting the psyche	Psychodynamic, Analogy-Based
Health and wellbeing	Complexity, Culture-Centered, Quantum

Describing Each Approach Using a Single Case Study

Having identified the role of the music therapist, means for engagement, sites and boundaries, aims and means, and assumptions and attitudes of each approach (Appendix B), I attempted to describe an example of a music therapy session that I might lead with one client from the perspective of each approach (Appendix D). I selected the case study of Anabel, a 14-year-old girl diagnosed with Rett Syndrome, described in Garred (2006). This case study was selected because it was published in a book that can be accessed by others wishing to replicate this analysis and to reduce bias that might occur from using a case example from my own clinical practice. Garred described this case in enough detail, and I do have clinical experience

with individuals diagnosed with Rett Syndrome, so I felt I could realistically imagine how I might lead a session with the client described in the text.

In many of the examples of how I would work with Annabel within each approach, elements of the session would likely be the same, such as organizing the setting or environment where therapy would take place, obtaining information through a review of available clinical records or interviews with caregivers, assessing the client, designing and implementing the treatment plan, evaluating the effectiveness of the treatment plan, and documenting progress.

There were five approaches that did not appear to be a good fit for Annabel: BMGIM, Psychiatric Music Therapy (Psychiatric MT), Vocal Psychotherapy, Compassion-Focused Relational Music Therapy (CRMT), and Therapeutic Music Training (TMT). Three of those approaches (Psychiatric MT, CRMT, TMT) are used in specific settings or with specific client populations. Psychiatric MT is used with populations that have psychiatric needs or diagnoses; CRMT is specifically used for those on hospice; and TMT is designed for clients recovering from traumatic brain injuries. Rett syndrome is considered an autism spectrum disorder (American Psychiatric Association, 2013), and is not typically treated in psychiatric, hospice, or brain injury rehabilitation settings. The other two approaches (BMGIM, Vocal Psychotherapy) seem more appropriate for clients with more verbal communication skills.

Garred (2006) began working with Annabel by singing some songs for her. Annabel responded minimally to this, so Garred guided her hand towards her lap and placed a tambourine near her other hand, which continued the “hand-washing” movement. She startled when she heard the tambourine sound in response to her hand movement. Next, he sang an improvised song about her playing the tambourine. After repetition, Annabel started to recognize the song and appeared to make an effort towards playing the tambourine. Garred then added pauses in his

singing to stimulate a more intentional response from her and engage her more fully in making music. He sang, “Annabel can play the tambour- …,” pausing on the fifth note of the F scale, then waited for her to play the tambourine with her hand. When she did, he immediately finished the word “-rine” on the tonic note of the scale. She responded by laughing (pp. 89-91).

The description of this session seems to relate to Behavioral Music Therapy, where the music would provide the antecedent for the desired behavior and then reward the behavior, thus increasing the likelihood that the behavior would occur again. It also sounds similar to the NMT technique, Musical Sensory Orientation Training (MSOT), in which music would stimulate neurological arousal leading to a neuromuscular response. One could also describe this as a NRMT technique, in which the therapist helps Annabel engage in music-making and awaken the music child; or as adding complexity to her dynamic environment and human system and creating the emergent property of health and wellbeing.

This session description does not align with AnMT, BMGIM, Psychiatric MT, AeMT, Vocal Psychotherapy, CRMT, or TMT approaches. However, it could reflect music therapy within all the other approaches. Therefore, the case study described in Garred could belong to 26 approaches and would not belong to seven approaches.

Comparing Garred’s session to the case studies in Appendix D, the session I would initiate with Annabel would likely look very similar in all but six of the approaches: Beginning with setting up the carefully selected instruments, I would then sing an introduction of myself to Annabel, similar to a hello song. It might be pre-composed but would more likely be improvised to match her mood and the environment. Next, I would attempt to connect with her and engage her in music-making, probably by gently guiding her hands to an instrument, like the tambourine. The reasons for the clinical decisions I would make in choosing what to sing, when,

how, why, and the use of the instruments would be different for each approach, but what I actually do would probably look very similar in most approaches.

These findings indicate that there are similarities in the implementation and outcomes, even when practicing within different approaches, suggest that a unifying philosophy of music therapy that encompasses the diversity of music therapy practices is possible. The fundamental nature of knowledge, reality, and existence in music therapy is engaging in music/musicing, integrating identity and stimulating peak experiences, achieving emotional change or competency, achieving neurological engagement or change, and targeting the psyche.

Notation of Personal Reflections

Throughout my reading of each source and taking notes in the lab journals, I made notes of any personal reflections, thoughts, or ideas that came to me (Appendix E). Some repeated ideas that came up in these reflections include that many approaches seem to exclude or disrespect approaches that appear to be on the opposite side of the science-art divide and yet, many approaches shared similar ideas about music therapy training and practice. Several times throughout my reading, I concluded that bachelor's level training of music therapists requires a good foundation in music skills (aural skills, notation, theory, performance) and a broad understanding of several approaches, with a specific understanding of the therapeutic process (safety/ethics, referral, assessment, treatment planning, implementation, documentation, evaluation, and termination). Master's level training provides advanced practice skills and specialization within a particular approach or client population, with more in-depth understanding of the therapeutic process and application of music as or in therapy. In order to advance the profession, doctoral level music therapy training with paths for research and education is needed. All types of research are necessary to improve understanding of the field.

Clinical music therapists might perform action research and case studies most effectively, whereas academic music therapists would be better equipped to publish randomized control studies and other qualitative and quantitative research. These findings suggest a need for a general music therapy education at the bachelor level, specialized music therapy education at the master's level, and an education and research focus for doctoral levels of music therapy education.

Summary of Key Findings

The themes that emerged from the most music therapy approaches from the first phase of the analysis are improvisation, brain function, musicing, spiritual concerns, community, and NRMT-CMT. Dalcroze-Eurhythmics in music therapy contained the most themes (10), while Quantum Music Therapy, contained the fewest (1). The chronological sorting of approaches revealed that most approaches appeared in the literature from 2000 – 2009 (11) and that music therapy approaches are still being identified (two sources used in this analysis were published in 2020). Music therapy approaches are being written about by male and female music therapists equally (15 sources were written by males, 15 by females, 3 coauthored by a male and a female) and that those outside the profession are also writing about music therapy approaches (*Approaches* Special issue on Dalcroze-Eurhythmics in Music Therapy and Music Education). The primary identity and role of music therapists within each approach is to engage the client in music. The sites and boundaries are different for each approach. The primary aims in music therapy are to engage in music, facilitate identity integration, stimulate peak experiences, develop emotional competence, improve neurological function, connecting with the psyche, and health and wellbeing. The means for achieving these goals are different for every approach, since they are each based on different attitudes and assumptions. The case examples revealed

similarities for working within each approach include organizing the environment where therapy will take place, obtaining information about the client, completing an assessment of the client to determine goals of therapy, designing and implementing a treatment plan to address those goals, evaluating the effectiveness of the treatment plan, and documenting the sessions.

CHAPTER 5

DISCUSSION AND CONCLUSION

The purpose of this dissertation was to investigate the feasibility of a unifying philosophy for music therapy and to offer an identity for the music therapy profession that is appropriate for the various ways in which music therapy is practiced throughout the world. The central research question for this dissertation was, "Is it possible to articulate a unifying philosophy of music therapy that is inclusive of the diverse ways music therapy is currently practiced, and if so, what is an integrated philosophy of music therapy?" This question was investigated through an interdisciplinary analysis of existing models, approaches, and theories that was inclusive of the diversity in music therapy practice. There are many models, approaches, and theories in music therapy, but they were not previously analyzed through an interdisciplinary lens to determine whether a unified music therapy philosophy is possible. This investigation was completed to offer an identity for the music therapy profession that is appropriate for the various ways in which music therapy is practiced throughout the world.

The thesis was that a unified philosophy of music therapy which encompasses the diversity of approaches to the practice of music therapy is essential for the continued and positive development of the profession. The antithesis was that a unified philosophy of music therapy is impossible because of the diversity of approaches to the practice of music therapy; therefore, the profession must develop along different paths. The findings of this investigation

support the thesis that although there is significant diversity in music therapy approaches, a unifying philosophy for music therapy is feasible.

The first research question was, “Is it possible to articulate a unifying philosophy of music therapy that is inclusive of the diverse ways music therapy is currently practiced?” To answer that question, I looked at the personal context of the authors of each source, common themes among the approaches, the chronology of the development of each approach, and the similarities and differences between each approach. I also provided case examples to illustrate the similarities and differences between each approach and investigated ideas relating to education and training of music therapists.

Personal Context

When analyzing the authors’ personal contexts, the findings indicated diversity within the practice of music therapy and highlighted multidisciplinary aspects of music therapy. Music therapy practices in 37 countries were represented and NRMT was practiced in 28 of those countries, indicating that NRMT had a widespread influence on the development of music therapy in multiple countries. Several of the authors were trained in or influenced by NRMT and four others were trained by Gaston. Some approaches were written by authors from disciplines other than music therapy, which speaks to the interdisciplinary nature of the profession. The profession of music therapy is predominantly female (86%). However, 50% of the authors of approaches are male, which may indicate that male music therapists have a higher percentage of academic appointments or publishing opportunities than female music therapists, and perhaps have a disproportionate voice in the profession.

Common Themes Among Approaches

When common themes were identified among the approaches, the widespread influence of behavioral psychology, NRMT, and psychoanalysis was confirmed. Additionally, improvisation, the brain, musicing, community, and spirituality are important in music therapy approaches.

The 13 themes that were identified in the analysis were: Improvisation, Brain, Musicing, Community, Spiritual, Behavior, NRMT, Psychoanalysis, Psyche, Culture, Music Centered, Movement, and Complex. While not all the themes were present in the notes for each approach, the most common themes could be included in many of the approaches. The most common themes were improvisation, brain functioning, musicing, community, and spiritual. Improvisation is a common music therapy technique no matter which approach one uses, which was indicated by the number of approaches that mentioned improvisation as a clinical technique. Even in an approach like BMGIM, where the therapist relies on specific programs of recorded music, one must improvise within that approach when the client comes to the session with a problem that is different and more urgent than the originally intended focus for music therapy.

All humans exhibit brain functioning, which may malfunction through injury or disease, creating challenges in daily living and is typically the impetus for seeking therapy. Therefore, even approaches like TPMT, NRMT, or CoMT would address human brain functioning.

Musicing is common to all music therapy approaches. The primary way music therapy works is through engaging in music in some purposeful way to achieve health and well-being. Engaging in music is a primary focus because every music therapy approach values the central importance of music and allows music to play an important role in the therapeutic interventions. Community engagement is inherent in musicing, either through cultural participation, integration

into society, entrainment, group identification, or identity formation, so the majority of approaches deal directly or indirectly with a community.

Additionally, regardless of one's beliefs, all humans exhibit spiritual needs. These are typically expressed as a need to feel a part of something bigger than oneself and may or may not include religious aspects. Because all music therapy approaches work with humans, they would all address spirituality, directly or indirectly, through the nature of working with human beings.

Dalcroze-Eurythmics included the most themes (10) of all the approaches, and yet, the primary source for this approach was written by music educators and neuroscientists, rather than music therapists, which could indicate that music therapists underestimate the usefulness of this approach, or that this music education approach is not widely used by music therapists. Perhaps a greater emphasis should be placed on music therapy research and education in this approach.

Quantum Theory included only one theme: Complex. However, this theme (Complex) was identified in 10 other approaches, perhaps indicating that there is a lack of understanding of quantum music therapy leading to a lack of referencing it as such in the literature. More research and education in this music therapy approach would increase understanding of its practical applications.

Chronology

Music therapists have been seeking and developing theories to support their work for decades. Thirteen of the 32 approaches were published since 2000. This growth indicates that music therapy is developing quickly in the 21st century, and that the foundational approaches that were developed in the first 50 years of music therapy's existence had a profound influence on the theoretical development of music therapy approaches.

Similarities and Differences

The role of the music therapist and the aims of music therapy are similar in many of the approaches. The role of the music therapist in each approach is to engage the client in musical experiences, while the aims of music therapy approaches include: (a) engaging in music and music-making, (b) stimulating peak experiences and identity integration, (c) developing emotional competency or change, (d) promoting neurological engagement or change, (e) targeting the psyche and (f) improving the clients' health and well-being. On the other hand, the assumptions and attitudes for each approach were unique. Attitudes are similar across many approaches, but the foundational assumptions for each approach are quite different. Additionally, the means for achieving the goals of music therapy and the sites and boundaries in which music therapy is practiced are different for each approach.

Music therapists who practice in the different approaches tend to focus on how their approach is different from another approach. For example, NMT therapists focus on how their techniques are standardized and based on neurologic research, instead of on sociological research, whereas NRMT therapists focus on how their techniques are individualized and based on the musical expression of the client. If the focus were on the similarities between the approaches, would music therapists come to better conclusions and explanations for how music therapy works? Both NMT and NRMT therapists use music to facilitate change in how the client functions. The NMT techniques use music to facilitate change in brain function and NRMT techniques use music to change musical functioning. However, NMT techniques could not work unless musical engagement influenced brain function, and NRMT techniques could not influence musical functioning without also influencing brain functioning. If NMT therapists and NRMT therapists worked together, or at least respected the work and research of the other approach,

would they have a stronger rationale for their work than if they relied purely on their respective research? Perhaps both approaches would be stronger, which could lead to a stronger music therapy profession.

Case Examples

Bruscia (2014) stated that music therapy is too diverse and complex for a single theory. However, in the case examples, there were many similarities to how a music therapy session might look, even though the assumptions and attitudes of the music therapist leading the session would be vastly different based on the approach. I have often wondered if the various music therapy approaches were actually referring to similar concepts, only using different terminology. Eschen inferred this idea after sharing his perspective of the First International Symposium on Music Therapy Training in 1978: "Music therapists of different backgrounds listened to work of others, realizing, in spite of differences of theory, that parts of the work were very close to what they themselves would have done with such clients" (Wheeler, 2003, p. 57). A biomedical music therapist would explain the musical responses as coming from the stimulation of neurological networks. A NRMT would explain the same musical responses as coming from the awakening of the "music child." Either explanation can be true, and both are likely influenced by the same mechanisms: The music child is awakened because neurological networks are stimulated; and music stimulates neurological networks because humans are innately musical. Music therapy is art, science, and humanity. Each approach is client-centered in that the therapist will adjust the implementation of the treatment plan based on what the client needs in that moment.

These findings that there are similarities in the implementation and outcomes, even when practicing within different approaches, suggest that a unifying philosophy of music therapy that encompasses the diversity of music therapy practices is possible, even if a single theory is not. A

philosophy is the study of the theoretical basis of a particular branch of knowledge or experience; whereas, a theory is the supposition or system of ideas intended to explain something, especially one based on general principles independent of the thing to be explained (Himes & Schulenberg, 2013). The fundamental nature of knowledge, reality, and existence in music therapy is engaging in music/musicing, integrating identity and having peak experiences, achieving emotional change or competency, achieving neurological engagement or change, and targeting the psyche. The strategies used to achieve these aims in music therapy are diverse and can be tested in a multitude of ways.

Education and Training

Throughout my reading, I repeatedly concluded that there is a need for a general music therapy education at the bachelor level, specialized music therapy education at the master's level, and an education and research focus for doctoral levels of music therapy education. However, there is disagreement on what can be included in a general music therapy education without causing harm to clients from a lack of education and training. This disagreement has fueled the debate over whether music therapy should continue to be certified at a bachelor-level education or if the field needs to move to a master's level entry.

Currently, 15 states recognize board certification with a bachelor-level entry (CBMT, 2022c). If a master's-level entry were required, the states would likely not pass laws requiring the MT-BC credential for licensed practice of music therapy at the current bachelor-level education. Licensing, or other forms of state recognition of the MT-BC, in all 50 states should be the focus of the collective efforts at this time. If that is the case, though, how can music therapists be trained appropriately at the bachelor level for the various ways in which music therapists work?

The answer may lie in the similarities within each approach. The role of the music therapist in each approach is to engage in music with the client. Therefore, an understanding of music and competent performance of musical skills, as well as how to help people with various skills and abilities engage in music are necessary. Music therapists would need to experience identity integration and peak experiences stimulated by music, as well as having a theoretical and academic understanding of these experiences and how they help humans improve health and wellness. Being emotionally competent and knowing how music may change emotions, as well as an understanding of neurology and how music influences brain function are essential. Music therapists would also need to understand the psyche and how music may target that aspect of human existence.

Many of these aspects are evident in the Board Certification Domains (CBMT, 2020). The domains are based on a practice analysis conducted by CBMT every five years and fall under the following categories: Safety; Referral, Assessment, Interpretation of Assessment, and Treatment Planning; Treatment Implementation and Documentation; Evaluation and Termination of Treatment; and Professional Development and Responsibilities. Within the domain for Implementation, recognizing how theoretical frameworks and music therapy approaches inform clinical practice is included. The document specifically lists the following theoretical frameworks: Behavioral, biopsychosocial, cognitive, holistic, humanistic/existential, neuroscience, and psychodynamic (CBMT, 2020). Behavioral, community music therapy, culture-centered music therapy, developmental, health and wellness, humanistic, improvisational, medical, neurological, and psychodynamic are the approaches that are specifically listed (CBMT, 2020). Therefore, bachelor-level education in music therapy should include a basic competency within each of those theoretical frameworks and approaches.

Professional competencies are determined by AMTA, and there has been significant debate over whether the competencies required by AMTA relate to the Board Certification Domains identified by CBMT. The competencies include the following areas: Music Foundations (including music theory and history, composition and arranging skills, major performance medium skills, functional music skills, conducting skills, and movement skills); Clinical Foundations (including therapeutic applications, therapeutic principles, and the therapeutic relationship); and Music Therapy (including foundations and principles, client assessment, treatment planning, therapy implementation, therapy evaluation, documentation, termination/discharge planning, professional role/ethics, interprofessional collaboration, supervision and administration, and research methods) (AMTA, 2022). As part of the music therapy foundations and principles, music therapists are expected to demonstrate competency in the ability to "demonstrate basic knowledge of accepted methods of major therapeutic approaches" (Competency 8.3, AMTA, 2022) and to "apply basic knowledge of existing music therapy methods, techniques, materials, and equipment with their appropriate applications" (Competency 10.1, AMTA, 2022). Demonstrating a basic knowledge of accepted methods of major approaches is possible within a bachelor-level music therapy degree program, as evidenced by the number of music therapists who pass the board exam following completion of a bachelor's degree in music therapy. The first-time candidate pass rate is 74.1% and there are 9,264 board certified music therapists as of October 31, 2021 (CBMT, 2022b).

The second research question was, "If a unified philosophy of music therapy is feasible, what might be that resultant integrated philosophy of music therapy?" A philosophy of music therapy is a coherent belief system on which music therapy is based. The extensive review of the

sources conducted in this study revealed the following core beliefs stated by researchers in the field:

1. Music is a natural human activity (Aigen, 1991; Bruscia, 2018; Byers, 2016; Davis & Gfeller, 2008; Gaston, 1968c; Hodges & Haack, 1996; Taylor, 2010).
2. Music affects and changes people (Aigen, 1991; Bruscia, 2018; Byers, 2016; Davis & Gfeller, 2008; Gaston, 1968c; Hodges & Haack, 1996; Levitin, 2006; Ruud, 2020; Taylor, 2010)
3. The jurisdiction of music therapy is the music-client-therapist relationship (Byers, 2016).
4. Music therapy is multidisciplinary (Aigen, 2014; Bruscia, 2018; Byers, 2016; Davis & Gfeller, 2008; Gaston, 1968c; Garred, 2006; Kenny, 2002; Ruud, 2016).
5. Music is helpful to humans and can be used systematically to achieve goals (Bruscia, 2018; Davis & Gfeller, 2008; Sears, 1968/2007; Summer, 2002; Standley & Walworth, 2010; Thaut, 2005)
6. Values of music therapy include:
    a. the central importance of music (Aigen, 2005; Alvin & Warwick, 1991; Ansdell, 2002; Crowe, 2004; Forinash & Kenny, 2015)
    b. prioritizing a commitment to people over a conceptual system (client-centered) (Bruscia, 2010; Schwabe, 2005; Stige, 2002)
    c. letting music do the work (Aigen, 2005, Proctor, 2011; Robbins, 2005; Schwabe, 2005; Sekeles, 1996; Summer, 2002)
    d. diversity (Aigen, 2005; Bruscia, 2010; Hadley, 2006; Stige, 2002)

Given that music is a natural human activity through which people are affected and changed; given that music is helpful and can be used to systematically achieve goals; and given that music therapists receive multidisciplinary training to use music to promote health and wellbeing within a music-client-therapist relationship, the following coherent belief system for music therapy may be derived: *Music therapy occurs when a trained and qualified music therapist helps humans systematically achieve their goals through musical engagement within the music-client-therapist relationship.*

Implications

Because the term "music therapy" is often simplified and misused in ways that discount or ignore the field, music therapists need to be able to explain what therapy is to others in a way that helps them understand what music therapy is, as well as what it is not. Music therapists know that listening to music selected by oneself or attending a musical performance or playing a musical instrument may be therapeutic is not music therapy, but many people in the United States do not. Using this unified philosophy to identify what music therapy is and how it works is essential for the public to understand, in order to reduce confusion and increase access to quality music therapy services.

Defining music therapy has been a conundrum since the beginning of the profession (Bruscia, 2014). Taylor (2010) defined music therapy as the "enhancement of human capabilities through the planned use of musical influences on brain functioning" (p. 259). Ruud (2010) defined music therapy as "the use of music to give people new possibilities of action" (p. 130). Aigen (2005) defined music therapy as an approach that places music and musical experiences in a central role. Combining all three of these definitions, I believe, is closer to an actual definition of the way music therapy is practiced. The philosophy of music therapy proposed in this

dissertation is, “Music therapy occurs when a trained and qualified music therapist helps humans systematically achieve their goals through musical engagement within the music-client-therapist relationship.” This philosophy encompasses not only the three definitions mentioned above, but also fits with each of the approaches studied in this dissertation. Taylor (2010) would likely argue that because it does not explicitly identify the brain as the primary target of music therapy, that the definition is insufficient. However, since humans cannot engage in music without engaging the human brain, this is implicitly included. Aigen (2005) might be satisfied with the inclusion of the phrase “musical engagement within the music-client-therapist relationship” and dissatisfied with “helps human systematically achieve goals;” however, helping humans is the basis for therapy in general, and systematically achieving goals is necessary to justify third-party (i.e., insurance) reimbursement for music therapy.

Having multiple definitions is insufficient, because it confuses the public and peers in healthcare as to what music therapy is and what it is not. Whether one uses music therapy primarily as a process in which the experience is measured by qualitative means or a product with outcomes measured quantitatively, music therapists take one board certification examination and maintain one credential to indicate competent practice. The multitude of approaches in music therapy reflect the multitude of practitioners, serving a multitude of clients, in a multitude of settings, for a multitude of goals. Therefore, Bruscia’s (2014) proposed integral practice of music therapy is congruent with how music therapy is currently practiced throughout the world and reflects the current trends in the training and education of music therapists.

Limitations

A limitation of this study is that the analysis may have missed some important music therapy literature published in journals that are not being included here, either because they were

not accessible or because they were not written in English. Another limitation is that there may be publications that are unable to be accessed through the university library or the author's personal collection of books that related to music therapy approaches.

The analysis of approaches included books about music therapy approaches published between 1950 and 2020 that were accessible through the university library or the author's personal collection of books that relate to music therapy approaches. Some journal articles published in *Approaches: An Interdisciplinary Journal of Music Therapy, Journal of Music Therapy*, *Music Therapy Perspectives, Nordic Journal of Music Therapy,* and *Voices: A World Forum for Music Therapy* that related to music therapy approaches were also be included. However, in order to limit the scope of this study to a manageable size, music therapy journals from other countries were not included.

My personal bias and experiences may have influenced the findings of this study, as well, since I practice integrally by selecting the method that will achieve the best outcomes for a particular client based on the circumstances, needs and desires of the client, and my clinical decisions. However, I also believe that most music therapists work integrally and base their clinical decisions on the needs and desires of the client, as well as the circumstances. Regardless, LGBTQ+ and issues significant to those of non-dominant or marginalized races or ethnic backgrounds were not included in this study because I did not feel competent to address them adequately, nor did I believe that my voice as a white female in the United States would be appropriate to address these issues.

Recommendations

As music therapy continues to evolve, it is imperative that further research be conducted to solve the terminology problem so that there is a clear understanding of what is a music therapy

theory, music therapy orientation, music therapy approach, music therapy model, music therapy method, or music therapy technique. This research should include a review of the terms as they are used in other disciplines, as well as how practicing music therapists are using them.

Based on the sources that were selected for this study, it appears that male music therapists have a higher percentage of academic appointments or publishing opportunities than female music therapists, and perhaps have a disproportionate voice in the profession. Future research could determine if this is true and make recommendations for assuring diversity, equity, and inclusion of the voices that are representative of the profession and the communities in which music therapists work.

To continue and refine the unifying philosophy of music therapy, future research should include interviews and data collection from the primary authors and practitioners of each music therapy approach. One case study could be presented to specialists in each approach so they may describe how they would work with a particular client. The results would then be analyzed and compared to the results of this study. Additionally, expanding the scope of this research to include LGBTQ+ voices and voices of those from different races and ethnic backgrounds as practitioners and clients should occur.

Although improvisation was a theme in most approaches, surprisingly, no one theme was consistently mentioned in every approach. More research is needed to determine whether this is significant to defining music therapy.

Education and training programs for music therapy should be reviewed to ensure they include a basic understanding of each of the major music therapy approaches, as well as a clear identification of which approaches require advanced training for competent practice. Bachelor-level programs should provide a broad education of several approaches and how to practice

integrally, whereas master's level programs should provide in-depth education on one or more specific approaches for advanced levels of practice. Doctoral programs specifically to advance research and education for music therapy need to be accredited with standards and competencies established by AMTA.

Conclusion

Since the inception of music therapy as a discipline and a profession in 1950, music therapists have disagreed about whether the foundation for music therapy is as an art or a science. The time to end the identity crisis has come so that music therapy may no longer struggle to gain credibility as a health profession. If music therapists can embrace this unified philosophy, music therapy jobs that pay a living wage will become more available and instances of non-credentialed musicians or health professionals publishing about recreational uses of music for health-related gains using the term "music therapy" to describe their work will decrease. Music therapy is an interdisciplinary profession that encompasses art, science, and humanities, which requires an interdisciplinary education including music, biomedical foundations, psychological foundations, social sciences, neurological sciences, and humanities. With agreement on a unified philosophy of music therapy, interdisciplinary education and training, and a focused state recognition operational plan, music therapists can engage in a strategic research agenda to confirm the efficacy of music therapy, advocate for greater access to quality services, and educate healthcare professionals and the public about the differences between music therapy and other applications of music for health benefits.

APPENDIX A

IMAGES OF SELECT PAGES FROM LAB JOURNALS

Figure A1: Front covers

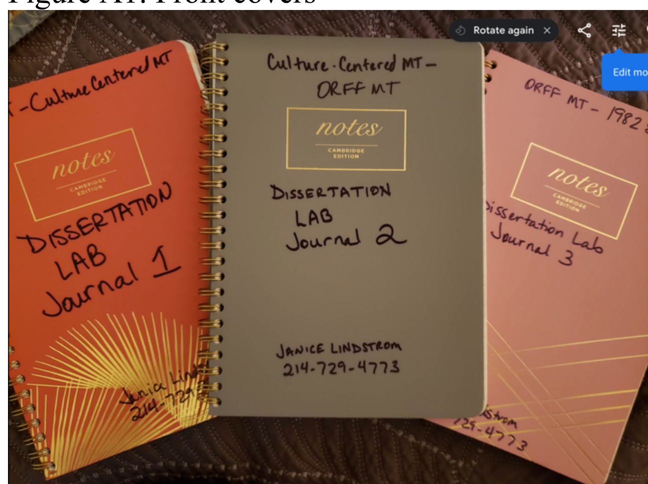


Figure A2: Two pages from the table of contents

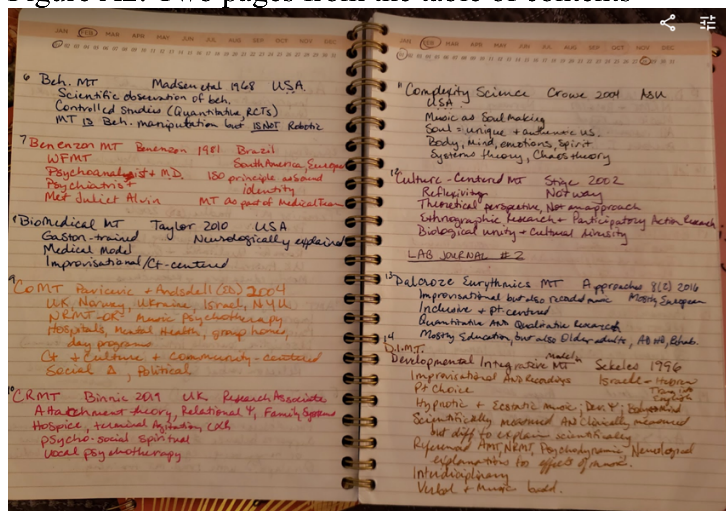


Figure A3: Two pages from the notes on Garred (2006)

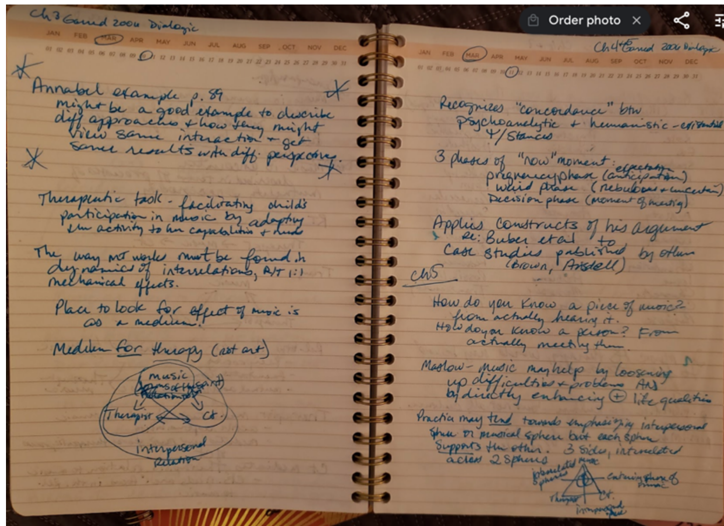
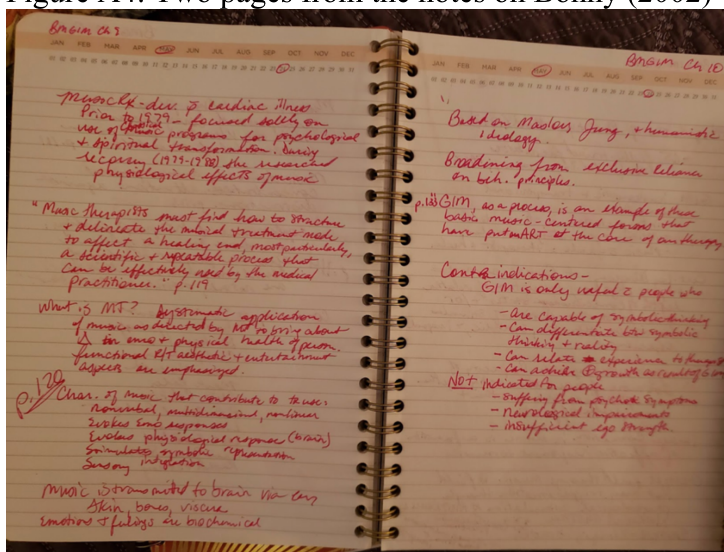


Figure A4: Two pages from the notes on Bonny (2002)



Appendix B: Categorized Findings From the Lab Journals

Table B1

Notes From the Lab Journals Categorized into DLS Topics

Approach, model, or theory	Source	Historical context	Philosophical context	Creativity influences	Human rights influences	Scientific method	Cultural context
Aesthetic Music Therapy (aemt) – Improvisational approach that views musical dialogue at its core. Interpretation of process comes from understanding of musical structures and how structure is balanced with clinical relationship	Lee, 2003 Lee is male from England, taught in Canada. Composer, NRMT. Worked with AIDS, Down Syndrome, Autism, Hospice, bereavement	Understanding the complex strands of clinical improvisation; MUSIC-CENTERED "If I trust music then I can trust the therapeutic process. If I understand music then I can understand the therapeutic relationship. Finally, if I know music then I can know the possible outcomes that music will have for the client and the developing work." P. 242	Aesthetics – beauty and meaning; study of relationship of music to human senses and intellect; Music is intrinsically healing; music as tool to influence human growth; Music reflects both living and dying; nonverbal communication is critical; Music is spiritual and transcends realities of living and dying; nonthreatening and flexible; improvisation reflects passing nature of living and dying	Western Classical music, Bach, Beethoven, Cage, avant garde experimental music; Disability as creativity; Orchestral instruments; To improvise is to live peaceably with time. Creativity is the essence of life; LISTENING	Musical equality of client and therapist; strength of music to express loss; Music is life-giving force that can express essence of dying; Acceptance and Respect. "Being musical should not be limited to knowledge and composing should not be confined by rules." P. 223 "In music there can only be consonance and normality. In music the client is free and empowered to be healthy and it is through creativity that healing occurs". P. 233 Aemt is based on the belief that all clients have limitless potential.	"MT as art needs innovation and speculation, whereas MT as science needs stability and replicability" p. 85; Notation and musical analysis of improvisation; P. 185 "aemt is the science of musical components, relationship, and artistry." "To make music therapy an entirely empirical science is to take the heart out of what brought the profession into being." P. 185 Research is generated from clinical practice; creative and not bound by methodology; Attempt to answer most intimate of questions and not constrained or reductionist; available to all mts; serves both the needs of the profession and the questions of the researcher; accessible and clear	Western Classical Music; Pure silence is physically impossible. Every performance is unique. Accidental sounds and noises are as important as music itself. BALANCE: Ambiguity and certainty; order and chaos; known and unknowable; illness and life; freedom and structure; musical and clinical
Analogy-based – Improvisational sounding of	Smeijsters, 2005	Author's personal research and experiences.	Improvisational, psychological, direct connection between	Sounding of the Psyche; establishing conservation and	Mts are not musicians who listen to and	Qualitative, naturalistic inquiry; treatment modalities:	European Conferences, practice. Peer

Approach, model, or theory	Source	Historical context	Philosophical context	Creativity influences	Human rights influences	Scientific method	Cultural context
psychological process in music	Male from Netherlands	Netherlands. Founded on concrete processes that take place in music activities during MT and on mt's statements about these processes; describes similarity btw change in music and psychological change in client. Model fits each client, therapist, and method.	what happens audibly and visibly in music and what happens in psyche; Stern – developmental psychology	variation; cause and effect (self-agency)	follow aesthetic rules of music, they are therapists who listen to and follow psychological processes sounded in music.	Rehabilitative, developmental, supportive, palliative, re-educative, reconstructive. MT can provide additional assessment data and therapeutic strategies. Data linked to existing sources of Data	conversations with Carolyn Kenny, David Aldridge, Dorit Amir, Lars Ole Bonde, Kimmo Lehtonen, Wolfgang Mahns, Mercedes Pavlicevic, Brynjulf Stige, Eckard Weymann, Kenneth Aigen, Diane Austin, Evan Ruud. Arts Therapies and Psychology
Analytical Music Therapy (AMT) – analytically informed symbolic use of improvised music by music therapist and client. Used as a creative too to explore client's inner life and provide growth and greater self-knowledge. AMT is non-directive. Expanded on by practitioners from Eschen book who trained with Priestley and then trained others.	Priestley, 1994 – UK, clinician, violinist, psychoanalyst. Developed ideas in Intertherapy, then tried them on clients Also: Eschen (ed) (2002) – world congress track org by Aigen and Bruscia in 1999. Multiple authors mostly from Europe: Denmark and Germany	Influenced by Freud, Jung, Klein. Developed in Priestley's 20 years of clinical work in psychiatric hospitals and private practice (primarily). Since 1955. Based on her own Kleinian psychoanalysis experiences as a client. Developed to meet the needs of clients.	Music and psychotherapy. Music therapy is to BE WITH emotions. Techniques for probing conscious: Holding/containing, splitting, investigation of emotional investment, entering into somatic communication. Techniques for accessing unconscious: Using symbols, guided imagery (during improv) Techniques for Ego Strengthening: Reality rehearsal, wholeness, exploring relationships, affirmations, subverbal communication, patterns of significance, programed regression	Client engages in musical duet, shares feelings after playing. Lively, emotional, reciprocity between therapist and client. Therapist is container for all extremes of emotions. Requires therapist to have been in contact with extremes of own emotions with a good container. "Music is an art which exercises every part of a person: physical, emotional, mental, and spiritual." (p. 251) Takes place through time allowing for change from one emotion to another and tension-release; adaptable to wide range of clients. RCE – receptive creative experience, seems similar to FLOW.	Uses Countertransferen ce – therapists' intuition about what emotions are projected by client. Potential for abuse. Quotes Frankl: relationship is more important than method used in psychotherapy. Ultimate goal of AMT is greater love of self, life, others Self-care of therapist is essential.	Descriptive, qualitative, therapist journals, intuition. Rigid rcts would be difficult. Meaning of music is mysterious at best and indecipherable at worst (p. 142) Impossible to teach AMT, must experience it. Inter therapy training.	Primary aim is to make a relationship. Firm boundaries and yet also compassion and relationship. MT in UK: musician first with more training as musician than as therapist. Therapeutic aspect is in music and words: words lead to area to be explored, so title can be set for improv. Leads to more words. "make sounds to let me know what you are feeling"
Anthroposophical Music Therapy (anmt) – use of special musical elements,	Intveen & Edwards, 2012 – mts who are not trained in	Based on Anthroposophical medicine created by Rudolf Steiner	Steiner's model of 3 fold human being with systems linked to soul activities and musical	Uses scales and tonalities in typical music (major/minor) but also mirrored planetary	Ultimate goal is to support client's self-regulation on a spiritual,	Pseudoscience with no basis in reason or logic. Uses drugs	Germany, Austria, Switzerland. Music-centered in that it addresses musical

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tonalities, and instruments to strengthen and support soul forces so that healing development can occur. Integration/Re-integration of body, soul, and spirit **North American Anthroposophic Music Therapy Association (NAAMTA)** Anthroposophic music therapy is the deliberate use of the musical elements of melody, harmony, rhythm, tone, interval, and movement employing a variety of stringed, wind, and percussion instruments as well as the human voice with the intent of supporting the balance and integration of the four members of the human being: the ego, astral, etheric, and physical bodies.	anmt but interested in the approach. The Mission of the North American Anthroposophic Music Therapy Association (NAAMTA) is to provide a vessel for those individuals who are working with music as a healing art, based on the knowledge of spiritual science. The Association seeks to raise awareness among professionals in medicine, education, and the arts, about the potential of music as a therapeutic modality.	in 1920. Primary influences are curative education and eurhythmy therapy. Anmt training founded by Maria Schüppel in 1963 – composer and pianist. 4 years plus internship.	elements: Upper system – head and CNS, thinking, melody; Middle system – circulation and respiratory systems, feeling, harmony; Lower system – limbs and metabolism, willing, rhythm. Steiner's 4 fold human being: physical body, ether body (maintains vegetative function), astral body (emotions), and ego (responsible, independent and creative personality)	scales or certain sequences like Tao or Mercury Bath.	emotional, vital, and physical level.	based on alchemy and homeopathy	goals in musical relationships. Had a difficult relationship with NRMT. "New Age"
Behavioral Music Therapy – MT is method of behavioral manipulation and therefore can automatically be considered as falling within purview of behavior modification movement.	Madsen et al., 1968 – mts trained by Gaston, educators at FSU	Developed in 1960s along with behavioral psychotherapy movement.	Relies on learning principles. Behavior is motor responses, emotional responses, cognitive responses, and ideational responses.	What behavior is maladaptive/should be increased or decreased? What environmental contingencies currently support the behavior? What environmental changes may be manipulated to alter the behavior?	Often believed that therapist attempts to negate complexities of human behavior and will dehumanize clients but these are misunderstandings.	MT is behavioral science concerned with human being and their responses to music and the effects of a musical environment upon their behavior. Quantitative research with rigorous, controlled experiments to determine MT's effectiveness	US behavioral movement. Observations of external behaviors, rather than unconscious processes

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Benenzon Music Therapy – Field of medicine which studies the man-sound-man complex in order to use movement, sound, and music to open communication channels to produce therapeutic, psychoprophylactic, and rehabilitating effects in man and society p. 3. MT is both art and science. MT is a relational historical process in a nonverbal context which occurs between the therapist and his client or group of clients or people. P. 22	Benenzon, 1981 – distinguished psychiatrist and accomplished musician. Buenos Aires Neuropsychiatric Hospital. Influenced by Juliette Alvin. Influential in WFMT and first World Congress. Based on clinical experiences as psychotherapist, MT with Autistic Children, supervisor of didactic MT groups	"All relational experiences during pregnancy will be complemented by sound, vibration, and movement experiences which are the principle means of communication and stimulation at that stage of development." (p. 5) ISO – Individual sound identity. Based on psychotherapy. Method has 2 parts: diagnosis – discover the patent's ISO and intermediary and integrating objects that will make treatment easier; MT sessions – warm up and catharsis, perception and observation (establishing channel of communication), sonorous dialogue (climax of session).	Philosophy comes from medicine, music, magic, and astrology. ISO principle – to produce a channel of communication between a therapist and client, client's mental tempo needs to match sound-music tempo expressed by therapist. SUBCONCIOUS: Universal ISO (archetype) – shaped by ontogenetic and phylogenetic heritage (heartbeat, inhale/exhale, water, wind, rhythm of walking, pentatonic scale). Gestalt ISO – develops on basis of sound archetypes (words, singing, whispering, crying, body sounds). PRECONSCIOUS: Cultural ISO – stimuli repeated in similar circumstances and at specific times (sound identity of relatively homogenous cultural community, linked to Gestalt ISO). Complementary ISO – changes with individual state of mind in particular circumstances and with person he communicates with. Group ISO – history of a particular process that occurs with particular people in a time period. Individual discharges energies from sum of isos into consciousness.	3 characteristic times in MT: Chronological – measured by clocks (cultural ISO). Biological – time brought with us from fetal period, gradually lost during living in civilization. Therapeutic – time created during bonding process between client and MT, history between MT and pt over sessions. Corporal instruments (body). Created instruments. Musical instruments. Piano is counterproductive in first 10 sessions, more useful after 15th session. Instruments categorized as fetal, maternal vaginal, paternal phallic, hermaphroditic	MT wants to change other. Training in collateral knowledge (psych, medicine, rehab, music, etc). Acquires technical knowledge (what to use, how, why, where, and with whom). Practical observation and supervised experience. Own restructuring and recognition in personal therapy. MT must undergo both psychotherapy and didactic MT so they can discover own ISO and clarify own nonverbal thinking and that of the client. Not necessary to have deep scholastic knowledge of music. Consent and confidentiality; presence, continuity, and receptivity. Contraindications: music that does not promote interaction, connection, communication. Functional music (background) designed to increase productivity in	ISO principle is measured by intensity, timbre, rhythm, and pitch. Scientific studies, training based in medical schools, but explains the omnipotent, magic, and suggestive power of music as means of change	Brazil, South America, Europe. MT is fundamentally a psychological technique – its therapeutic contribution lies in the modification of emotional problems, attitudes, and the energy of psychic dynamics, which is the predominant effort made to change any human pathology, whether of psyche or soma (p. 149). Aid to other therapies.

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					workers and decrease boredom and anxiety in waiting rooms. Musicogenic epilepsy – most examples related to trauma-induced head injury or musical training trauma with severe performance anxiety. Electronic sounds may have hallucinogenic effects		
Biomedical Music Therapy – Music therapy is the enhancement of human capabilities through the planned use of musical influences on brain functioning. P. 259 Biomedical theory of MT: Music influences human behavior by affecting the brain and subsequently other bodily structures in ways that are observable, identifiable, measurable, and predictable, thereby providing the necessary foundation for its use in treatment procedures. P. 101	Taylor, 2010 – Studied with Gaston undergraduate. Masters thesis proposed stimulative and sedative effects of music have more to do with how brain responds than type of music. Dissertation: historical research on clinical use of music to treat physical illness in medical settings. Professor of MT	Based on large growing body of research findings and clinical data pointing to biomedical basis for MT. Basic capacity for auditory perception was established in evolution to process sounds that are musical in nature – music is a biological imperative.	Because the human brain must first interpret any sound as “music” before there can be a “musical” influence and because every client has a brain that must change its way of doing things in order for therapy to take place, the human brain must be recognized as the basic domain of treatment and the primary focus for change in all MT applications. Because music has observable effects on human behavior through its influences on BRAIN functions, its effects can be used therapeutically. (p. 46) Using music to release unconscious material, awareness and expression of these responses require activity in the client’s brain.	The use of improvisation in playing instruments to express emotions and to activate one’s inborn musicality can only be done by stimulating the client’s brain through musically facilitated emotional, motor, and auditory experiences.	Maintaining enjoyment of musical experience is prime feature of client-therapist relationship. Expressive Emphasis Therapy (EET) for reversal of suicidal behavior p. 177	Based on a biological model of human response to musical experience. Its purpose is to provide scientific basis for interpreting receptive expressive, and physiological behavior human organism during musical participation p. 80. There are specific neurophysiological structures and processes that must be activated in order for certain behavioral responses to occur. Therefore, any occurrence of those behaviors in response to musical experience must result from the effects of music on those musical effects enables their use in medical, psychiatric, rehabilitative, and other therapeutic applications. P. 80	Humans are born with innate capacity for music that is shaped by culture. Music is a series of sounds that are created with the intent of the aesthetic expression and selected with full consideration of the specific musical background of individuals receiving MT p. 59

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Community Music Therapy (comt) – anti-model that encourages therapists to resist one-size-fits-all-anywhere models (of any kind) and instead follow where the needs of clients, contexts, and music leads. (p. 28). "Joined-up music therapy" MT is musicing in pursuit of well-being wherever, whenever, and however it happens (p. 230). MT always takes place in context of sociocultural life. Not a Model of practice, but a set of values and basic assumptions.	Pavlicevic & Ansdell, 2004—edited book with 17 authors, mostly trained in NRMT in London. Authors from UK, Norway, NYU, Israel, South Africa, Ukraine. 8 female, 9 male	Human existence is coexistence and culture enables and regulates such co-existences. Music = *mode* of coexistence; Health = *quality* of coexistence. Roots of comt: models of conventional modern MT especially NRMT, Ruud, Kenny; community healing rituals of traditional cultures	Community is both social systems (locality and inhabitants) and experience (of togetherness and having mutual support). 3 basic assumptions: culture is central to MT theory and practice, health is expressed as mutual care, mutual care is related to the issue of human and social welfare. Comt practices = welfare-related practices where community is a context to work in and with. Health = quality of interaction and activity that humans engage in. Therapist as musician ethnographer listening intently and being inquisitive about customs, texts, dancing patterns that go with music. Leads to trust and empathy with culture. Focus is to enable clients to use cultural heritage to facilitate healing.	Ripple effect metaphor. 1:1 MT – group MT with family – social musicing on unit with staff, visitors, and clients – community workshops – social music consumers and participants Musical written by psychiatrist and performed by staff and clients. Broke down barriers and created community and self-reflection. Musicing contributes to the quality of life and understanding musicing is part of understanding ourselves and our relationships with other people (p. 254). In comt approach, musicing is the main activity. Main goal: improving clients participation in any kind of musicing.	Music is not designed for privacy or containment – it naturally reverberates, permeates, goes through boundaries and walls. And in so doing it calls to others, attracts, gathers, connects people together. It creates community (p. 16). Comts are concerned with social and cultural change. Proctor: Music therapy is a political act. To deny this is to side with the powerful. Psychiatric system prescribes drugs developed, produced, and marketed by a small group of multinational corporations. AND non pharm interventions (i.e. MT) are now required to demonstrate their ability to produce drug-comparable results in drug-comparable terms. Health changed from focusing on how people are within a social context in relation to other people to	Based on practice, theory, and *context*. Context defines how MT happens and how we think about it. We = collective physical, mental, and social reality of all musicing participants. Ethnography (groups in context) and action research (user focused research for social change).	21st century society is changing from monoculture to multiculture. Musical communities: a common shared world of time, space, gesture, and energy, which allows diversity AND unity. Examining unfamiliar practices, one might discover biases and assumptions, patterns of similarities, develop cultural sensitivity. Music is a social act. Human beings are cultural beings. Human beings are musical beings. Both culture and music play an important role in building and strengthening cultural self-identity. (p. 250). Multiculturalism is an integral factor in dealing with the question of identity and quality of life issues.

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					one which sees people as discrete bundles of physiological and psychological functions which can be assessed and treated in isolation. Music changed from a way of being together to a product we consume. "Through musical activity, they can recognize humanity in another person, humanity that extends beyond their culture and experience of trauma." (p. 241) MT is campaigner for music as "force of change" in a community		
Compassion-focused Relational Music Therapy (CRMT) – intervention used at bedside with agitated or delirious cancer clients in last days/hours of life. Offers support to anxious family and relieves burden on staff. Mindfulness-based approach to care, grounded in mindfulness training and in an embodied, daily practice. MT is non-pharmacological, holistic intervention to	Binnie, 2019 – UK MT Research associate at University of Bristol. Psychospiritual palliative care. Hospice-based MT.	Attachment theory, Relational psychology, Family Systems therapy; Staff referral to "do something" with hard-t0-manage situation	Buddhist philosophy of mitta (loving kindness) generated by practice of self-awareness and self-compassion "good death" – peace, letting go, love, forgiveness, safety. Dying person's spiritual, psychological, and emotional needs must be assessed and reviewed and outcomes discussed with client and family	Creative psycho-social-spiritual intervention to support pt and family at end of life; voice and guitar (DADGAD) nonverbal vocal holding for client. "Lullament" – lullaby (spacious 3-time simple melody timed to client's breathing, vocalization, and movement) and lament (expression of sadness and grief reflecting emotions of family)	Provides an important bridge between caregiving and bereavement and promotes a positive relational legacy for those left behind. May support staff with moral distress of not being able to "fix" a distressing situation, allowing creative spiritual space for *being* held by music rather than medical space for *doing*	Mixed methods feasibility study informed by interpretive phenomenological analysis. Frameworks: triangular model of suffering, distress as systemic construct reverberating through family systems in palliative care.	Blends Western psychodynamic and Eastern philosophical and practical approaches. Integrative psycho-social-spiritual complement to best medical practice in dying phase. Cultural and spiritual sensitivity to terminal delirium is important to "good death"

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support client, family caregivers, and staff							
Complexity Science – attempt to formulate a philosophy of music therapy, theory: Music as Soulmaking – providing music experiences in all areas of human functioning to foster a more complete way of being in the world. MT is a processed-based intervention combining the art of music and the interpersonal interaction of therapy verified by science; engaging people in experiencing and making music to accomplish nonmusical goals in various areas of functioning	Crowe, 2004 – director of MT at Arizona State University since 1981. Past President of NAMT. Co-author of standards for educational and clinical training from AMTA	SOULMAKING implies human development, maturation, and evolution of humanness in its complete and fullest sense p. 341 Process of bringing information (complexity) into the human system to create emergent property of health	Based on Chaos theory and systems theory. Music is a biological imperative: -Pleasure -Aesthetic response -support to basic humanity -touching the divine -communication -effects on activity level -support of human culture. Functions of the mind (cognition, consciousness) are dependent on neuronal processes for their existence but they still have an emergent independence from the brain.	Role of therapist: presence, interactions, intentions. Continuity of effort, interactions where process unfolds as ever-changing interrelationships MT must be a scientist with systematic approaches to knowledge acquisition and an artist who relies on intuition, creativity, and spirituality	MUSIC IS FUNDAMENTAL TO MENTAL, EMOTIONAL, AND SPIRITUAL GROWTH	MT traditionally is a Behavioral science. Complexity science: real world phenomena are complex systems in constant movement of unfolding process. "The effectiveness of music therapy as a treatment intervention cannot be proven in a reductionistic approach because the process involved must be considered as a whole. There is value, however, in understanding the mechanisms of a system to show the reasons why certain effects might occur." P. 50 Interdisciplinary research is required to fully study MT	Roles of music in ancient cultures: Key to knowledge of universal law, way to worship/ interact with/ placate/ engage with divine, direct healing tool and support for general well-being 1700s physicians also trained musicians and wrote about music and medicine. 1800s scientific medicine was norm; medical uses of music declined but continued as therapeutic activity for mentally ill and SPED 1900s phonograph used in operating room to decrease anxiety. Profession of MT developed more similarly to activity therapy movement than healing effects, within and part of scientific biomedical model
Culture-Centered Music Therapy – theoretical perspective of MT, not a new model. All mts integrate cultural perspectives in their thinking. Culturally specific. Awareness of MT AS culture and IN culture. Music therapy is a situated practice –	Stige, 2002 Norway – 15 years of clinical practice; NRMT; music psychotherapy	Brusica forward: Forces of thought in MT 1st – how music influences human beh and physical world 2nd – unconscious dimensions of music experiences	Reflexivity – ability to think of one's self in relation to others; identifying one's own frame of reference in relationship to another. Local vs general knowledge – recognizing that one's understanding are delimited by the contexts and cultures in	MT is interdisciplinary field. What MT's have in common is the use of music for some purpose related to health and wellbeing (p. 79).	Rights to Arts and aesthetic experience should be given to everyone. Gender, ethnicity, social class, age, or personal resources should not interfere with a person's right to participate and	Musicology impacts MT theory through study of music on human nature and study of music as culture. Ethnographic research with thick description and participatory action research. Room for both quantitative	Culture-centered: all work (theory, practice, research) takes place in specific and unique contexts. Four layers of context: Microsystem (interpersonal relationships), Mesosystem (relationships btw 2+ settings), Exosystem

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no final or universal definition will suffice. MT as professional practice is situated health-musicking in a planned process of collaboration between a client and therapist. Focus upon individuals and groups in context. What counts as therapy is dependent on time and cultural context. MT as situated practice is health-related rituals embedded in culture and enclosed in social contexts.		3rd – role of music in self-actualization 4th – role of music in spiritual development 5th – culture-centeredness Genetic evolution and cultural history developed equally in humans: Co-evolution. Both influenced each other. Humans have ability to identify with characteristics that also belong to other species, AND to develop theory of mind (empathy & understanding of others as similar to self) which enabled cultural learning through imitation, teaching, and collaboration which led to development of cultural artifacts and traditions of conduct.	which they were derived.		neither should geographic location. GIVING VOICE to experiences that have been silenced.	and qualitative research to explain effects of MT. Relationism – if and how a principle operates depends on situatuation. Data is POLYPHONIC dialogue of perspectives rather than merging empirical material	(relationship btw setting and individual), Macrosystem (subculture, culture as whole)
Dalcroze-Eurhythmics in Music Therapy – Role of movement in musical activity and understanding; usefulness of harnessing music – movement relationships in therapy.	*Approaches* 2016 Authors from various countries: UK, Germany, Spain, Denmark, Poland, Mexico, Finland, Switzerland,	Pioneer of NMT. Interrelatedness between auditory perception, somatosensory and visual experience, and movement structuring; Teaching students to trust in their	"Musical consciousness is result of physical experience" Embodiment (sensorimotor feedback, real time activities), Embedment (situated in sociocultural niche), Enactivism (relying on	Music is a relational action. Human beings construct meaning *from* bodily experiences. Ex-pressing (taking out something that presses from inside) Creating (giving it form) and communicating (sharing it with others)	Whoever you are now is fine. ALL have a right to MUED so the coming generation will be trained to a greater flexibility of spirit, a firmer will-power, an intellect less dry	NMT, NRMT, Humanistic, Improvisational. Quantitative and Qualitative.	Mostly European, developed during/after WWI and II. Rejects Cartesean Mind-body dualism. Inclusive

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One uses whole self creatively to analyze and solve problems, express thoughts or moods, and react to musical challenges. Engages sensorimotor system over time, entrained by music	Austria. Many not mts. MUED, Neuroscientists Emile Jaques-Dalcroze (1865 – 1950)	instrument (the body) and increasing mental and emotional awareness to overcome cognitive inhibitions.	the history of couplings between agent and environment), Externalism (emotional and cognitive processes lead to internal and external resources).		and exclusive, more refined instincts, a richer life, and a more complete and profound comprehension of the beautiful. Respect is crucial for development of identity.		
Developmental-integrative model (D.I.M.T.) – MT is complex multidisciplinary field: musical skills, developmental and clinical psychology, neurophysiology, medicine, anthropology. MT is profession that uses inherent therapeutic potential of basic music components (frequency, duration, intensity, timbre) AND music as complex art form. Pt-therapist relationship, music as intermediary agent, therapist role: guide pt. Through audiotry experiences to develop qualities essential for health and growth. Mental problems are treated by strengthening the link between body and mind. Physical problems are treated by strengthening link between mind and body. DIMT – free flow and balance between	Sekeles, 1996 – MT in Israel. Written in Hebrew and translated into English. DIMT formed during clinical experience in psych and neuropsych 1:1 MT, not group. 1963-1990. Written word cannot fully describe music experience. Audio, video, transcriptions, and reports.	Roots of MT in traditional rituals: trad healing rituals = ancient origins of MT. Witch Doctor, healer, herbalist, shaman. Enters altered state of consciousness during which shaman's spirit makes magic journeys. Studies dreams, trance, ecstatic flights, gods and spirits, myths and genealogies of ancestors, secret languages, and drumming, songs, and dances of ritual. Inherits role from gods – devoted to overall health of whole being by means of suggestion and fantasy. Naturalistic healing – natural forces or obvious symptoms of imbalance such as fever or chills – perceives only disease and	Major aspects: Physiological & psychological descriptions of traditional healing practices; Different goals and methods and rationale btw traditional healing and MT; Difference btw use of music in SPED and MT; Continuity music affords various activities; music is communicative, supportive link; music contributes to self-expression; holistic being requires integrated treatment approach.	Compared physiological aspects and musical aspects between ecstatic healing rituals and hypnotic healing rituals. Similarities to elements of music used to relax or stimulate pts. Improvisation and recorded music from pts culture. Wide variety of music available for pt choice. Active and receptive uses. Balance between being and doing. Development is perceived in terms of human relationships. Therapeutic triad – pt. – th. – music Therapist links through mirroring, holding, elaborating, transference, etc. Needed for pt to comprehend body messages during musical activity (fixation, distortion, pain) or psychological expression (repression, aggression, inability) and to use music to achieve efficient and satisfactory change. Flow and control, movement and arrest =	Pt. Choice is important. Th. Training is important. Ethics is important. Professional study of music, Understanding of therapy, Development of self-awareness, Field of MT. Continuing education for specialization. Therapist accepts and contains all aspects of pts' musical expression exactly as they come and avoid any "artistic" criticism. Musical expressions serve as link to repressed emotions (even accidental music)	Stages of development: Erikson, Piaget, Freud, Klein, Winnicott. Psychodynamic, Neurological, Biomedical, and NRMT explanations for how MT works. Psychoacoustics. Balanced combination of elements can induce psychophsiological equilibrium with flexibility of movement and balance btw tension/relaxation, expressed in changes of rhythm, melody, harmony, etc. Appears to rely on psychodynamic theory and chaos theory. Basic questions that remain unsolved: How to determine the exact effect of a complex musical composition on pt. (much research available on elements of music on	Cultural consideration and CIQ are very important. Hypnotic healing rituals – unity of the world and duality of forces active within it. Healing = balance and harmony – order, health, perfection. Imbalance caused by actions which go against taboos which clearly define the difference btw good and evil. Ecstatic healing rituals – disease, disaster originate in supernatural world. Punishment for transgression of social norms or family unity. Penalty is interference with smooth progress of natural existence. Spirit must be identified, contacted, and negotiated with. Studied cultures like Navaho, Vezo tribe,etc. The more complex the music, the greater

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dynamics of voice and body movement. Makes deliberate use of elements of music to create mood, excitation, relaxation, altered state, etc. Requires profound understanding of pt and needs.		symptoms and treats as best it can. Personalistic healing – deliberate intervention of various agents: Human, extra human, and superhuman.		basics of art of music AND human development Balance between verbal processing and musical processing		pt. But difficult to determine effect of music). Improv is preferred over recordings despite improv never matching level of musical sophistication of recordings. How can anyone express self in music without any knowledge of music (because humans ARE music). Musical development begins in the womb. MT has aspects that can be measured scientifically, and others that are proved in practice, but not scientifically (yet).	the need for wider information about pt in order to understand possible influences it may have. Cultural and personal background of pt is key for selection of appropriate music.
Dialogical Perspective – MT is about the benefits that may come from applying music therapeutically, rather than specifically directed towards a problem. Thesis: A dialogical perspective may provide theoretical grounding for music-centered MT. Music *as* therapy: intentional use of music in healing, not spontaneous healing that may occur when engaging with music in everyday life. Similar to how one can learn without a classroom/educational institution. But	Garred, 2006 – Norway, NRMT, BMGIM	Musicking is essential human activity. Lack of opportunity to music is reason for coming to therapy. Assumption: musical improvisation and listening can reflect and activate relational patterns and senses of self, supported by similarity of pre-verbal interaction. 3 sides (music-client- therapist) interrelated across 2 spheres (interpersonal, music) NOT iso-principle, where music	Buber I-Thou (talking to) and I-It (talking about) relations. Both are necessary. Used dialogical principle as metaphor for relational processes. MT triad – music-therapist-client. Music is a spiritual form as a product of human culture. How music affects us is not predetermined. Recognizes concordance between psychoanalytic and humanistic-existential psychology. 3 phases of "now" moment: pregnancy phase (expectation/anticipation), weird phase (nebulous and uncertain), decision	Encounter is about attitudinal mode with which music is met. Relating to music in its immediate presence. New encounters with music may bring up something new. So music will never become a completely defined object (It). Creative act = choosing from endless options in a process of discovery-forming (Thou) process that results in a work (It).	Recording are not same as unique performance because not same element of risk and surprise or of direct personal communication. May be aspects of MT based on Means-end logic, but restricting role of music in MT to means is too narrow. Using music in only a technical way may lead to/entail treating people as things, too. Dehumanizing. Ethical basis: compassion and care using music	Science paradigm: Music is sound waves (longitudinal pressure waves in air) – physical object, described in terms of cause-effect. But it must be *heard*. Dialogic paradigm: Music is encounter described in terms of processes of mutuality and reciprocity. The way music works must be found in dynamics of interrelations, rather than 1:1 mechanical effects. Place to look for effect of music is as a medium for therapy (not art). Music has a side of nature to it (natural sciences, p. 197)	Relationship between client and therapist is mediated by music – reciprocity through music, facilitates communication through music, mutual address and response through music. Therapist mediates client's relation to music and how music serves therapeutic process of client. Client mediates therapist's relation to music – client's needs are primary focus in therapist's relation to music. Music *is* culture, but not *all* culture (p. 196)

Approach, model, or theory	Source	Historical context	Philosophical context	Creativity influences	Human rights influences	Scientific method	Cultural context
institution is intentional facilitation of learning within socially instituted educational setting.		matches client. But Conversational principle where client and music are related. Resource-oriented MT. Community MT. Interrelation between work and play. Potentials (instead of outcomes).	phase (moment of meeting) THEORY OF MUSIC *AS* THERAPY: humanistic philosophy, dialogue (I-It and I-Thou), Developmental psychology, perspective of relation to music in MT, dynamic interrelation between spheres of interpersonal and music, Anthropological theory. Main thesis: In music AS therapy, there is a 2-sided, dynamically intensified implicit relational change process that may bring about change in the sense of self for the client. Phenomenologically oriented to aesthetics of music.		to help people to heal, grow, develop, change.	Music made is not predetermined, but also not arbitrary. Address and response, not stimulus and response. Therapist is not "all knowing" expert, but creating music conversationally in relation to client. Playing clinically means that you relate the music made to the client instead of to yourself. Needs multiple approaches to research: quantitative, qualitative, historical, theoretical, arts-based. Effect of music AS therapy depends on how it is used/applied.	
Feminist Perspectives – Looks at 1st person accounts to gain imaginative access to others' experience. Embodied, flesh and blood, sociocultural, political, philosophical movement predominantly created by and for women's liberation/emancipation for various forms of male hegemony (p. 7) Central goal: to unmask forms of male hegemony at various sites that parade as neutral and/or objective when in fact they hide profound levels of male interest, male norms, and male	Hadley, 2006 (Ed) Multiple female authors from Belgium, Canada, UK, Norway, US, Australia, et al.	Typically thought of as 3 waves (but this ignores work of women before and leading up to 1st wave): 1st wave – women's suffrage, with roots in abolition movement. Vote as means to other rights (divorce, abortion, equal pay, etc) 2nd wave – grew out of emancipation movements, including Civil Rights movement in US. 3rd wave – 1990s – need to develop	There is no self if not in relation with others. Know yourself, honor the gifts the creator has bestowed upon you, stay in balance, show respect, stand tall. Focus on self-reflection and self-examination. Respect for diversity. A call for activism	Community MT, AMT, BMGIM, Improvisational, Medical, Psychodynamic, Cognitive therapy, LISTEN, SAFETY, EMPOWERMENT, ADVOCACY, UNIQUE VOICES, POWER, DIVERSITY and MULTIPLICITY, RELATIONSHIPS, REPRESENTATION Rediscovering musical and creative impulses. Helping clients trust their own experiences and intuition. Enabling clients to appreciate female-related values. Assisting client in taking care of	In what ways are mts perpetuating oppression of clients? Prominent concerns: inadequate salary, lack of advancement opportunities, leisure time, time or money for continuing Ed, prestige, and professional recognition. Goals: give voice to pain, distrust, anxiety, and to power and determination to live and have different lives.	Some argue that only qualitative research is appropriate, but there are examples of Feminist MT quantitative research. Consensus seems to support both types, depending on the question being researched. Demystification, power analysis, gender-role analysis, egalitarian relationship Feminism is a perspective rather than a method of research. Uses methods that serve the inquiry rather than drive the inquiry	Must be competently trained in basic sociology theories and sociological theories of gender. Intersections of race, class, gender. Chapters from Western countries, Eastern countries, Aboriginal perspectives, Colonization perspectives

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value-laden assumptions. (p. 8) Finding, rediscovering, and strengthening human characteristics such as ability to feel, express, share, support, care, nurture, hold, contain, intuit, understand with, without, and between words.		feminist theory and politics that honor contradictory experiences and deconstruct categorized thinking.		themselves. Helping women accept and like their own bodies. Helping women define and act in accordance with their own sexual needs. Creative place of wisdom within humans (aka music child, inner child, transcendent self, authentic self)	Women guard morality of the people. Non-hierarchical. Duty to remove barriers that limit clients personal, social, political, economic, creative, sexual, spiritual potential.		
Free Improvisation Therapy – music used as means of development through which identity could be integrated. Controlled use of music in therapy, rehabilitation, education, and training of children and adults suffering from physical, mental, or emotional disorder. Based on exhaustive use of everything music is made of	Alvin, 1978/Alvin & Warwick 1991 – Cellist, Britain, Founder of British Society for MT Died 1982 age 85	Music as emotional, social, and mental force of integration, decreased anxiety and frustration.	Psychoanalytic – ego strength, projection onto instruments, sometimes behavioral	3 stages – freedom as long as not destructive. Therapist provides musical, safe, and predictable experience, sensory integration, musical development. Musical and social sense of behavior.	Develop relationship based on mutual trust and respect without creating feeling of dependence. Music and sound are creative and liberating force Autistics can use and control themselves. Therapist creates safety through carefully arranged room that is same every time.	Primarily case descriptions	Music Centered. Respect and trust. Based on needs of client. Free to make any sounds or movements (as long as not hurting self/others/instrument s) Instrumental more than vocal
Guided Imagery and Music (GIM/BMGIM) – conscious use of imagery which has been evoked by relaxation and music to effect self-understanding and personal growth processes. Treatment or healing is broad term that denotes inner balance of the elements (mind/body/spirit) which make up a person. Holistic – considers all areas of	Bonny/Summer (ed), 2002 – MT pioneer, collection of seminal works by Bonny. Maryland Psychiatric Research Center. Violinist, mother. Trained (MT equivalency) with Gaston after a transcendental experience	BMGIM was created during psychedelic drug trials (LSD). Precedents in both art and science. GIM has 2 core beliefs: that music more than words is able to create transformation. That Behavioral MT ignores aesthetic dimension of music.	Influenced by Maslow, Music Psychotherapy, humanistic, transpersonal. Goal: psychological and spiritual transformation; Jung. Maslow's self-actualization and Roger's client-centered therapies. Ego receptivity (allowing) is foundational to the philosophy behind holistic processes.	Goal: Peak Experiences – a sense of unity or oneness, transcendence of time and space, deeply felt positive mood, sense of awesomeness, reverence and wonder, meaningfulness of psychological or philosophical insight, ineffability. Added Mandala drawing Metaphorical thinking is foundational to learning Music evokes 6 responses that	MT that ignores the aesthetic beauty and value of music ignores the aesthetic beauty and value of the client. P. Xvi Belief: Humans are capable of exploring depths and heights of our potentialities, and psychological aberrations are a growth potential, rather than an illness.	Gaston: "But the work must be scientifically correct or we will be laughed out of the house!" P. 8 LSD studies: Music used as safest accompaniment to high dose drug use with 8-10 hours "trip". Classical music found to be safest and most effective guide. Attempted to find same experience without drugs. Music listened to in Altered	Personal preferences played little role in effectiveness of music. Music programs built using mood and elements of music. Based on Western ideas and music and culture.

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person to hold importance for exploration and growth. Rational-analytic mind is equally important as intuitive-metaphoric mind (not more important). 3 years of training post therapy training (MT or psychotherapy) MT- systematic application of music as directed by MT to bring about change in emotional and physical health of person. Functional rather than aesthetic and entertainment aspects are emphasized. GIM – form of music-assisted psychotherapy BMGIM- a music-centered transformational therapy which uses specifically programmed classical music to stimulate and sustain a dynamic unfolding of inner experiences in support of physical psychological and spiritual wholeness.	playing violin during a prayer service. Conflict with Gaston who said never speak of mysticism. Bachelor and Master at KU – Beh. MT. Taught at Catholic University in DC. 1966-1968 Central Office Coordinator for NAMT 1979-1987 – cardiac illness. 1987 began medical applications of GIM. 1989 GIM Fellow began 1994 wrote Music and Your Mind. 1991 Lifetime achievement award from NAMT		Healing comes from the within the person. Purpose of therapist is to facilitate this healing. Purpose of GIM is to “mine the depths in order to bring reintegration, insight, and wholeness” p. 96 Catharsis, Insight, and Action/integration of new learning.	contributes to its effectiveness: provides structure for exploring difficult conflict areas but does not limit flow; Nonverbal means of establishing rapport; easy access through spontaneous regression; Mood changer; Fosters positive, expansive religious experiences; Past, present, and future may be experienced concurrently		States of Consciousness elicited imagery of visual, kinesthetic, and sensory nature. LSD research (1972) contradicted simultaneous LSD research by Eagle and Gaston (1970) Non-drug replication of LSD studies: specially designed classical music programs with imagery induction. Trip is self-directed but guided with permissive or supportive attitude and active empathy of therapist. Describes music’s effects on Brain Functioning to explain GIM; quantum physics: as we interact with environment, we change environment. Self-organizing universe (complexity science)	
Humanities oriented – social sciences, philosophy, education, and systematic musicology. MT is more than a toolkit of intervention techniques; appreciates resource-oriented and	Ruud, 2010 – Norway, CMT (NRMT) & BMGIM; Psychologist	Basic needs (p. 22) – human motivations – humans seek contact and create meaning. Pulse, quality, and narrative – essential for communication	MT based on values from humanities emphasizes how we are users and interpreters of signs and symbols. Narratives give access to realities, feelings, and life world of others. Music as narrative, sign, symbol determines how	Music is important tool for infant-adult bonding; sense of self in relationship; provides opportunities for skill building and joy/pride; differentiate self and include in groups; authenticity and values, moods and memories;	Humanistic perspective = caring for individual and respect for human dignity. Musical identities are respected as signs of human dignity. Empathy-how	“An integrated field of music therapy would perhaps one day be able to synthesize perspectives both from the natural sciences, the social sciences, and the humanities” p. Ix	Clients come to MT because of biomedical, historical, biographical, and relational aspects of illness and health. Contextual understanding, music, person, situation are

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community MT approaches. MT – a discipline involved in relationship between humans and sound within a health perspective. MT – use of music to give new possibilities of action. Requires knowledge of human body and physiological function, understanding of culture and communication, understanding of social structures and forces that create disability.			meaning is produced, interpreted and gives rise to action.	sense of belonging and way to connect with larger world. Musicking is a powerful tool to generate well-being and optimism, to foster resiliency through agency, to work through positive emotions, and experience flow in order to equip clients with strategies for living a good life (p. 87) Positive emotions expand thought-action repertoire.	individual experiences illness as cultural and historical being with an idiosyncratic psychology and communication and autonomy. Not just scientific manipulation of illness. Close connection between humanistic values and concern for individual. We only become human beings through other individuals. Recognition, self-identity, and dignity are fundamental to therapy.	Based on attitudes, principles and approaches from both humanities and natural science. Reflexivity, Empirical Documentation, Interpretation, Criticism. Postmodern – aware of how language constructs reality.	in mutual relation – changes to any of these alters the meaning. Because of culture/exposure to certain types of music, certain musical structures performed a certain way will AFFORD a certain meaning. Because of contextual understanding, MT cannot provide music that will affect all people in same way in a certain situation.
Music-Centered Music Therapy – attitude toward MT and music possessed in relative degrees among clinicians and theorists from variety of orientations, clinical models, and milieus. Can be *identity* of MT or *aspect* of MT practice. Includes AMT, NRMT-CMT, BMGIM, aemt, comt, Culture-centered MT, specifically.	Aigen, 2005 – NRMT, BMGIM, NYU student and faculty for entirety of career. AAMT president instrumental in unification.	Joy of listening to, composing, creating music is at heart of all processes in MT. Music Therapy originates from 2 spheres of human activity: the arts & healthcare. Use of music is universal to every application and model of practice in MT.	Schema theory and Zuckerkandl's Dynamic Theory of Tone. MT is more a specialized application of music than a specialized means of conducting therapy. Theory and practice rest primarily on musical foundations. Musical experience is primary clinical focus.	Musicking is goal and outcome. Client's experience in music is primary. Musical goals = clinical goals. Primary focus is enhancing client's involvement in music. Personal process is reflected in musical development. Intrinsic rewards of musicking: creativity, expression, aesthetics, community, transpersonal	Affirms basic humanity of the individuals that mts work with. Emphasizes common bonds of all humans.	Do theories have to provide prediction and explanation in order to be scientific? Experience of musical process is therapy; interventions are guided by musical properties; music is autonomous clinical force; therapy can incorporate a focus on performance and products; musical analysis highlights clinical processes; therapeutic relationship is a musical relationship; embraces holism	Folk MT – all ways humans use music to promote health and wellbeing. MT as discipline – branch of learning identified by field of study, tradition of inquiry, and disciplined discourse MT as profession – vocation requiring training in identified body of knowledge MT as practice – interactive process of making music in service of health and wellbeing

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Neurologic Music Therapy (NMT) – therapeutic application of music to cognitive, sensory, and motor dysfunctions due to neurological disease of the human nervous system. Based on neuroscience model of music perception and influence of music on functional changes in brain and behavior functions. Evidence-based treatment techniques. Tmes adapted to client needs. Education=NMT, music, neuro anatomy and physiology, brain pathology, medical terminology, rehabilitation of cognition, motor, speech and language functions.	Thaut, 2008 – German, professor of music and neuroscience at CSU. Fullbright scholar, Advisory board of World federation of neurologic rehab, VP of ISMM	Music is a biologically deeply ingrained function of the human brain. Brain has neural circuitry dedicated to music. Common neurological basis of rhythm formation in human brain is neural modularity that allows human brain to build develop, juxtapose different subcomponents of rhythm into complex rhythmic grammars of different cultures. Biomedical implication of music's influence on brain and behavior functions.	Aesthetics and psychobiology (Berlyne 1971) – how art perception influences physiological (arousal) and associated behavior state (activation)	Affective-aesthetic response to art (value and worth). Brain NEEDS to engage in art in order to build, sharpen, maintain, and create order in its perceptual machinery as an essential aspect of brain function. The brain that engages in music is changed by this engagement.	Biology of human perception and cognition is fundamental element of all human behavior: Individual, societal, and cultural.	Research in music must be linked to complex understanding of music and aesthetic theory; Rhythm is OK to reduce to meet needs of science and anti-reductionist artists. Complexity science concepts (fractal analysis, stochastic noise, nonlinear). Time constraints (via rhythm) on duration of movement is key to optimize therapy. Neuroscientific research shows effective use of music with therapeutic outcomes that are stronger and more specific than general well-being. RSMM & TDM	Rhythm is structured differently in various cultures. Time receives structure in music – rhythm is primary element that creates perception of time. Roles for music have changed, functions have not: Roles-education, religion, work, social rituals, political rituals; Functions-evoke emotional response, entertain, transmit social knowledge & norms, trigger physical response
Nordoff-Robbins Music Therapy-Creative Music Therapy (NRMT-CMT) – improvised musicing to awaken the Music Child – source of energy and motivation that supports all development and therapeutic processes in music therapy. Clinical musicianship. Music – conveyor of meaning in time, mediates historic, emergent, dynamics of our past and continuing evolution	Robbins, 2005 – work spanned 60 years, MT pioneer, UK, US, Denmark, Finland, Norway, Sweden, Holland, Germany, Switzerland, Italy, Canada, France, Australia, New Zealand, Israel, South Africa, Lithuania, Russia, Estonia, Japan, Taiwan,	Anthroposophy – Rudolph Steiner, Sunfield Children's Homes cared for profoundly disabled children. Met Paul in 1958 – American music professor, composer, pianist. Made music with children improvised around themes. Robbins worked on game of Pif-Paf-Poultrie. Nordoff improvised music for it. Beginning	Maslow's self-actualization, humanistic. Activation of the Music Child – unique significance of awakening the musicality inborn in a multiply disabled child. Engaging the individual communicatively and interactively in a widening process of musically supported self-discovery, self-expression, and self-actualization. Characterizing concept emphasizing the relationship uniting child's expanding sense	Identified patterns in ways children responded to music through listening to recordings of sessions and transcribing music.	Improvised musicing offers possibilities of bringing children into interrelating activities. Music Child is given and universal function of intelligence, purposefulness, human companionship, and fulfillment which offers possibilities of growth.	Recordings of sessions analyzed and music transcribed. Videos and pictures show that it works. How it works is a mystery. Qualitative research	Music improvisation to connect with clients regardless of language. Developed mt internationally.

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	Korea, Columbia, Brazil, Uruguay, Argentina, China, Poland	of their collaboration.	of self within capaicities for one or more interactive forms of musicing and into the knowing-meeting with the therapist.				
Orff Music Therapy – Developmental Approach to MT within framework of social pediatrics. MT based on developmental psychology – MT method that focuses on emotional and developmental needs of a child and contributes to new experiences of emotions.	Voigt, 2013, plus other articles from the Special Issue 5 of Approaches. Founded by Gertrude Orff (1914 – 2000), married to Carl Orff 1939 – 1953. Began developing Orff MT in 1970 for children with developmental delays. Munich Germany	Developmental psychology: Piaget – social-cognitive development: Infant's discovery that there is a connection between our own behavior and reactions of others as a primary form of learning. Stern – Dev. Of senses of self: Emergent self formed through interhuman contact. Core self develops self-agency, self-coherence, self-history, self affectivity. Intersujectivity – differentiation of self and other. Brazelton – Beh. Organization – modes of behavior reveal emotional state; allows adults to respond with support. Formation of Interpersonal Relationships – interacting with parents develops capacity to trust others and connect.	4 elements: *musiké* – total presentation in word, sound, and movement Elemental music – unity of music, movement, dance, and speech, active participation in music-making Instrumentarium – made 3 types of communication possible: with instrument, with therapist, with another child Multisensory aspects of music – auditory, visual, tactile, kinesthetic within social context; Strength-based, Resource-oriented, child-centered. Relationship is central factor. ISO and provocation – meeting child where they are and stimulating with new ideas and impulses in therapy to support developmental potential. Strong emphasis on developmental processes. Emphasis on PLAY, includes family	Multi-sensory – starting just where an important sense organ is weak or damaged. In spontaneous creative activity the child should express self freely, give form to expressions, and use it in social relationships. Everyone has creative skills.	The multisensorial approach through speech, free and bound rhythm, movement, singing, and playing instruments provides possibilities for spontaneous creative play in a social context, even if one important sensorial area is damaged. Every member of an integrative music movement group is participating actively in a creative process. Instrumentarium allows participants to play together in a spontaneous way. Relationships developed through musical expression and play as an encounter between 2 people forms the basis for emotional development. Musical reception and expression is independent of intellectual capacity, age, and previous musical	Qualitative research via video microanalysis. Even if interaction in music therapy can be observed, the therapeutic effect of MT always takes place invisibly. Lies in specific acoustic-musical climate that is animating and stimulating, calming and soothing, intensifying and moderating. Climate is formed through movement, rhythm, and sound	Orff-Schulwerk – a way to engage the child in the imaginative processes that derive from the natural self-expression of the child. Concerns the way in which music, speech, and movement are linked through engagement with language and textual connection to nursery rhyme and folk song. Through improvisation and elemental music experiences children can create rhythmic and movement patterns that emerge from natural development. "I hear myself," "I hear you," "I hear us"

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		Emotional development – social frame and parental beh regulates infant's emotions. Musical development – interactions btw mother and child			experience. Basic human needs: feeling loved, being embraced, nourishing one's self-respect, having space for self expression and self realization		
Psychiatric Music Therapy – MT brings about behavioral change to induce emotional and social growth through functional applications of music. MT via instruction in wide range of instruments, voice, and theoretical subjects. Agency for advancement of social rehabilitation.	Tyson, 1981 – pioneer in community music therapy and application of psychodynamic principles to MT. RMT since 1958. Founder and Director of CARC in 1963 in New York City. 1952-1962 Director of mental health division of Musicians Emergency Fund. Active in NAMT – MAR. Adjunct faculty at NYU	Music is audible expression of internal reactions to sensory, motor, and psychological stimuli. Music is symbolic language through its *form* not its *content*. Has similar forms of human feelings.	Psychodynamic, psychoanalytic, object relations. Fruedian psychoanalytic theory. Milieu therapy. Erikson – play is ego's tool for self expression and mastery	Primary goal: reactivate feelings through musical stimulation and encourage expression. Helps client perceive, experience, and integrate inner reality.	Music therapists functions to reinforce positive response to increase interest in music. Interest is used as motivation for new learning and relationships and reintegrate into society. Achieve diagnostic, supportive, and rehab goals.	Case studies	Uses Developmental MT, NRMT, GIM, Orff MT, Behavioral MT, Kodaly MT, Psychodynamic MT, and Psychiatric Musicology. Therapeutic relationship is key to change. Supervision is essential. Encouragement of individual musical capacity and interest as source of health needed to support relationships and ego strengthening
Psychodynamic – Explores depths of human psyche using musical tools. Advanced level of practice; Framework within which to analyze and interpret behavior. Provides conceptual tools used to enhance understanding of clients and their experiences. Theory-	Hadley, 2003 – Bachelor's in Australia, Masters and phd with Bruscia at Temple. Faculty at Slippery Rock U in Pennsylvania; Client in AMT, NRMT, and BMGIM Metzner, 2016	Psychodynamic therapy – outgrowth of trad. Psychoanalysis. Approach to diagnosis and treatment characterized by a way of thinking about both client and clinician that includes unconscious conflict, deficits and distortion of intrapsychic	Includes drive theory, ego psychology, object relations theory, self psychology, Jungian theory. Human behavior is determined by psyche. Humans interact and relate to world with varying layers of consciousness. Humans develop unique patterns for relating to world based on interactions/relationships experienced in past	Techniques evolved from free association and the couch to include various domains of observation and varied techniques of intervention, including play and creative arts.	Id, Ego, Superego; self-esteem; individuation; defenses, transference, countertransference	Qualitative, Case Studies	Archetypes, collective unconscious. Both client and therapist bring their own unique patterns of relating to world to therapeutic relationship

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informed rather than theory-led		structures, and internal object relations.	with family of origin. Humans use these patterns repeatedly by replicating them in present relationships or generalizing				
Quantum Therapy – principles of quantum physics correlated to therapeutic action.	Eagle, 1991 – Student of Gaston. Professor of MT at SMU	The equations of quantum mechanics have higher isomorphism with the observed universe than anything else in science. Principles of quantum physics are bases for conceptual shifts in disciplines of physiology and psychology.	Systems theory. People come to therapy because they need reconciliation with their universe and in which they can more meaningfully participate. Therapist has a worldview (all-encompassing operational theory) through which therapist perceives information, makes connections, organizes connections into patterns, and makes clinical decisions	Interpretation of assessment (reconciling needs of client and nature of presenting problem) relies on theoretical orientation – enables therapist to distinguish between content (various pieces of info) and process (how pieces are related)	When perceiving music, client is perceiving universal order. Task of music therapist: to bring order to chaotic life of client. Purpose of Music therapist: guiding clients to a balanced and harmonized state of meaningful awareness. No matter how objective you are, you are never entirely separate from the client you observe.	4 basic principles of quantum universe: Bohr's complementarity, Heisenberg's uncertainty, Einstein's special relativity, Bohm's holonomy. Music therapy MUST assume a greater role in interfacing science, especially quantum science, and music.	Ultimate knowing is in the immediate sensing and intuitive feeling of the nonverbal whole of the clinical universe. Music IS the implicate, enfolded order of the universe, from which all processes and/or products can become explicate.
Resource-Oriented Music Therapy - salutogenic focus, development of emotional resonance and expression of awareness and social interaction. Music as medium for expression, communication, and expression.	Schwabe, 2005 – East Germany neurologic-psychologic hospital 1960-1980. 1981-1992 Lecturer on educational psychology. 1992 founded Academy of Applied Music Therapy	Activating self-healing forces in client rather than treating pathological aspects of personality 3 characteristics: Releasing self-healing forces; Establishing direct constructive, active contact with structured objects of surrounding reality; Therapeutic approach determines focus on early disorders	Resource activation = build on existing abilities; to release blocked abilities - Differentiation of emotional competencies - Development of broadened and differentiated awareness potentials - Development of competencies for social interaction	Music is both a stimulus for initiating intra-psychic processes AND object, reality, structured time.	Clients with severely impaired psychological experiences also possess a wide repertoire of "normal," "healthy," and constructive interaction behavior Resources: Sum of all aspects of psychic processes; whole life context of a person: motivational readiness, taste, attitude, knowledge, education,	Music as object – created and time dependent structure flowing within time (composition, songs, improvisations). Music is action (improvisation, performance, listening)	Developed in East Germany, influenced by unification in 1990s; closely connected to consequences of political changes in Germany: Collapse of psychotherapy and music therapy structures in East Germany – had to adapt rapidly to West Germany standards; Became necessary to develop music therapy concepts – more exact differentiation of resource-oriented MT; Fitness culture –

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		or early potentials of client			abilities, habits, interaction styles, and physical characteristic (Appearance, strength, perseverance, financial situation, social relations) – Opportunity space in which person can use positive potential to satisfy basic needs		integrated by seduction, advertisement, and raising needs (vs surveillance, indoctrination, and normative rules)
Social Capital Theory – Sense of community, shared values, and trust. MT generates social capital through repairing communicative musicality. MT=music therapist engaging client in some form of musicing to improve quality of life	Proctor, 2011 – UK NRMT	People making music together contributes to generation of social capital – loose social networks with opportunity to experience trust and reciprocity	MT offers environment in which social capital can be observed to be developing: musical norms afford a framework in which to interact, to perceive the interaction and to add this to one's accrued experiences of interactions characterized by trust, reciprocation and enjoyment; Music gets us into a groove and helps us stay in them longer – good feeling about being with others	Performance – excitement, concentration, and intensity of attunement – networks and norms facilitating the risk taking and leading to increased trust	Social capital is generated by entering cycle of risk and receiving if we have the capacity to do so and are not inhibited by previous experience of risk being unreciprocated and dangerous	Ethnographic to support/explain/enhan ce rcts	Music supports social capital generation: norms are culturally constructed; structure acts as a physical framework for participation and fresh starts; we are hard-wired for musical participation – communicative musicality equips us with use of musical elements as primary means of social interaction. Musical capital – proto-social, operates through repair of communicative musicality.
Sociology of MT- Immunogen that protects us from a sense of alienation under cultural condition of modernity. Sociology is the study of social life, social change, and the social causes and consequences of human behavior.	Ruud, 2020 – Norway, Emeritus status, reflections on music therapy	Challenges resulting from globalization and technology, climate crisis, war and conflicts, an increasing divide between rich and poor, inhuman treatment of people dislocated from their land and homes bringing	Influenced by Deleuze and Guattari concepts of mulitplicity, rhizomatic thinking, field of MT is an assemblage (collection or constellation).	4 major musically induced antigens: vitality (emotion regulation), agency, connectivity, meaning-making – multiplicities that relate to each other and to identity, self-efficacy, and empowerment; emotions and meanings; network and belonging;	Posthumanism, health is how and where you live, what you eat, and how you make a living. Feeling well physically, being mentally at peace, living in a family setting where there is respect, affection, and equality	Rhizomatic research – recognizing how things are connected, create new offshoots, establish new territories, invent lines of flight, deterritorialize, find new connections and create new networks and territories. Interconnectivity of	Deleuze – differing and becoming are basic characteristics of life

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		forth a critical response to our very conception of What It Means To Be Human; Critical posthumanism		spirituality and transcendence	among all, respecting nature and living in a society in which justice and equality coexist. Disability is socially and culturally constructed	ideas, artifacts, and mundane events	
The Field of Play – ecological or environmental model; organic, process-oriented energy system; beauty and wholeness conforming to ancient healing concepts; attempt to describe the music therapy experience in ways that other professionals could understand. MT is process-oriented art and science; process and form which combines the healing aspects of music with issues of human need to move toward health and development of individual and society at large.	Kenny, 1989 – Influenced by Bonny, Nordoff and Robbins. MT educator in Quebec. First nations	Within structure of musical experiences relationships develop – to music, btw ct and therapist, between sound, thought, feeling, etc 4 essential elements of MT: conditions, fields/environments, relationships, organization/self-organization.	Ritual form to embody myths of human growth and change.	Loving and creating. Creative process of human growth and change within field of loving and creating sound	Primary Fields: aesthetic, musical space, field of play Secondary fields: ritual, state of consciousness, power, creative process. Movement towards wholeness	Phenomenology and heuristic inquiry.	Systems thinking – scheme or structure. Interdependence among elements (field theory). Magnifies unifying principles of MT discipline
Therapeutic Music Training (TMT) – MT model where learning to play piano is used to address cognitive impairments.	Jones, 2020 – phd in Neuroscience and music, Canada, NMT Fellow, Con Brio Music Therapy, Piano	Cognitive impairment after brain injury impacts rehab. Music training improves phonological awareness, speech processing, listening skills, perceiving speech in noise, reading, attention, and executive function.	Remedial approach to Cog rehab. – goal: to drive, strengthen, and improve underlying neural processes involved in target cog areas (in contrast to compensatory approach where goal is to provide strategies and accommodations to deal with cog impairment). Distinct from modified MUED because goal is	Tasks that place demands on prefrontal cortex – target selection, specific behavioral response, monitoring of errors. Attention, memory, and executive function are functionally interconnected. Attention is foundational to memory and executive function. Improvements in attention leads to	Cognitive impairment after brain injury impacts rehab, so it is a primary goal.	Attempting to close the gap between experimental research and clinical application. Case Study as pilot, recommending RCT.	Neuroplastic response of PFC is stimulated through repeated experience.

Approach, model, or theory	Source	Historical context	Philosophical context	Creativity influences	Human rights influences	Scientific method	Cultural context
			remediation of cog processes rather than music performance. Distinct from NMT because uses music training as intervention for rehab	improvement in other cognitive processes.			
Transpersonal - TPMT –surpassing the existential issues of life generated by the ego and encompassing all areas of human experience not usually addressed in psychological therapy through music. (states of consciousness, behaviors associated with extreme health and wellbeing)	Crowe, 2017 – USA, NRMT, BMGIM, Professor at Arizona State University	Emerged from humanistic psychology, psychotherapy methods, Eastern meditative experiences. Begun by Bonny. Ultimate purpose is to achieve an integrated state of consciousness where there is a balance of rational awareness and intuitive, imaginal functioning. Based on ancient and modern spiritual practices and psychology methods that strives for transformation and spiritual growth, not just adjustment. Founded by C Jung-human development becomes fully intelligible only when seen in light of spiritual symbols based on archetypes rooted in human unconscious that guides us to self-realization.	Spiritual experiences involve a personal, direct knowledge of the sacred in order to bring us to our true self and our relationship to greater whole. Acknowledges forms of experience beyond the ordinary, rational ego identity and consciousness. Understanding the psyche from a unified perspective with inclusionary attitudes of love, acceptance, and joy. Maslow – peak experiences	Transpersonal context – intention and mental orientation of the therapist. Transpersonal content – 3 levels: biographical/pathological; perinatal/existential questioning/reactive states; transpersonal growth into meaning. Imaginal realm. Transpersonal process – music as a disrupting force and a re-patterning force – improvisation, imagery, relaxation, expression, iso-principle, ritual, spiritual.	Acknowledges and promotes human wellness and adjustment beyond personal ego and life dramas and "normal" Requires advanced training in Ethics	Qualitative or complexity science methods	Necessary to have an open approach – open to needs of client, open to change, open to adapting a session according to state of health of client. Level I – Recognition and self-realization Level II – personal growth Level III – Spiritual growth

Approach, model, or theory	Source	Historical context	Philosophical context	Creativity influences	Human rights influences	Scientific method	Cultural context
Vocal Psychotherapy – use of vocal improvisation for integration	Austin, 2016 – private practice, USA	Based on premise that voice is primary instrument in MT. Bodies become instruments. We make the music, are immersed in music, are the music. Transpersonal	Vibrations of singing can break up energy blockages, releasing feelings and allowing natural flow of vitality.	Voices resonate inward to connect with body and outward to express emotions. Healing occurs when we connect with true voice.	Breath is core of singing and life. Reciprocity between physiological and psychological effects of breathing.	When we breathe deeply to sustain tones, decreases heart rate and calms nervous system. Qualitative – narrative and arts based methods	Vocal connection between mothers and infants. Songs chosen in presence of therapist can reveal inner thoughts and feelings.
Humanism – Existentially informed humanity centered understanding of music therapy.	MTP 2018, Abrams – guest editor. Hadley and Thomas – critical theory. Andsdell and Stige – posthumanism	Core principles: uniqueness of human and disciplines that are uniquely human (humanities), significance of individual identity, principles of logic and reason and scientific realism, pursuit and development of human virtue and benevolence	Roots in Buddhism, Taoism, Confucianism, Zoroastrianism, pre-Socratic Ionian philosophies of Greece.	Human meaning and value – being, self-hood, hope, self-esteem, love, creativity, individuality, authenticity. Arts centered and person centered roots: Alvin, Priestley, NRMT, BMGIM. Musica Humana – way of understanding humanity, persons, and human wellbeing musically.	5 human centered tenets: selfhood, agency, relationality, ethicality, aestheticality Critical humanism in MT: Critical race humanism, feminist humanism, queer humanism, critical disability humanism.	Participatory action research	Posthumanism challenges individualism, internalism, and exclusivism. Extended humanism: social musical process; performative feature. Take interest in strengths of individual but also social awareness

Table B2

Number of Common Words in Table B1

Approach, theory, or model	Primary Source	Improvisational	NRMT-CMT	Music Centered	Spiritual	Psyche	Psychoanalysis	Movement	Behavior	Community	Brain	Culture	Musicing	Complex	Totals
Aesthetic Music Therapy	Lee, 2003	X	X	X	X	X							X	X	**7**
Analogy-based Music Therapy	Smeijsters, 2005	X			X	X	X		X				X		**6**
Analytical Music Therapy	Priestley, 1994 & Eschen (ed), 2002	X		X	X	X	X	X	X		X		X		**9**
Anthroposophical Music Therapy	Intveen & Edwards, 2012		X	X	X			X			X				**5**
Behavioral Music Therapy	Madsen et al., 1968	X						X	X		X			X	**5**
Benenzon Music Therapy	Benenzon, 1981					X	X	X		X	X			X	**6**
Biomedical Music Therapy	Taylor, 2010	X							X		X	X	X		**5**
Community Music Therapy	Pavlicevic & Ansdell, 2004	X	X	X			X			X		X	X		**7**
Compassion-focused Relational Music Therapy	Binnie, 2019	X			X	X	X			X		X			**6**
Complexity Science Music Therapy	Crowe, 2004	X			X			X	X	X	X	X	X	X	**9**
Culture-Centered Music Therapy	Stige, 2002		X	X	X		X			X	X	X	X		**8**
Dalcroze-Eurhythmics in Music Therapy	Articles from *Approaches* Special Issue on Dalcroze-Eurhythmics in Music Therapy, 2016	X	X		X	X		X	X	X	X		X	X	**10**
Developmental-Integrative Model in Music Therapy	Sekeles, 1996	X	X		X		X	X			X	X	X	X	**9**

Approach, theory, or model	Primary Source	Improvisational	NRMT-CMT	Music Centered	Spiritual	Psyche	Psychoanalysis	Movement	Behavior	Community	Brain	Culture	Musicing	Complex	Totals
Dialogical Perspective of Music Therapy	Garred, 2006	X	X	X	X		X			X		X	X		**8**
Feminist Perspectives in Music Therapy	Hadley (ed.), 2006	X	X		X	X	X			X	X	X		X	**9**
Free Improvisation Therapy	Alvin & Warwick, 1991	X	X	X			X	X	X						**6**
Guided Imagery and Music	Summer, 2002 (ed.) & Bonny, 2010			X	X	X	X				X			X	**6**
Humanities Oriented Music Therapy	Ruud, 2010									X	X	X	X		**4**
Humanistic Music Therapy	Articles from *Music Therapy Perspectives* Special Issue on Humanistic MT, 2018	X	X	X						X		X			**5**
Music-Centered Music Therapy	Aigen, 2005	X	X	X						X		X	X		**6**
Neurologic Music Therapy	Thaut, 2005	X						X	X		X			X	**5**
Nordoff-Robbins Music Therapy/Creative Music Therapy	Robbins, 2005	X	X	X		X							X		**5**
Orff Music Therapy	Articles from *Approaches* Special issue on Orff Music Therapy, 2013	X						X	X				X		**4**
Psychiatric Music Therapy	Tyson, 1981						X		X	X	X				**4**
Psychodynamic	Hadley, 2003; Metzner 2016	X	X			X	X		X		X				**6**
Quantum Therapy	Eagle, 1991													X	**1**

Approach, theory, or model	Primary Source	Improvisational	NRMT-CMT	Music Centered	Spiritual	Psyche	Psychoanalysis	Movement	Behavior	Community	Brain	Culture	Musicing	Complex	Totals
Resource-Oriented Music Therapy	Schwabe, 2005	X				X			X	X		X			**5**
Social Capital Theory	Proctor, 2011		X							X			X		**3**
Sociology	Ruud, 2020				X				X	X	X		X		**5**
The Field of Play	Kenny, 1989	X	X		X										**3**
Therapeutic Music Training	Jones, 2020							X	X		X				**3**
Transpersonal Music Therapy	Crowe, 2017	X	X		X	X					X		X	X	**7**
Vocal Psychotherapy	Austin, 2016	X				X	X								**3**
Totals	**33**	**23**	**14**	**11**	**15**	**13**	**14**	**11**	**14**	**15**	**17**	**12**	**17**	**11**	**187**

Appendix C: Analysis of Approaches Using Ansdell (2002)

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Nordoff-Robbins Music Therapy-Creative Music Therapy	Engaging the individual communicatively and interactively in a widening process of musically supported self-discovery, self-expression, and self-actualization. Characterizing concept emphasizing the relationship uniting child's expanding sense of self within capacities for one or more interactive forms of musicing and into the knowing-meeting with the therapist.	UK, US, Denmark, Finland, Norway, Sweden, Holland, Germany, Switzerland, Italy, Canada, France, Australia, New Zealand, Israel, South Africa, Lithuania, Russia, Estonia, Japan, Taiwan, Korea, Columbia, Brazil, Uruguay, Argentina, China, Poland	Improvised musicking to awaken the Music Child – source of energy and motivation that supports all development and therapeutic processes in music therapy.	Anthroposophy – Rudolph Steiner. Music Child is given and universal function of intelligence, purposefulness, human companionship, and fulfillment which offers possibilities of growth.	Male	1958
Anthroposophical Music Therapy	New Age music facilitator	Anthroposophical schools	Support client's self-regulation on a spiritual, emotional, vital, and physical level through special musical elements	Curative education and eurhythmy	Female	1963
Behavioral Music Therapy	Behavior analyst	With observable and measurable behaviors, but not with unconscious or spiritual material.	Change environment, consequences, or antecedents to change behavior	Motor, cognitive, emotional, and ideational responses are behaviors.	Male	1968

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Humanistic Music Therapy	Core principles: uniqueness of human and disciplines that are uniquely human (humanities), significance of individual identity, principles of logic and reason and scientific realism, pursuit and development of human virtue and benevolence	Various	5 human-centered tenets: selfhood, agency, relationality, ethicality, aestheticality	Roots in Buddhism, Taoism, Confucianism, Zoroastrianism, pre-Socratic Ionian philosophies of Greece.	Male and female	1970
Dalcroze-Eurhythmics in Music Therapy	Structure movement and music improvisation/activities for clients	Educational settings, Older adults	Engage sensorimotor system over time, entrained by music	Musical consciousness is result of physical experience	Male and female, mostly music educated and neuroscientists	1970
Guided Imagery and Music	Conscious use of imagery, which has been evoked by relaxation and music to effect self-understanding and personal growth processes. Purpose of therapist is to facilitate this healing. Purpose of GIM is to “mine the depths in order to bring reintegration, insight, and wholeness” p. 96	Support of physical, psychological, and spiritual wholeness.	Goal: Peak Experiences – a sense of unity or oneness, transcendence of time and space, deeply felt positive mood, sense of awesomeness, reverence and wonder, meaningfulness of psychological or philosophical insight, ineffability. Catharsis, Insight, and Action/integration of new learning.	Influenced by Maslow, Music Psychotherapy, humanistic, transpersonal. Jung. Maslow’s self-actualization and Roger’s client-centered therapies. Ego receptivity (allowing) is foundational to the philosophy behind holistic processes, Healing comes from the within the person	Female	1970

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Free Improvisation Therapy	Therapist provides musical, safe, and predictable experience, sensory integration, musical development. Develop relationship based on mutual trust and respect without creating feeling of dependence. Respect and trust. Based on needs of client. Free to make any sounds or movements (as long as not hurting self/others/instruments) Instrumental more than vocal	Controlled use of music in therapy, rehabilitation, education, and training of children and adults suffering from physical, mental, or emotional disorder.	Music used as means of development through which identity could be integrated.	Psychoanalytic – ego strength, projection onto instruments, sometimes behavioral Music Centered	Female	1978
Orff Music Therapy	MT method that focuses on emotional and developmental needs of a child and contributes to new experiences of emotions.	Strength-based, Resource-oriented, child-centered. Relationship is central factor.	Core self develops self-agency, self-coherence, self-history, self-affectivity.	Orff-Schulwerk – a way to engage the child in the imaginative processes that derive from the natural self-expression of the child	Female	1980
Benenzon Music Therapy	Trained in psychology, medicine, rehab, music. Discover client's ISO; warm up, catharsis, perception and observation, sonorous dialogue	With other therapists/medical practitioner. But not to promote communication or interaction.	Modification of emotional problems, attitudes, and energy of psychic dynamics	Music is magical and omnipotent, has power to change others.	Male	1981

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Psychiatric Music Therapy	Functions to reinforce positive response to increase interest in music. Interest is used as motivation for new learning and relationships and reintegrate into society	Mental Health settings	Reactivate feelings through musical stimulation and encourage expression. Helps client perceive, experience, and integrate inner reality	Psychodynamic, psychoanalytic, object relations. Freudian psychoanalytic theory. Milieu therapy. Erikson	Female	1981
Quantum Therapy	Guiding clients to a balanced and harmonized state of meaningful awareness	Various	To bring order to chaotic life of client.	Bohr's complementarity, Heisenberg's uncertainty, Einstein's special relativity, Bohm's holonomy	Male	1981
The Field of Play	Process-oriented art and science; process and form which combines the healing aspects of music with issues of human need to move toward health and development of individual and society at large.	Various	Loving and creating. Creative process of human growth and change within field of loving and creating sound	Primary Fields: aesthetic, musical space, field of play Secondary fields: ritual, state of consciousness, power, creative process. Movement towards wholeness	Female	1989
Analytical Music Therapy	Musician, non-directive, container, clinical improvisation, Be With emotions	Psychiatric hospitals, private practice	Greater love of self, life, others	Freud, Jung, Klein psychoanalysis	Female	1994
Developmental -Integrative Music Therapy	Guide client through auditory experiences to develop qualities essential for health and growth. Strengthen link between mind-body	Private practice?	Musical expression serves as link to repressed emotions. Psychophysiological equilibrium	Stages of development & Traditional healing practices	Female	1996

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Public ation date
Biomedical Music Therapy	Use music to influence human behavior by affecting the brain and subsequently other bodily structures in ways that are observable, measurable, identifiable, and predictable.	Because the human brain must first interpret sound as music before there can be a musical influence, and because every client has a brain that must change its way of doing things in order for therapy to take place, the human brain must be recognized as the basic domain of treatment for all MT applications	Maintaining enjoyment of musical experience is a prime feature of the client-therapist relationship. Activating client's inborn musicality by stimulating the client's brain through musically facilitated emotional motor, and auditory experiences	Based on a biological model of human response to musical experience.	Male	1997
Culture-Centered Music Therapy	Situated Health musicking in a planned process of collaboration between client and therapist.	All humans have the right to arts and aesthetic experiences should be given to everyone.	Use of music for some purpose related to health and wellbeing. Working within culture.	All work (theory, practice, research) takes place in specific and unique contexts.	Male	2002
Aesthetic Music Therapy	Western Classical Musician, Clinical Improvisation/Listen	Down syndrome, autism, Hospice, AIDS – clinical improvisation	Transcend living and dying, creativity	All people have limitless potential. Music is intrinsically healing	Male	2003
Psychodynami c	Explores depths of human psyche using musical tools. Both client and therapist bring their own unique patterns of relating to world to therapeutic relationship	Framework within which to analyze and interpret behavior.	Techniques evolved from free association and the couch to include various domains of observation and varied techniques of intervention, including play and creative arts.	Drive theory, ego psychology, object relations theory, self-psychology, Jungian theory	Female	2003, 2016
Community Music Therapy	Facilitates musicking in pursuit of well-being; Follow where the needs of the clients, the contexts, and the music leads.	In context of sociocultural life. Within client's community	Improving client's participation in any kind of musicking	Human beings are cultural beings and musical beings. Multiculturalism is an integral factor in dealing with question of identity and quality of life issues.	Female and male	2004

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Complexity Science	Scientist with systematic approaches to knowledge acquisition and artist who relies on intuition, creativity, and spirituality to be present, interact and hold intentions with/for client.	Music is fundamental to mental, emotional, and spiritual growth – so MT works anywhere those occur	Process of bringing information (complexity) into the human system to create emergent property of health	Real world phenomena are complex systems in constant movement of unfolding process. Music is a fundamental, holistic experience that imp ats functioning in all areas.	Female	2004
Analogy-based	Therapist who listens and follows psychological processes sounded in music, Improvisation	Rehab, palliative, developmental, supportive, re-educative, re-constructive	Sounding the Psyche, conservation, and variation	Developmental psychology; Essentialism – music therapy is indicated because humans are musickers. Holism – everything influences everything therefore music therapy works.	Male	2005
Music-Centered Music Therapy	MT is more a specialized application of music than a specialized means of conducting therapy. Theory and practice rest primarily on musical foundations.	AMT, NRMT-CMT, BMGIM, AeMT, CoMT, Culture-centered MT	Musical experience is primary clinical focus.	Schema theory and Zuckerkandl's Dynamic Theory of Tone Joy of listening to, composing, creating music is at heart of all processes in MT. Music Therapy originates from 2 spheres of human activity: the arts & healthcare.	Male	2005
Neurologic Music Therapy	Evidence-based treatment techniques. TMEs adapted to client needs.	Therapeutic application of music to cognitive, sensory, and motor dysfunctions due to neurological disease of the human nervous system.	Neuroscientific research shows effective use of music with therapeutic outcomes that are stronger and more specific than general well-being.	Common neurological basis of rhythm formation in human brain is neural modularity that allows human brain to build develop, juxtapose different subcomponents of rhythm into complex rhythmic grammars of different cultures.	Male	2005

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Resource-Oriented Music Therapy	Activating self-healing forces in client rather than treating pathological aspects of personality; Releasing self-healing forces; Establishing direct constructive, active contact with structured objects of surrounding reality	Clients with severely impaired psychological experiences	Resource activation = build on existing abilities; to release blocked abilities - Differentiation of emotional competencies - Development of broadened and differentiated awareness potentials - Development of competencies for social interaction	Music is both a stimulus for initiating intra-psychic processes AND object, reality, structured time	Male	2005
Dialogical Perspective	Intentional use of music in healing, musicking is essential human activity	Various	Compassion and care: using music to help people heal, grow, develop, change	Buber I-Thou/I-It relationships	Male	2006
Feminist Perspectives	Finding, rediscovering, and strengthening human characteristics such as ability to feel, express, share, support, care, nurture, hold, contain, intuit, understand with, without, and between words. There is no self if not in relation with others. Know yourself, honor the gifts the creator has bestowed upon you, stay in balance, show respect, stand tall. Focus on self-reflection and self-examination. Respect for diversity. A call for activism	Community MT, AMT, BMGIM, Improvisational, Medical, Psychodynamic, Cognitive therapy	Rediscovering musical and creative impulses. Helping clients trust their own experiences and intuition. Enabling clients to appreciate female-related values. Assisting client in taking care of themselves. Helping women accept and like their own bodies. Helping women define and act in accordance with their own sexual needs. Creative place of wisdom within humans give voice to pain, distrust, anxiety, and to power and determination to live and have different lives.	Intersections of race, class, gender. unmask forms of male hegemony at various sites that parade as neutral and/or objective when in fact they hide profound levels of male interest, male norms, and male value-laden assumptions.	Female	2006

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Humanities oriented	Music as narrative, sign, symbol determines how meaning is produced, interpreted and gives rise to action. Musicking is a powerful tool to generate well-being and optimism, to foster resiliency through agency, to work through positive emotions, and experience flow in order to equip clients with strategies for living a good life (p. 87)	MT is more than a toolkit of intervention techniques; appreciates resource-oriented and community MT approaches.	Positive emotions expand thought-action repertoire.	Based on attitudes, principles and approaches from both humanities and natural science.	Male	2010
Social Capital Theory	MT generates social capital through repairing communicative musicality. MT=music therapist engaging client in some form of musicking to improve quality of life	MT offers environment in which social capital can be observed to be developing	Music supports social capital generation: norms are culturally constructed; structure acts as a physical framework for participation and fresh starts; we are hard-wired for musical participation – communicative musicality equips us with use of musical elements as primary means of social interaction	Social capital is generated by entering cycle of risk and receiving if we have the capacity to do so and are not inhibited by previous experience of risk being unreciprocated and dangerous	Male	2011

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Transpersonal	Music as a disrupting force and a re-patterning force – improvisation, imagery, relaxation, expression, iso-principle, ritual, spiritual.	Necessary to have an open approach – open to needs of client, open to change, open to adapting a session according to state of health of client. Level I – Recognition and self-realization Level II – personal growth Level III – Spiritual growth	Ultimate purpose is to achieve an integrated state of consciousness where there is a balance of rational awareness and intuitive, imaginal functioning	Emerged from humanistic psychology, psychotherapy methods, Eastern meditative experiences. Begun by Bonny.	Female	2012
Vocal Psychotherapy	Use of vocal improvisation for integration	Private Practice	Vibrations of singing can break up energy blockages, releasing feelings and allowing natural flow of vitality. Healing occurs when we connect with true voice	Breath is core of singing and life.	Female	2016
Compassion-Focused Relational Music Therapy	Holding creative spiritual space for *being* instead of *doing.* Support for client, family caregivers, and staff.	Hospice, bedside with agitated or delirious clients in last days/hours of life	Promotes positive relational legacy for those left behind. Supports a Good Death: peace, letting go, forgiveness, safety	Buddhist philosophy of *mitta* (loving kindness) generated by practice of self-awareness and self-compassion	Female	2019
Sociological	Immunogen that protects us from a sense of alienation under cultural condition of modernity.	Various	4 major musically induced antigens: vitality (emotion regulation), agency, connectivity, meaning-making – multiplicities that relate to each other and to identity, self-efficacy, and empowerment; emotions and meanings; network and belonging; spirituality and transcendence	Influenced by Deleuze and Guattari concepts of mulitplicity, rhizomatic thinking, field of MT is an assemblage (collection or constellation)	Male	2020

Approach	Identities and roles	Sites and boundaries	Aims and means	Assumptions and attitudes	Author gender	Publication date
Therapeutic Music Training	Learning to play piano is used to address cognitive impairments.	Brain injury Rehab	To drive, strengthen, and improve underlying neural processes involved in target cognitive areas	Neuroplastic response of prefrontal cortex is stimulated through repeated experience	Female	2020

Appendix D: Case Examples Using Case Study in Garred (2006)

Annabel is a girl of about 14 years of age, with Rett Syndrome. This is a progressive neurological condition, almost exclusively contracted by girls, in which the child from a very early age on starts losing basic already-acquired abilities, like walking and talking, and develops a multi-handicap condition. Very often there is a characteristic movement of the hands resembling hand washing. She is very much in recluse, sitting quite self-absorbed in her wheelchair, and with a rather incessant movement of the hands. She does not have any functional verbal language and remains very much in a world of her own, not being easy to reach or connect.
1:1 MT in a special education setting. Goal: to engage her in some meaningful activity (Garred, 2006, pp. 89-91)

As an **NRMT**, I would be at the piano while a co-therapist helps Annabel play drums, cymbals, or xylophones, or encourages vocalizing. I might start by singing her name and introducing myself and the co-therapist within the song. The music I play might reflect the movements I observe from her hands and my goal would be to enhance or support her engagement in making music. Since her arm movement is likely to be limited, the co-therapist might offer a hand drum or tambourine that could be held closer to the position of her hands. If she seems willing or indicates some interest through eye contact or body positioning, the co-therapist might try offering physical assistance so that Annabel could reach the other instruments or hold a mallet or play instruments in different positions. I would provide a rich musical accompaniment supporting her musicing on the piano and potentially improvise vocally as well.

As an **Anthroposophical** music therapist, I would support Annabel's self-regulation on a spiritual, emotional, vital, and physical level. I would use the elements of music to influence her lower, middle, and upper systems with rhythm, harmony, and melody to aid or support her will, feelings, and thoughts. I might use scales based on planetary systems and tones related to the zodiac to help Annabel engage in meaningful activity.

As a **Behavioral** music therapist, I would provide musical antecedents and consequences that might increase the likelihood that she would engage in music-making. To encourage use of her hands, I would place the tambourine in successively further positions to increase her range of motion and sing a song that promotes a response, for example, "Annabel can play the tambourine with her hand." I might hold "her" on a leading tone to help cue the movement of her hand, provide physical support to use her hand, and sing "hand" on the tonic with smiles and verbal praise or continued singing to reward the movement and increase the possibility that the movement will happen again.

As a **Humanistic** music therapist, I would seek to enhance her experience of aesthetics, relationship, and agency by looking closely for her attempts to communicate her desires. I would attempt to support this communication by listening closely to any sounds she makes or watching for any movements that might indicate preferences while providing aesthetically pleasing music based on her culture, age, background, and experience. Minute attempts at communication will be respected, validated, and reflected back to her musically and verbally with a goal of increasing her decision-making and expression of preferences in the session.

As a **Dalcroze** music therapist, I would provide music that stimulates entrainment and movement, with a strong rhythmic component and support her movement to the music with physical guidance as needed. The music and movement activities would be improvised to match her natural movement and encourage exploration of new movements.

As a **BMGIM** therapist, I would probably not accept her as a client since I she would not be able to communicate verbally with me and entering an altered state of consciousness might not be appropriate for her. However, if I were qualified to provide BMGIM with clients like her, I might select programs that are designed to enhance positive affect. I would begin with a preliminary conversation reflecting what I observe about her affect or body tension/positioning. I would lead a brief induction to increase physical relaxation, being very careful to observe for any adverse responses. Then I would sit near her as we listen to the music. I might rely on my intuition for any imagery that arises for me being very careful to remain in a typical state of consciousness and work within supervision to make sure I'm not imposing my own imagery on her.

As a **Free-Improvisation** music therapist, I would make sure the environment is safe and non-threatening where Annabel is free to move and make sounds. In the beginning, I would improvise music that makes no demands on her using physical contact as tolerated to rock with her or hold her hand, establishing trust. I would provide a musical, safe, and predictable experience each session helping her become aware that the sound is produced by the instruments, that she is free to express choice and preference, and support movement to create a body image and a feeling of orderly movement.

As an **Orff** music therapist, I would set up the room with the instrumentarium. Using musical games, play, and improvisation, I would develop her sense of body cohesion, emotional development, and ability to interact through music, movement, dance, and speech. I begin by attempting to make contact with her by provoking some reaction to the music through perception. Then we would work on functional contact and affect attunement.

As a **Benenzon** music therapist, I would produce a channel of communication by matching the sound-music tempo to Annabel's mental tempo and identify the intermediary and integrating objects that would work best for her. I would begin with a warmup and catharsis, then establish the channel of communication by perceiving, observing, and matching her mental tempo by matching her breath or heartbeat, and then we could engage in a sonorous dialogue.

I would probably not see this client as a **Psychiatric** music therapist since Annabel is not a psychiatric client. However, if I were to have her as a client and work within this method, I would play music and reinforce her positive responses to increase her interest in music. This interest would then be used as motivation for new learning and relationships and reintegration into society. (This sounds behavioral to me.)

Using **Quantum** music therapy, my goal would be to guide Annabel to a balanced and harmonized state of meaningful awareness. By experiencing music, Annabel would

experience universal order, so I would engage her in as many musical experiences as possible so that she may bring order to her chaotic life.

Operating within a **Field of Play** approach to music therapy, I would determine a ritual for our music therapy sessions, based on Annabel's responses and needs. Her needs would be determined collaboratively through improvisation and strive to move towards wholeness. The primary work would be a creative process of growth and change for Annabel within a field of loving and creating sound. The growth and change would be determined by Annabel and I would support her within the music.

As an **Analytical** music therapist, I would *be with* Annabel in her emotions and provide a non-directive musical container, probably improvising music that reflects or validates her emotions and encourages expression. Our primary goal would be greater love of herself, her life, and others.

Using a **Developmental Integrative** music therapy model, I would guide Annabel through auditory experiences to strengthen the link between her mind and body. I might reflect what I perceive her thoughts or feelings to be through improvised singing and guiding her hands to play instruments or assisting her to move to the music to obtain psychophysiological equilibrium.

As a **Biomedical** music therapist, I know that Rett Syndrome is a rare genetic disorder caused by a random mutation of a specific gene that likely affects proteins essential for brain growth and is characterized by slowed brain growth, seizures, loss of muscle control, and anxiety. I would focus on reducing anxiety and use rhythm to help entrain her heartbeat and respiration to become more regular and provide some recordings that the family might use to help reduce sleep disturbances. I would also use music to help her maintain as high a quality of life as possible, using music to help her play and develop her identity as a teenager by using music that she enjoys and responds to.

In **Culture Centered** music therapy, I would recognize that Annabel has a right to aesthetic experiences and would therefore provide musicking opportunities for her to engage in. I would strive to engage in music collaboratively with her, using music from her ethnic and family culture as a way to develop cultural and social connections.

As an **Aesthetic** music therapist, I would play classical music or improvise clinically and help Annabel engage with the music. The music is intrinsically healing so just providing music opportunities would positively influence her health and wellbeing.

As a **Psychodynamic** music therapist, I would use music engagement to help uncover Annabel's unconscious material and explore the depths of her human psyche. The nonverbal nature of music would be especially beneficial since Annabel would not be able to engage in a verbal dialogue. Through musical play, we would strengthen her ego and relationships with caring adults.

As a **Complexity Science** music therapist, I would add musical experiences to Annabel's environment and human system to increase the complexity of those systems. By doing so, her system will create the emergent property of health and wellbeing. Since music is fundamental to mental, emotional, and spiritual growth, providing ways for Annabel to engage in musicking will facilitate this growth, if the optimal level of complexity is achieved.

As an **Analogy-based** music therapist, I would rely on improvisation to help Annabel sound her psyche and then I could help uncover unconscious processes. I would join in her musical expression and use countertransference to understand and describe what she is experiencing. I would help establish a feeling of predictability in the sessions to promote conservation and variation until Annabel feels a personal will to act.

As a **Music Centered** music therapist, I would know that a relationship to music is required in order to be fully human, so I would engage in music with Annabel to facilitate her relationship with music. We would experience beauty, transcendence, connection, flow, *communitas*, personal sources of strength, and provide a means for expression within and through musicking.

As a **Neurologic** Music Therapist, I would use Musical Sensory Orientation Training (MSOT), which is providing musical stimuli to increase her arousal and orientation to facilitate meaningful responsiveness. I would also use Therapeutic Instrumental Music Performance (TIMP) to provide visual, auditory, and kinesthetic targets, plus rhythmic cues, to exercise and stimulate functional movement patterns. For communication, I would use Developmental Speech and Language through Music (DSLM) to enhance and facilitate speech and language development.

As a **Resource-oriented** music therapist, I would activate Annabel's self-healing forces using music to establish direct, constructive, active contact with structural objects of her surrounding reality. I would use music as a medium for her expression, communication, and reception to help her develop competencies for emotion regulation, social interaction, and perception of internal and external realities.

In a **Dialogical** music therapy perspective, I would use music to help Annabel heal, grow, change, and develop. Because I want to develop an I-Thou relationship with her and for her with the music, I would improvise a song with her name, my name, and describing what we are there to do, matching the tempo and other characteristics of the song to her movements and mood. I would attempt to entrain with her through the music and then let the music develop as her relationship with it develops.

As a **Feminist** music therapist, I would help Annabel understand herself in relationship to others, beginning with her relationship with music and with me. We would improvise or use her preferred music to help her trust in her own wisdom, intuition, and experiences. I would also trust my intuition, wisdom, and experiences to guide me through music selections and interventions.

As a **Humanities-oriented** music therapist, I would use music to generate well-being and optimism, to foster resiliency through agency, to work through positive emotions, and experience flow in order to equip Annabel with strategies for living a good life. I would help her engage in musicking with instruments, preferred music, and improvisation. Our primary goal would be to evoke positive emotions through musicking.

Within a **Social Capitalist Theory** of music therapy, I would build Annabel's social capital by engaging her in communicative musicality. I would respond musically to her sounds or facial expressions similar to how a mother and infant communicate musically. This would support her entering into the cycle of risk and receiving and provide a physical framework for participation.

As a **Transpersonal** music therapist, I would begin by working at a Level I for Recognition and Self Realization. I would use music improvisation or music listening to help Annabel move from involuntary responses to voluntary responses to music. Then I would provide instruments in a position to help her move from accidental playing to intended playing. We would progress according to her needs and work on developing environmental awareness and responses to external cues to broaden her sense of self.

I'm not sure I could use **Vocal Psychotherapy** effectively with Annabel. She would not be able to engage in free association or improvisational singing. However, perhaps I could rely on my therapeutic intuition or countertransference to help her connect with her true voice. I could support her vocalizations and provide possible verbal interpretations of her expressions while improvising musically. I would need to be careful not to project my own thoughts and feelings onto her and carefully monitor the effectiveness of this approach.

Compassion-Focused Relational music therapy is for people on hospice. Since Annabel is not on hospice, this approach would not be appropriate for her. Life expectancy for people with Rett Syndrome is not well known; however, the average age of death is 24 and is often sudden due to pneumonia (Cunha, 2020). Other risk factors include seizures, loss of mobility, and problems swallowing. If she were placed on hospice, I would provide creative psycho-social-spiritual interventions to support her and her family at the end of her life by singing words and phrases related to "good death," like peace, letting go, love, forgiveness, and safety. I would provide active music for her for about 15 minutes and provide about 15 minutes of verbal support and guidance for the family.

Using a **Sociological** approach to music therapy, I would provide music as an immunogen to protect Annabel from a sense of alienation under the cultural condition of modernity. I would work to build a relational connection with her through musicking to support her development and encourage health-promoting behavior.

I do not believe **Therapeutic Music Training** would benefit Annabel because she would not be able to learn to play piano or another instrument with her cognitive and motor deficits. I believe it might be more beneficial to engage in improvisatory approaches or NMT.

Appendix E: Transcriptions of Personal Reflections From the Lab Journals

After reading Chapter 6 of Lee (2003)

November 24, 2020: Listening to Michael and Collin's improvisation I feel very moved. I now know I want to immerse myself fully in each approach so that I can understand it more completely than skimming. The pain expressed is profound. The healing that takes place is beautiful. Orchestral instruments are important to this process. Also Western Classical music training as a foundation for learning about world musics. Theory, aural skills notation is key. I think this needs master's level training. I think I'm beginning to understand Arts-Based Research. Bach & Beethoven as a way to understand music therapy. How can this (AeMT) be used in other clinical populations besides developmental disability, hospice, bereavement?
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*From Smeijsters (2005) Chapter 2: What is the reason that music therapy should be used? Chapter 3: How can a theory of music therapy connect the universal and the special? Chapter 5: p. 56 In different perspectives there exists some shared idea about how music therapy works and what is essential to music therapy.*
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After reading Chapter 10 (York in Hadley, 2006) Feminist goals in therapy (helping clients trust their own experience and intuition, enabling clients to appreciate female-related values, assisting women in taking care of themselves, helping women accept and like their own bodies, helping women define and act in accordance with their own sexual needs).

December 3, 2020: Isn't that what we should be doing for all clients? The way we think about ourselves influences our neurology and biology and behavior and psyche, so it fits within all approaches. As a female-dominated profession shouldn't we all be, teach, practice feminism?

--Grounded theory – creation of theory by systematically and intensively analyzing data – often sentence by sentence or phrase by phrase – contained in field notes, interviews, or other documents. Goal is to uncover themes and broader ideas which emerge. (p. 253)

Ch 15 Streeter on Academia in Hadley, 2006, p. 364: Our job is to help music therapists acquire the necessary critical thinking skills to choose the right mix of music therapy techniques that relate to the problems of the individual client.

After reading Hadley Ch 16

December 6, 2020: This book has been hard to read because women's issue are often illustrated with case studies of abuse and violence. This brought up my own issues of history with abuse and violence. Perhaps as part of my analysis I need to include country of origin and professional practice for each author. I continue to think I can skim some chapters, but I continue to need to fully immerse myself in each approach.

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*After reading Priestley (1994) essay on transference and countertransference*
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December 12, 2020: I think the issue has been the disregard of the benefits of each type of approach. Music-centered discount neuroscience. Neuroscience discount "pseudoscience" of psychoanalysis. Maybe MTs need to learn about each approach and how to integrate the good parts of each in a way that fits them and their clients. So maybe each program could offer different focus – like they do now. Bachelor level could include more overview of all approaches (Breadth). Masters level could specialize by population, approach, technique, etc. (Depth), with research, clinical, supervision, education tracks. Doctoral level develops research agenda and advanced clinical techniques. Again, with research, clinical, supervision, and education tracks. Career advancement degree. So it's not linear or hierarchical – one approach is not easier, simpler, more basic, than another. Or better. It's a continuum and a muddling – like a recipe that gets slightly different flavors depending on how much of each ingredient you put in it.

After reading Priestley Postlude

December 18, 2020: It seems to me that there are indescribable effects of music therapy that arts-based folk want to protect, and science-based folk want to explain. Seems like magical thinking to me. Why can't we explain these wonderful things but still be awed by them? When I don't know what to do with a client, I trust that the client knows and that in the music and relationship the client's needs are met. But I know this based on research related to positive psychology and prayer and mindset and mindfulness. It's magical but not magic. Some things are studied better by qualitative thick description. But that doesn't mean RCTs are bad.

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After reading Eschen (2002)

December 21, 2020: It feels like many professional competencies came from various methods/approaches and they only make sense within context of that approach. i.e. AMT = movement for expressive purposes competency. I continue to find myself thinking of ways to incorporate each method into my teaching. Improvisation to feelings in chart in Priestley as a way to get in touch with each emotion and to work on improvisation skills. Using some of the Psychodynamic movement work – but figuring out how to make it appropriate for bachelor level training.

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After reading Community Music Therapy Ch 7 Aasgaard in Pavlicevic & Ansdell (2004)

December 31, 2020: What do MTs need at graduation? To be able to pass Board Exam and get a job. What is needed to pass Board exam? An understanding of current practice as outlined in Board Certification Domains: Safety; Referral, Assessment, Interpretation of Assessment and Treatment Planning; Treatment Implementation and Documentation; Evaluation and Termination of Treatment; professional development; professional responsibilities. What do they need to do to get a job? Music skills – excellent and diverse; understanding of therapeutic process and how to apply it in diverse settings. Advanced training = specialization in different models, research, etc.

After reading Ch 13 Bunt – Good plan for MT clinic. Can involve Grad students and undergrad. Can employ MTs. Connect with community. Involve MUED and Music performance students as well as MUTY. Action Research: define objective, fact-finding, making a plan, action, evaluation

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*After reading Stige 2002 Ch 6*

January 14, 2021: It took me a long time to understand Stige. Probably because of language barriers. As a Norwegian, his use of English words is different and took me time to translate his meaning into a way I can understand. I think anti-behavioralists do not understand how it is actually practiced. I think psychotherapy models have significantly restricted MT understanding to mean a certain way of practicing: 1:1 MT over long time (1-2 years) working with the unconscious. Culture centered is presented as brand new except it's exactly how I practiced with Joyful Singers etc. as a behavioral MT or NMT or biomedical MT. What this does, though, is gives a vocabulary for working with culture in micro, meso, macro, and exo systems. Provides some validity for addressing goals at these levels and treating community along with individual.

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After reading Garred (2006) Ch 9

April 19, 2021: Garred is the first music-centered author I've read that is respectful of music *in* therapy techniques. Music *in* therapy, says Garred, has already been provided a strong rationale. He is providing a rationale for music *as* therapy. Neither is better than the other. Choice is made based on client needs. He says one can't move between IN or AS in the middle of a technique because rationale, philosophy, theory of each are incompatible with each other.

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*In Ruud (2010) Ch 9 p. 151* In MT, we need knowledge of human body and physiological function, understanding of culture and communication, and social structures or forces that create disability. *On p. 150 regarding research in MT:* emancipatory interest – identifying sources of misunderstandings and ideological notions

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*In Thaut (2005) Ch 2* Brain needs to engage in arts in order to build, sharpen, maintain, and create order in its perceptual machinery as an essential aspect of brain function. *Personal connection* June 25, 2021—THIS IS WHY MUSIC CHILD EXISTS!

*After reading Thaut (2002) ch 3 p. 54 (Common neurological basis of rhythm formation in human brain = neural modularity that allows human brain to build develop, juxtapose different subcomponents of rhythm into complex rhythmic grammars of different cultures.)* June 26, 2021: Modularity – Mithen's ideas – check that. Western Music rhythm is hierarchical. Did society create that or was it influenced by it?

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*After reading Crowe (2017) ch 6*

September 7, 2021 – Bachelor level – generalist – know a little about a lot of approaches and techniques – Breadth
Masters level – specialist – depth – learn more deeply 1 approach or 1 population/setting
Doctoral Level – research, education, publishing

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*After reading Forinash & Kenny (2015) re: Eagle (1991)* September 22, 2021 – did Eagle steal this from Jackie Peters??
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Appendix F: Response from Triangulation Reviewers

Barbara Wheeler:
I am delighted to read Janice Lindstrom's research and be given an opportunity to comment on her findings. I appreciate the extent of her analysis and that she has spelled out for the reader what she has done to come to her conclusions. Because she has been so clear on her steps, I am able to follow what she did and trust her findings.

The steps that she took to arrive at her conclusions make sense to me. She has approached a question – whether it is possible to have a unified philosophy (or theory) of music therapy – that has been an issue for music therapists for decades. (I attended a symposium in 1979, titled "Developing a Theory of Music Therapy," in which many great minds in music therapy worked on this problem – but did not find an answer.) Janice's work approaches a solution to this question better than any other work of which I am aware.

The steps that she used include seeking information and placing it for each author/developer of the approach in a table. Although the table is concise, gathering the information involved a tremendous amount of reading and synthesizing information, all of which led to the reader's (and researcher's) ability to place the people in context and grasp something about who they are/were and their approaches.

Other steps involved counting words and related concepts. This included tabulation of common words or themes and their coding for each approach. They were compiled in a form that ultimately helped to make sense of these themes, including how frequently they appeared.

I found Lindstrom's use of questions developed by Ansdell to stimulate thinking and "to identify identity and roles of music therapy, sites and boundaries, aims and means, and assumptions and attitudes" to be very productive. It led to useful and insightful findings.

Her use of the case study to show how she might work with a client using most of the approaches was useful.

While it would be beyond what she has done or should do for this research, I hope that in the future, she will take her research and (current) conclusions to experts who practice or are still developing the approaches. This would bring the analysis to another level and could lead to stronger conclusions.

Although not directly related to whether it is possible to develop a unified philosophy of music therapy, I find Lindstrom's suggestions concerning the education of music therapists to be solid.

In summary, I find Janice Lindstrom's method – her rationale and the steps that she followed – to be logical and to lead to a very satisfactory conclusion – it *is* possible to develop a unified philosophy of music therapy.

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