Some thoughts about the role, function and identity of the music therapist in the 21st century: new research and thinking from a primarily UK perspective.

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Introduction

This invited editorial essay explores professional identity and contemporary issues for music therapy, primarily drawing upon the UK as a case study. It will pose questions about the future of the profession, highlighting new research showing different models of music therapy, including how music therapists can change environments. For the occasion of the new online British Journal of Music Therapy it will unashamedly aim to celebrate collective achievements in the UK, and throughout the world, through a potpourri of ideas and vignettes.

Music therapy dementia and research

When I was invited to contribute to the launch of this online journal we were planning an international conference on dementia and music therapy at Anglia Ruskin University, Cambridge. In collaboration with Methodist Homes(MHA) one of the largest providers of care for older people in the UK, and BAMT (British Association for Music Therapy), over 40 papers and round tables were included, with keynote speeches from international leaders in the field, Dr. David Aldridge, Prof. Hanne Mette Ridder, Ming Hsu and Dr. Orii Mcdermott. Held in September 2015 the conference attracted over 250 delegates, including carers, other professionals, family members, the press, and music therapists. The atmosphere throughout was buzzing. Music therapists and others were presenting as researchers, clinicians, in partnerships with families and carers, and as advocates for new music and brain research, an important advance in our field in the 21st century (Fachner and Stegemann 2013) 2014).

In a recent UK study, (Hsu, Flowerdew, Parker, Fachner and Odell-Miller 2015), music therapy is indicated as reducing agitation, changing and improving the environment, specifically carers' attitude, and possibly to reduce the use of. The power of music to help those with cognitive decline to relate with loved ones, feel validated and have an on going sense of self was reflected throughout the conference. Readers will have similar stories to this, reflecting the rich interest and collaboration about music therapy, including links with the international community. Our music therapy conference was linked to another international conference about arts therapies and dementia on the preceding day, for ICRA (International Council for Research in the Arts Therapies). Dr. Stuart Wood, UK music therapist was one of the keynote speakers, and the strength of collaborative work between arts therapists in the UK was demonstrated throughout the conference.

Research on music and the brain, and its relevance to music therapy has burgeoned during the 21st century, and featured in the international music therapy and dementia conference. Academic publications are crucial for dissemination of new research, and recently a whole volume of *Frontiers in Neuroscience,* a high impact online journal hosted from the Nature publishing Group, focuses on a dialogue between music therapy and neuroscience. The editors Julian O' Kelly, Jorg Fachner and Mari Tervaniemi aim to bridge the gap between scientific methods and clinical thinking of doing music therapy. In modern days, electronic academic and non-academic social and community impact is key, and there have already been 140,000 online viewings of these and similar articles by 100 researchers! Using biomarkers to look at unbiased

physiological responses to therapy is an important source of understanding of how music and therapy work together. The practice of brain imaging and doing therapy is included in research protocols which discuss implementation of home based music therapy interventions for stroke clients' emotional responses of daily music listening and how anger is expressed in music. Papers offer a viable insight on the effects of music on the body and the brain. This type of research substantiates and supports the variety of clinical and research writing about modern music therapy from around the world, as highlighted in this volume, by Tara Stuckey, Juliet Wood, Stephen Sandford, Emma Bailey, Laura Medcalf and Kat Skewes.

New perspectives professional development

Music therapists in the UK are currently responding to areas thus far not highly developed here. Last week at Anglia Ruskin University, we hosted Dr. Joanne Loewy from New York, in partnership with UK music therapist Claire Flower: at a one -day conference about music therapy in NICU's (Neonatal Intensive Care Unit). Sixty attendees on a cold day in January 2016 heard about new research and clinical approaches for music therapy with babies and families in the NICU. Attending music therapists and other professionals wrote lullabies and heard about how improvised music and songs of kin in music therapy are shown, through research and clinical practice, to help parent infant bonding, and increase weight gain. This is substantiated in a recent study in which music therapy in NICUs in Columbia was studied (Ettenberger, Odell-Miller, Rojas, Serrano, Parker, and Lanos 2014; Ettenberger 2015). Collaboration across different countries has always been strong, and understanding cultural aspects of music therapy is an important factor in respecting different identities, as discussed in a recent study about the use of Gamelan in music therapy (Loth 2015).

In the 21st century music therapy is now highly developed internationally, both in terms of clinical approaches relating to diagnosis and desired outcomes. There is much to celebrate. The training and professional development of specialist music therapists at all levels including Doctoral level, is increasingly formalized, for example in the UK music therapists have to be legally registered in order to practice as music therapists with the Health and Care Professions Council (HCPC). However, there are also other professionals who use music in their work, and increasing community and arts for health agendas, where music is applied more generically and across disciplines, cultures and populations. This means that being clear about the music therapist's role, task and identity is crucial at all times, including how we can be involved in training the workforce in what music and music therapy can offer to our populations.

Music therapy is a clinical, health and sometimes, medical discipline. In some countries music therapists are titled 'music psychotherapists'. In others, music therapists are working as adjunct activity therapists, or as community music therapists. In my view the nomenclature is not necessarily the salient issue, but what we actually do, how we think and how we respond to the environment and to others around us who need our services.

Travelling around the world, I discover there are many different ways of organizing our profession, and many countries are curious and interested in how our UK system works. Colleagues in Japan and Romania recently, for example, have asked for presentations about the UK story. I found myself in Romania in a joint event between

the UK based organization *Music as Therapy,* led by Alexia Quinn, and The University of Transylvania. Narrating about the earlier days before music therapy heads of training regularly worked together, I gave examples of early beginnings, and the development of our professional identity in the UK, which were welcomed in both countries. The formation of the original *Association of Professional Music Therapists in Great Britain* in the 1970's enabled us to gather together and work across trainings; not in order to iron out difference; but to respect differences in approach and find the common areas of 'basic training' within a framework. At the Romanian event, Clare Reynolds from Scotland and Una McInerney from Ireland gave country-specific case histories.

In order to become a profession, music therapy in the UK needed to demonstrate to the government that there was an agreement about the main components of music therapy training and practice, and a growing body of research. In the 1970's we discovered through dialogue, that similar areas of music therapy practical, theoretical, multi-disciplinary, and professional elements underpinned different music therapy training courses. Prof. Leslie Bunt, the late Prof. Tony Wigram andI, as representatives from the then professional association of music therapists, held meetings with the three heads of music therapy training courses Sybil Beresford Peirse, (Nordoff Robbins), Juliette Alvin (Guildhall School of Music) and Elaine Streeter (Roehampton). This led to defining the basic elements needed for music therapy training in the UK. Subsequently, a new career structure with the Whitley Council was established, culminating in the 1982 agreement. Later, in 1997, Registration of music therapists became a legal requirement, with the Council for Professions Supplementary to Medicine (CPSM) through the House of Lords bill,

(Hansard 1997) and subsequently in 2006 through the HCPC as our registration body. This professional history is reported in more detail in Darnley-Smith and Patey (2002), Barrington (2008), and Odell-Miller (2014). The early professional history is still relevant to us in the 21st century, but with the expanding roles of music therapists, how can we be clear to others about our role and hold onto the complexities of a music therapy identity?

Music therapy and identity

There are still questions, in all countries about whether music therapy is an art, a science, allied to medicine, a psychological or sociological treatment, or all of these phenomena.

The next vignette illustrates this complexity of modern music therapists' identity, within an organization close to home, in Cambridge. The main work of our music therapy team takes place within a university in a state of the art Music for Health Research Centre, housed in The Jerome Booth Music Therapy Centre at Anglia Ruskin University. Our identity as artists and health professionals is interesting, as we are a clinical, teaching and academic research provider. In structural managerial terms, our music therapy centre is part of the Faculty of Arts Law and Social Sciences, within the Department of Music and Performing Arts, and yet our new building is next to the Faculty of Health and Social Care, and Education. Further, some of our team members work in schools, in the National Health Service (NHS) with children and adults with mental health problems and learning disabilities, in our music therapy clinical centre itself and in the wider community. Increasingly universities have music therapy partnerships with NHS organizations. Recent initiatives in the UK have developed partnerships between NHS Trusts, and trainings

within universities. Here we see cross-disciplinarity: arguably music therapy already has a cross disciplinary identity.

I would further argue that the role and identity of music therapy and music therapists depends upon the task in hand, and as part of that task, role and identity changes according to the setting, and the needs of the participants within the therapy. We need to be flexible, whilst maintaining our major skills as therapists and musicians, researchers and teachers. I am constantly impressed by many music therapists working in the UK who adapt and provide exactly what is needed for people in all settings-working in homes, community buildings, by the bedside, in community environments, encompassing the family and significant others in music therapy. The more formal professional structures enable a framework for delivering what is needed creatively and professionally, and facilitate public recognition. BAMT's recent initiatives to hold events in Parliament offices on music therapy and dementia –in Portcullis House in June 2015, and in Holyrood in Scotland in February 2016- are crucial for the future development of music therapy. The identity of BAMT and other music therapists linked to this type of event is rather of an ambassador and informant. We now need to work with colleagues to produce clear guidance and documentation on when and where music therapy is most appropriately delivered at which point in care, and in collaboration with other music activities and arts in-put, to provide a joined up picture. The new BAMT Dementia Working Group initiated by Grace Watts, held its first meeting in January 2016, and is committed to working on a five year strategy, with all stakeholders and leading organisations for music therapy, music and dementia. The strategy will include a plan for access to music therapy for the

benefit of people living with dementia, their families and carers, from diagnosis, to end of life care.

NICE (National Institute for Health and Care Excellence) guidelines now mention music therapy across some diagnostic groups for example for people with schizophrenia and personality disorder. Related areas such as singing and musical activity are included for people with dementia, which adds to the importance and access to music therapy for many and diverse populations. Music therapists need to be daily ambassadors for their work within each environment.

Some music therapists have a growing identity as researchers. To be a clinical researcher, we need to have an identity as a researcher and clinician, philosopher, sometimes psychotherapist, statistician, and also as a business organizer. To work in a research unit, we have to be business minded in order to gain funding for new research and to enable as many people as possible to have access to music therapy. In our university, recent larger grants have been awarded for research in music and brain research, from the Music Therapy Charity, and for our current NIHR (National Institute for Health Research) funded TIME-A music therapy multi-centred Randomised Controlled Trial (RCT) looking at the effectiveness of music therapy for children (aged 4-7) on the autistic spectrum, and their families. Through this we are collaborators with schools, other universities, in this case Imperial College, London University, and the University of Bergen, Norway, with Cambridgeshire Music, and with schools, other agencies, working music therapists and researchers nationally and internationally.

The TIME-A research will end in November 2016 and across the world, around 350 children and families will have taken part, and around 120 participants in the UK. Thanks to enormous hard work and energy (using all the roles and identities mentioned thus far in this essay), our teams in the UK have recruited more participants than the other countries taking part. As an international team, we are interested in exploring why this might be. What are the cultural differences in our approaches and settings, whilst using the same music therapy protocol? (Geretsegger, Holck and Gold 2012; Geretsegger, Holck, Carpente, Elefant, Kim, and Gold, 2015). In research there are always findings and outcomes, which were not part of the original design, and these are often the most interesting. In addition, there are 'spin-off' outcomes: new music therapy posts have been created as a result of delivering music therapy to many children and families for the research; parents are becoming school governors in order to push for more music therapy, even before we have the clinical and scientific outcomes and results of the study. Environments can be changed by music therapy.

Sometimes research designs and protocols appear a far cry from our first and foremost identity as music therapists –that of being human. This human aspect of our identity is crucial in our understanding of the people we work with, but one that is not always acknowledged in public discussion. Within our diverse roles as therapists, clinicians, researchers, scientists, social and community music therapists; psychotherapists and teachers, how can we clarify our human role to ourselves, and others?

I mentioned before that I consider the task in hand to be crucial, and this may change from moment to moment. In one session, we may see ourselves as composers,

performers, improvisers, music psychotherapists, philosophers, magicians, healers, facilitators, assistants, agents and carers. We may be viewed as professionals, volunteers, therapists, psychotherapists, musicians, shamans, group-workers, community musicians, teachers, ‘the music person’; the list is endless. Having a sense of the central task is what matters and it is not always easy to hold this in mind with so many competing dynamics.

Perhaps our identity and task is clearest when in the room working as a music therapist. Nonetheless, communicating what happened in the room to significant others, funders or relevant institutions, when participants cannot do this on their own, is a challenge but necessary. There are many using music in health settings. How to be human and professional as Allied Health Professionals (AHPs), is different for each one of us, but an important balance to find.

Musical identity and music therapy

Darnley-Smith (2013, 2014) a UK music therapist explores the philosophical and clinical question of the nature of improvisation in music therapy, with particular reference to musical ontology and aesthetics. With the recent emergence of notions of health musicing, the nature of a distinction between clinical and non -clinical music making is not always clear. She helpfully examines how a consideration of ontology enables a distinction to be drawn between the music made within the clinical setting, known as clinical improvisation, and music that is made elsewhere. Through an examination of the recent history of approaches in clinical practice, she emphasises two distinct approaches to clinical improvisation in the UK, music-centred and psychodynamic.

My next vignette is clinical, and about musical identity, working with adults in different settings and within different music therapy contexts and approaches. In the improvisational model, music therapy involves the therapist and participant/patient making music, or listening together, or one listening to the other, with an emphasis upon what can be learned, changed or alleviated by the process. Central to this process is the nature of the relationship between therapist and patient, or group members.

In the penultimate session after four years weekly individual music therapy, with 'Michael', a young man with bi- polar disorder, there is harmony, occasional dissonance and a balance of reciprocal roles. Music was used to understand his violent mood swings in the context of his life and relationships. The music therapy was delivered in an NHS context where the identity of the music therapist was recognised as professional - working alongside doctors and nurses in an 'equal' role, as part of a central multi-disciplinary team. The example, if you could hear it, shows how in the moment, improvisation can foster developing relations. In this session subsequently 'Michael' reflected on his views and perceptions of our relationship in a way he had previously not been able to do. Earlier in the therapy he was only able to be totally absorbed with his own playing where I as therapist was nurturer, supporter and enabler for his painful feelings and memories to be explored and understood. In this penultimate session after four years, the acknowledgement of 'the other' is apparent in his listening and playing and smiling. In his earlier improvisations he was quite regressed showing me his responses to his early deprivation and abuse. In those periods, he drummed in a disorganised chaotic manner, unleashing and expressing his

feelings of anger and aggression, an important stage prior to his later work such as in this example where he is more integrated in his playing and state of mind.

In this snapshot justice cannot be done to music therapy with Michael, but with his permission more detail is written elsewhere in the context of a psychoanalytically informed approach. (Odell-Miller 2001, 2003). Here, the music therapist is working more as a musician and analytical psychotherapist – the therapy moves between active music making, talking and interpretation. This approach was specific to the setting and context, and appropriate at the time. Music therapists need to be flexible and not bound to one theory and practice in the 21st century where jobs include working across different populations and environments.

Work with Michael was very different to the next case vignette, where the music therapist was employed as a regular professional in a prison. The late Helen Leith (Leith 2014) worked as a music therapist and researcher looking at how self-concept changed for women prisoners. These women sometimes developed an identity as composers of songs, drawing upon improvised material made jointly by the music therapist composer, and participant. During the making of these songs in music therapy, the music therapist guided the process by using familiar harmonic patterns and idioms from popular music. Without knowing the in-depth case history, listening to a musical example of the session might sound like a *music for health* or *recreation* session. The making of a song with lyrics composed by the woman prisoner participant was the process for therapy. However it is the intention and process that identifies the work as music therapy, and the context and training of the therapist. The therapy was monitored, researched, and formalised; the participant committed to

coming every week, and wanted to gain insight into herself and her life –a form of musical psychotherapy or a psychoanalytically informed music therapy model. The music therapist was again an 'equal' member of the multidisciplinary team.

In this work the identity of the women prisoner patient/participant changed from criminal to reflective composer, and the therapist became an interactive composer. The music, heard from the therapy room by another participant, Ellen, drew her into therapy. She was back on drugs after being clean for 3 years. In that time she had cared for her mother who had terminal cancer. Following her mother's death she relapsed and started using drugs again. She started stealing to fund her habit and was given a short custodial sentence for petty crime. She made contact with the music therapist in the prison for the first time when she heard someone singing "Let it be" by the Beatles in the music therapy room. She burst into the room in tears and explained that that song was sung at her mother's funeral. She made an appointment to sing it herself with the therapist. She started attending music therapy regularly twice a week, and used the sessions to write about her mother in a song, titled 'I couldn't ask for a better Mum' which, as well as providing her with a means of communicating by recording the song, enabled her to show her love to her Mother, and gave her a sense of purpose and achievement. She gained insight and changed her view of herself with the help of the music therapist. This is an example of the compositional role of the participant and music therapist, and the identity of musician for both therapist and participant, within the psychoanalytically informed music therapy approach.

Past present and future

In the forensic field, other recent research must also be celebrated, arising from the UK, Scandinavia and China. Music therapy is particularly significant in areas of

developing empathy, reparation and remorse, the latter often related to the index offence, and to the reduction of depression (Chen 2014). A recent book (Compton-Dickinson, Odell-Miller and Adlam 2013) published in the UK emphasises the importance of new models such as Group Cognitive Analytic Music Therapy (G-CAMT) (Compton-Dickinson 2015). This highlights other recent developments where approaches arising from psychotherapy–based traditions including mentalisation-based therapy (Bateman and Fonagy 2004) are included and embedded within music therapy approaches. In the 21st century new models are appearing such as Mentalisation-Based Arts Therapies, developed with psychotherapist Peter Fonagy within the Central and North West London NHS Trust (CNWL).

The power of music to change dynamic, reflect relationships and to arouse emotion is at the heart of why music therapy has become a recognised treatment for people with mental health problems over the last 55 years. Culminating in a wealth of research and publicised materials, music therapy approaches and techniques include community music therapy, psychoanalytically informed music therapy, interactive music therapy, receptive music therapy, music therapy and song writing, neurologic music therapy, music psychotherapy, and more.

In the UK the focus upon the music therapists' musical identity and high level of ability as a musician is reflected in many previous publications. One of the most recent books, reviewed in this volume (Oldfield, Tomlinson and Loombe 2015) includes over 50 chapters from music therapists all over the world. Focussing upon orchestral instruments and how they are used within music therapy, the book firmly puts active music making at the heart of our practice.

Catherine Carr in her recent NIHR funded research investigates the important ingredients needed for working in music therapy groups for in-patient adults with mental health illness, in NHS settings. Her research identifies which music therapy techniques are most valued. Structured instrumental work and singing are particularly noted as important for this group. (Carr, Odell-Miller and Priebe 2013; Carr 2014).

Music therapy in mental health services in the UK has increasingly focused upon group work, particularly through influences from the therapeutic community movement (Clark 1996). Music therapy has also been broadly defined as including community change or enrichment of every day life (Ansdell 2014), and as helping to improve specific conditions such as communication difficulties, and more widely as aiding the ability to cope with illness or stress. Music is a social activity and when used in groups, members in music therapy can learn more about how to understand others and relate to them – both within therapy and outside in their lives. In their recent book, reviewed in this volume, (Davies, Richards and Barwick 2014), the authors emphasise the relevance of music therapy and groups, the influence of group psychoanalytic theory, and the links between musical structure form and process, with music therapy.

Another development in the last two decades has been that of linking specific music therapy approaches and techniques to what is likely to help most (Odell-Miller 2014). From studying 23 music therapists' practice, we found that structured free improvisation is ranked jointly with composed song as most used for people with schizophrenia most usually in groups. This supports the now well-known Cochrane

review findings (Mossler et al 2011) on music therapy and schizophrenia –that patients' negative symptoms, particularly lack of motivation and isolation, are significantly helped by music therapy. The diagnostic drive in medical fields may appear at opposite poles to community-orientated approaches, but there is room for diverse approaches as long as the rationale outcome and benefits to populations are clear. The recent BAMT conference in April 2016 in Scotland, led by Mercedes Pavlicevic and the BAMT team, will I am certain be a living testimonial to the richness and diversity of music therapy approaches.

After the Second World War, music therapy was defined as a form of help towards lifting mood and encouraging motivation and physical activity for war veterans in the USA and in the UK. Musicians and music educationalists discovered how performance of music made connections, initially with war veterans and prisoners and for children with special needs, and later for wider populations. In the UK this work developed primarily from musical roots, for example through the work of cellist Juliette Alvin and composer Paul Nordoff, who worked in partnership with music educator Clive Robbins. It is striking that during the last half century music therapy has moved from being defined as 'remedial' practice, which sounds rather applied and clinical, to current descriptions that music therapists are 'reflective practitioners' trained in psychological development and treatment delivery (BAMT 2016).

Returning now to the modern role and function of the music itself in therapy, the improvisation model largely practised in the UK can include using composed and pre-composed music, as the music is adapted to suit the people undertaking therapy in the moment. Thus the intention and process rather than the end product is emphasized

within music therapy. This approach is strikingly different from the USA and Australia, where receptive techniques have been more prevalent. Grocke and Wigram (2007) in their book *Receptive Techniques in Music Therapy* show the efficacy of receptive approaches, but their absence in UK music therapy is possibly owing to a strategy and desire by early UK music therapists, to use the highly skilled approaches which other health professionals might not be able or trained to execute, and thus make a strong case for the new music therapy profession of the future. UK music therapists are becoming more interested in receptive techniques and this is likely to be reflected in training courses.

In the closing sections of this essay I want to consider what makes the use of pre-composed music different when used by a qualified registered music therapist, from when applied by a community musician, or performer. I mention this in relation to the UK music for health agenda, whilst examining how music therapists work differently from and together with those also using music in health related fields. In my view the specific identity of music therapy is the intention to use music for a specific therapeutic purpose, and for individually planned outcomes. I would even place the use of composed music within a music therapy session within an improvisation model. The music, whether derived from pre -composed idioms, or from new moment- to- moment ideas, is adapted to suit the people undertaking therapy in the moment. Thus the intention and process rather than only the end product is emphasised.

In this next vignette a composed Scottish folk song is used regularly in twice weekly individual music therapy with a 70 year old lady with dementia. The music therapist

is part of a UK research study which found that improvised music therapy and particularly pre-composed songs adapted for each person in the moment, reduced agitation, raised wellbeing, and changed staff attitude and the environment (Hsu et al. 2015). If readers could see a DVD musical excerpt, they would see and hear the music therapist and patient singing a song (well known to the patient), but the context and intention identify this as music therapy. Memory is stimulated through a process of changing music initiated by the music therapist in response to the woman's distressed behaviour. Her mood is lifted, with skilled subtle musical attunement by the therapist and both end laughing with exuberant matched body language. Physical stimulation and changes in body language are as a result of the jointly created music in the moment. In addition emotional change is apparent, where the woman recognises herself by pointing to her body with the beater when singing 'me'. This interaction has given her a sense of herself through her confusion.

My final vignette considers the changing identity of the music therapist through one long music therapy process. A young woman from my practice with borderline personality disorder in an NHS setting moved from weekly closed group music therapy treatment using psychoanalytically informed music therapy over two years, primarily using musical improvisation, to later work (after the end of the music therapy) with a singing teacher to whom I referred her. Subsequently at follow up she continued her recovery through singing and performing, and also sometimes with music therapy one- off meetings with the music therapist, who accompanied her singing. The early group improvisations helped her to understand her inner world, which led to her becoming discharged from hospital and able to live independently in the community with her three young children. In the music therapy group she

frequently used bongo drums to help herself think about her mood and affect, and also to connect with others in a way which, she said, relaxed her as she did not have to always talk. She had joined a community choir during her time as an outpatient on the unit, and sometimes she talked longingly about wanting to improve her skills as a singer. In two follow-up appointments after the ending of group therapy, she brought songs to show me her progress with her singing teacher and I accompanied her on the piano, reflecting her movement and journey into her much higher sense of worth and esteem, and towards expanding her performances to solo work within her choir. The music became what I would term 'improvised performance', which was informed by her relationship with me as therapist in the past, and in that moment. She subsequently ceased therapy and is managing well in the community, attending the choir regularly studying singing to grade 8 standard, but also drawing upon internalized processes of therapy that she developed in the group setting and through work with a music therapist.

The approach could be situated within a 'music for health' framework, as the singing is a means for recovery. However, the patient worked in collaboration with a music therapist, so this phase could alternatively be defined as activity based music therapy (Odell-Miller 2014), resource-orientated music therapy (Rolvsjord 2010) or Community Music Therapy (Ansdell 2002; Pavlicevic and Ansdell 2004;). This type of discourse and distinction of subtle and highly developed music therapy approaches is common in the twenty-first century, but as discussed elsewhere (Odell-Miller 2014), was less common in the early post-war period where music therapy related clinical and theoretical research, books and journal publications were sparse.

We return here to the question of whether nomenclature, theoretical orientation, or outcome task and benefit for the people concerned in music therapy is most important? Recent research (Carr, d'Ardenne, Sloboda, Wang and Priebe 2013) concludes that group improvised music therapy appears feasible and effective for patients suffering from post-traumatic stress disorder who have not sufficiently responded to cognitive behavioural therapy. Alex Street and Joanathan Pool found results for people with stroke, and improvement of upper limb movement through music therapy (Pool, 2012; Street, Magee, Odell-Miller, Bateman and Fachner 2015). Strange (2013) researched the prevalent but not often addressed phenomenon of non-music therapy assistants in music therapy sessions, and their identity within the musical relationship.

Hospice care work, music therapy with refugees and immigrants, victims of torture, work with adolescents (Derrington 2013); cancer care, cardiology and so many more areas are not discussed in detail here. The modern challenge is to define which aspects of music therapy or approaches are most helpful for which populations and contexts.

To conclude, the many identities of the music therapist discussed in this essay include: a human being, an Allied Health Professional, a musician, composer, improviser, performer; a facilitator, a co-creator, a co-participant, a researcher, scientist and statistician, a philosopher, thinker and analyst, a team member, a collaborator, an ambassador, an informant, an environment changer, a music psychotherapist, and more.

Every music therapist brings their own training and experience, style and musicality into the therapy room, which will determine the essence of the therapy. Music therapy

can maintain its unique musicality and techniques of live interactive connection, with enough free- thinking and creative professional practice which professionalism, including registration has enabled. The international profile of music therapy is higher than it has ever been, particularly when including its influence upon other disciplines such as psychotherapy, musicology, music psychology and allied health professional clinical practice. In the 20th and 21st centuries, there has been a consolidation of the clinical practice of music therapy, a rise in research and associated publications, a consolidation of training, and finally advances in technology in music therapy (Magee 2013). Debates now focus on the place of music therapy in the field and the type of framework within which it should be applied, but there is little question that it is a thriving and robust form of therapy both in the UK and around the world. We can celebrate the current state of music therapy in the 21st century.

Bibliography and References

Ansdell, G. (2014) How music helps in music therapy in everyday life. London: Ashgate ISBN: 978-1-4094-3415-3

Ansdell, G. (2002) Community music therapy and the winds of change in C. Kenny and B. Stige (eds) *Contemporary voices in music therapy: communication, culture and community*, Oslo: Unipub.

Barrington, A. (2008). Challenging the Profession. *British Journal of Music Therapy* 22, (2).

Bateman, A. and Fonagy, P. (2004) Psychotherapy for borderline personality disorders:mentalisation based treatment, Oxford: Oxford University Press.

Carr, C.; Odell-Miller, H., Priebe, S. (2013) A Systematic Review of Music Therapy Practice and Outcomes with Acute Adult Psychiatric In-Patients. PLoS ONE

Carr, C.; d'Ardenne, P.; Sloboda, A.; Scott, C. Wang, D. and Priebe, S. (2013) Group music therapy for patients with persistent post-traumatic stress disorder-an exploratory randomised controlled trial with mixed methods evaluation. Psychology and psychotherapy : research and practice, 85:179-202.

Carr, C. (2014) *Modelling of intensive group music therapy for acute adult psychiatric inpatients. PhD thesis submitted successfully to* Barts and London School of Medicine and Dentistry, Queen Mary University of London

Chen, X. (2014). *Music therapy for improving mental health problems of offenders in correctional settings*. PhD Thesis. Aalborg University, Denmark. http://vbn.aau.dk/da/publications/music-therapy-for-improving-mental-health-problems-of-offenders-in-correctional-settings(2e5fb025-d14c-4ac5-b57a-ec938ffb284c).html

Clark, D. (1996) *The story of a mental hospital,* London: Free Associations.

Compton-Dickinson, S.; Odell-Miller, H.; and Adlam, J. (2013) *Forensic music therapy.* London Jessica Kingsley ISBN 978-1-84905-252

Compton-Dickinson, S. (2015). *A feasibility trial of Group Cognitive Analytic Music Therapy (G-CAMT) in secure hospital settings.* PhD Thesis Anglia Ruskin University, UK. http://angliaruskin.openrepository.com/arro/handle/10540/86082

Darnley-Smith, R. (2013)*What is the music of music therapy? an enquiry into the aesthetics of clinical improvisation,* Durham theses, Durham University. available at Durham E-Theses Online: http://etheses.dur.ac.uk/6975/

Darnley-Smith, R. (2014) 'The Role of Ontology in Music Therapy Theory and Practice' in (eds) Jos De Backer & Julie Sutton, *The music in music therapy*. London: Jessica Kingsley Publishers.

Darnley-Smith, R.; and Patey, H. (2002) *Music therapy*, London: Sage

Davies, A.; Richards, E.; and Barwick, N. (2014) *Group music therapy: a group analytic approach.* London: Routledge

Derrington, P. (2013). *Music therapy for youth at risk: an exploration of clinical practice through research.* PhD Thesis Anglia Ruskin University. http://angliaruskin.openrepository.com/arro/handle/10540/86082

Ettenberger, M. (2015) Music therapy with infants and their parents in the neonatal intensive care unit (NICU) –a mixed methods study. PhD Thesis. Anglia Ruskin University. http://angliaruskin.openrepository.com/arro/handle/10540/86082

Ettenberger, M.; Odell-Miller, H.; Rojas, C.; Serrano, S.; Parker, M.; and Llanos S. (2014) Music therapy with premature infants and their caregivers in Columbia-a mixed methods pilot study including a randomized trial. *Voices* 14 (2) 2014.

Fachner, J., & Stegemann, T. (2013). Electroencephalography (EEG) and music therapy: On the same wavelength? *Music & Medicine, 5*(4), 217-222. doi:10.1177/1943862113495062

Fachner, J. (2014). Communicating change – meaningful moments, situated cognition and music therapy – a reply to North (2014). *Psychology of Music, 42*(6), 791-799. doi:10.1177/0305735614547665

Geretsegger, M.; Holck, U.; Gold, C. (2012). Randomised controlled trial of improvisational music therapy's effectiveness for children with autism spectrum disorders (TIME-A): study protocol. *BMC Pedriatrics* 201212:2. DOI: 10.1186/1471-2431-12-2

Geretsegger, M.; Holck, U.; Carpente, J.; Elefant, C.; Kim, J. and Gold C. (2015) Common characteristics of improvisational approaches in music therapy for children with autism spectrum disorder: developing treatment guidelines. *Journal of music therapy.* 52(2):258-81. DOI: 10.1093/jmt/thv005

Grocke, D.; and Wigram, T. (2007) *Receptive methods in music therapy: techniques and clinical applications for music therapy clinicians, educators, and students*. London: Jessica Kingsley.

Hansard (1997) 6 March 1997: 2026–2029.

Hsu, M., Flowerdew R., Parker M., Fachner J., Odell-Miller H. (2015) Individual music therapy for managing neuropsychiatric symptoms for people with dementia and their carers: a randomised controlled feasibility study. *BMC Geriatrics* 15:84 doi:10.1186/s12877-015-0082-4Published: 18 July 2015

Leith, H. (2014) *Music therapy and the resettlement of women prisoners.* PhD Thesis Aalborg University, Denmark.
http://www.mtphd.aau.dk/organisation/former/helen_leith/

Loth, H. (2015) *An investigation into the relevance of gamelan music to the practice of music therapy* . PhD thesis submitted successfully to Anglia Ruskin University.
http://angliaruskin.openrepository.com/arro/handle/10540/578535

Magee, W. (2013) *Music technology in therapeutic and health settings.* London: Jessica Kingsely.

Mossler, K.; Chen, X.; Heldal, TO.; Gold, C. (2011) *Music therapy for people with schzophrenia and schizophrenia-like disorder.* The Cochrane Library. Wiley Online Library.

Odell-Miller, H. (2014) The development of clinical music therapy in adult mental health practice: music, health and therapy. In V. Bates, A. Bleakley, S. Goodman (eds) *Medicine, health and the arts: approaches tot he medical humanities.* London: Routledge. p.264-280

Odell-Miller, H. (2003) Are words enough? Music therapy as an influence in psychoanalytic psychotherapy. in L. King and R. Randall (eds) *The future of psychoanalytic psychotherapy*. London: Whurr.

Odell-Miller, H. (2001) Music therapy and its relationship to psychoanalysis, in Y.Searle and I. Streng (eds) *Where analysis meets the arts*. London: Karnac Books.

Oldfield, A.; Tomlinson, J. and Loombe, D. (2015) *Flute, accordion or clarinet? Using the characteristics of our intruments in music therapy.* London: Jessica Kingsley

Pavlicevic, M. and Ansdell, G. (2004) *Community music therapy*, London: Jessica Kingsley.

Pool, J. (2012) Brief group music therapy for acquired brain injury: cognition and emotional needs. PhD Thesis Anglia Ruskin University.
http://angliaruskin.openrepository.com/arro/handle/10540/578535

Rolvsjord, R. (2010) *Resource-orientated music therapy in mental health care*, Gilsum, NH:Barcelona Publishers.

Strange, J. (2013) *Improvised music to support interaction between profoundly learning-disabled teenagers and their learning support assistants.* PhD Thesis Anglia Ruskin University. http://angliaruskin.openrepository.com/arro/handle/10540/578535

Street., A. J., Magee., W. L., Odell-Miller, H., Bateman, A., & Fachner, J. (2015). Home-based Neurologic Music Therapy for Upper Limb Rehabilitation with Chronic Hemiparetic Stroke Patients - a Feasibility Study Protocol. *Frontiers of Human Neuroscience*.