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"The Matrix": A Model of Community Music Therapy Processes

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Abstract

This article arises out of my research in a number of consecutive community music therapy projects,[1] and presents the model that resulted from these research periods. It is part of an ongoing study in which I track the development of my own community music therapy projects and explore a theoretical modelling to underpin it. The article proposes a model based on a matrix formation. It begins with a description of the 'matrix model' and goes on to set out the theoretical background, then survey the music therapy research data that led to its formulation. The article concludes with a discussion of how this model contributes to the evaluation of community music therapy practice.

Keywords: Community, music, music therapy, matrix, evaluation.

Introduction

The starting point for this article was a project called 'From Therapy to Community', and is described in detail elsewhere (Wood et al, 2004). The project was a community music therapy pilot that was based in a neurological rehabilitation unit in Aylesbury, South East England. It was set up to provide a programme of music therapy that was structured in three stages: individual music therapy in acute and in-patient medical settings; group music therapy in community medical settings; and finally workshops in arts and other community venues in the town. As people made their own progression in rehabilitation they participated in different 'formats' of music therapy. The creation of formats posed challenges to me as a music therapist trained in the Nordoff-Robbins tradition. I felt a commitment to follow where music led each participant in the programme, and a duty to ensure that each step was safe. I was challenged to conceive of a way in which the vast range of musical experience could fit together, creating a 'joined-up' system that was flexible and responsive to the needs of participants. I came to see that the agencies and disciplines surrounding this work also had to integrate in order to keep the process moving. Theory too needed to provide a meaningful system for reflection. On each level I was tending towards a view that allowed difference *and* unity, was non-hierarchical, networked and ensured an optimum connectedness. In searching for a model for this view I found that the 'matrix' formation allowed a new way of thinking. 'The matrix' is proposed as my response to the challenges of planning, practising and evaluating community music therapy. It is offered in the hope that it may help other music therapists facing similar challenges.

The Matrix

The matrix model arises from a music-centred, culture-based approach to music therapy. It is based on an understanding that the essence of any form of music-making is the way in which music works within and between people. All formats of music-making can therefore become

formats for music therapy, since all formats of music therapy are connected by this common operation of music. A music therapist can identify the most appropriate formats of music therapy for their client, and be confident that their musical work is part of an interconnected matrix of musical possibilities that has its own safety and rigour.

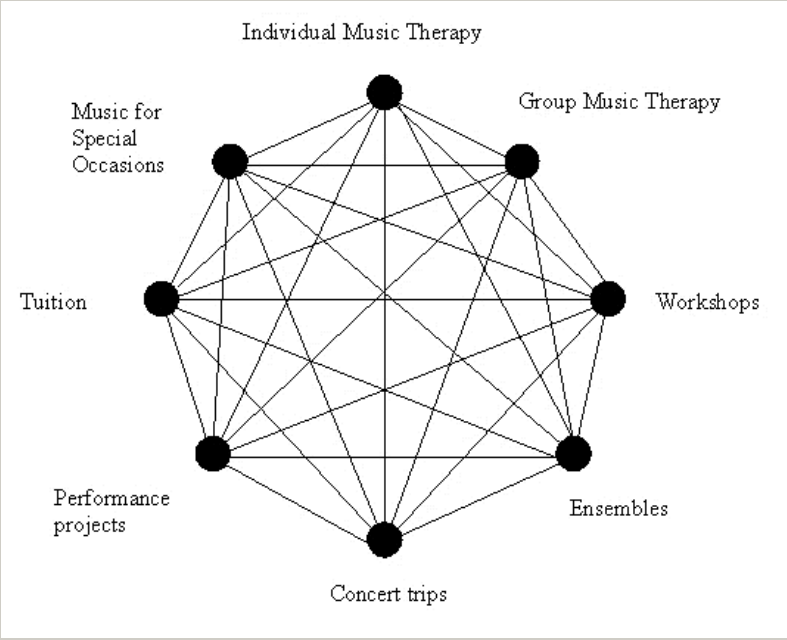
This interconnected matrix of possibilities is constructed by the way in which people are interconnected. It reflects a concept of selfhood that acknowledges shared, as well as individual, experience - what I refer to as 'interdependence' as well as 'independence'. In this article 'interdependence' refers to a state in which the person is separate but not disconnected, achieving full selfhood through experience of community with one or many others. It also reflects the influence of systems theories, and particularly theories of selfhood after postmodernity, which highlight the relationship between individuals and the contexts or systems in which they operate.

This is part of a wider movement in music therapy that has led to a number of new models or theoretical perspectives, including ecological music therapy (Ruud, 1998) and culture-centred music therapy (Stige, 2002). It is specifically allied to the music-centred approach pioneered by Nordoff & Robbins (1974) and to the diverse area of practice that has become known as community music therapy (Pavlicevic & Ansdell, 2004). One way to see the connections between these perspectives is to link them with what Stige (2002) calls a more "*integrative* conception" (p. 19) of selfhood. In this conception a person is not constructed in a series of layers ranging from the particular to the universal, but in a system of relationships between the various and interconnected aspects of selfhood, including biological, social, psychological, transcendent and cultural factors. This concept acknowledges and values the human experience of both independence and interdependence.

Music, like selfhood, is multimodal. It is the subject of a multitude of disciplines. The thinking behind this project involves neurology, psychology, education, sociology, spirituality, biomedical theory, and healthcare. In isolating our theoretical understanding to one field of experience we confine arbitrarily the power of music in our work. The matrix model re-conceives music as the point of connection, and also the evidence, of a system of knowledge and experience. Its starting point is a set of social structures. Music creates social structure, and is also created by it. This symbiotic relationship is at the core of the matrix model. Whether these structures are within an individual, between two people, or among large groups, they are the architecture of music therapy.

The music therapy structures shown in Fig 1 are the formats that arose during the research periods from which this article is drawn. They show traditional music therapy situations, like individual music therapy or group music therapy, but also less orthodox examples, such as workshops or concert trips. Another setting, with another music therapist, would produce a different list. The matrix model is not a way of adding on 'community' practices, such as open groups or performances, to a model of individual music therapy. Its basis is that all formats of music therapy are potentially of equal value, being practical examples of the same phenomenon: the way music creates structure within and between us.

Fig 1. The Matrix Model



Theoretical Background

Two main theoretical sources, neuromusicology and music sociology, have influenced the development of this model. I have found that writers in both fields conceive of music in similar terms: that it works in and between us as a way of organising - not as a function or an object. This way of organising works between us as a matrix for social experience.

Altenmuller (2004) shows how music works both in our individual, inner resources and also "in the organisation of community life and in the forging of connections among members" (p. 26). In music, the two modes of individual and social cannot truly be separated. He points out that in neurology music has long been studied in isolation - in the laboratory - not among people in their everyday settings. Laboratory experiments in the past have isolated functions associated with music, such as code recognition or physical memory, but may have missed the 'real music'. What he calls a person's 'real music' would be quite different from what has been observed under laboratory conditions:

> In summary, as soon as we consider 'real music' apart from laboratory experiments, we have to expect individually formed and quickly adaptive brain substrates, including widely distributed neuronal networks in both hemispheres. In our laboratories, we are just beginning to face the enormous challenges linked to the clarification of rules determining this puzzling variety of findings, determining the complexity and transitoriness of neuronal interactions during music processing (Altenmuller, 2003, p. 352).

In other words, 'real music' is music made in regular settings, among people. 'Real music' draws on widespread parts of the brain, in unpredictable ways, and in ways that are adapted to each individual in their context.

In another sense, music is considered by neuromusicologists to be universal not because everyone in the world makes it, but because we all operate musically (Munte, Altenmuller & Janke, 2002; Peretz & Zatorre, 2003; Altenmuller, 2004). If there is something universal about music it is our common musicality rather than our common music practices - *the way* music is made out of the connected operations within and among us rather than *what* is made. Similarly, Cross (2001a) writes that music is "universal yet multifarious" in that it is common to all, interdependently created, and simultaneously is experienced individually.

This requires us to work to a concept of music that responds to the context-bound varieties of musical experience, and yet depends upon how music works in and between us all. The precise nature of this universal musicality is of course harder to define. The consensus in neuromusicology suggests that music is not simply another function - it does not have a 'centre' in the brain - but rather a varying and overlapping set of neuronal relationships which work in a matrix, drawing together multiple and varied functions or operations. It is this organisation of relationships that characterises something as music. A key influence on this view is the idea of *modularity* (Zatorre & Peretz, 2003, for example). In this concept, the different parts of music are processed in not only different parts of the brain but also in different levels, creating separated, overlapping, and interrelated patterns.

Musical operations within people are considered to be variously independent and interdependent. They both create, and are created by, the connections between parts of the brain. They occur in the many actions we associate with music - playing, singing, listening and dancing (Cross, 2001b) - and provide the basis for social interaction.

The operation of music between and among us in social interaction is also to create, and be created by, the connections between people. Music helps to structure individual action, and also group organisation, ideas, or experience in similar ways. This also is influenced by the context in which it occurs and the individuals involved. Music sociologist Tia DeNora describes social life itself as a web within which music is a formative feature. She writes that for individuals "music provides a basis or reckoning, an animating force or flow of energy, feeling, desire and aesthetic sensibility that is action's matrix" (2000, p. 152).

Music provides this matrix for human action through the properties or in DeNora's term "affordances" (2000, p. 39) it holds. This marks an exciting shift away from concerns about what music is *about* to what it *makes possible*: "And, depending on how it is conceptualised, the concept of 'affordance' highlights music's potential as an organising medium, as something that helps to structure such things as styles of consciousness, ideas, or modes of embodiment." (2003, p. 46). This property of human structuring creates community in the same flow of organisation.

The idea of music as an organising medium, whether within or between people, is a core foundation for this model of community music therapy. Music's structural properties arise out of interdependent or shared experience whether that is in the realm of basic object relations or in sociological terms. In this way a person can participate in community music therapy even if they are in individual music therapy.

In music therapy accounts dating back to the 1970s (Pickett, 1976; Dickerson 1982, Odell-Miller 1995) music is described as something that mediates the relationship between individuals and communities. They acknowledge that for each person, music therapy touches upon 'inner', and also 'social', processes. Is it too ambitious to aim for impact both in the individual, inner world or functioning of a person and also in their social or 'political' life? Stige (2002) describes several projects that seem to deal with these parts of life as inseparable. In doing so, he points to the variety of properties possessed by music:

> Music is incredibly multifaceted; it is an acoustic phenomenon, it is a mode of expression with its own syntactic rules, it is a symbolic medium, and it is a tool for action and interaction in social contexts. Music may trigger physical reactions, emotions, association, and memories; and it may function as a personal, social, or transpersonal space (Stige, 2002, p. 49).

In recent music therapy literature, 'community' is a term that also refers to political status or citizenship. This again derives from an understanding of music as something that mediates the individual and group. Ansdell (in Kenny & Stige, 2002) relates this in the following way:

> The main agenda of Community Music has been the re-creation of community by providing opportunities for musical participation... The discourse is often a social and political one, setting an agenda for work with geographically - or socially-defined groups who suffer marginalisation... An important strand of this thinking considers how the individual and the group relate in contemporary society, and what role music-making has in the changing relationship between them (Ansdell, 2002, p. 116).

The musical structures that create and also result from the interplay between the individual and the group are the tools of our trade. In practice, the challenge is to build a way of using these tools in a safe and effective way.

Music Therapy Illustration: 'Pam'

This article draws from one project that set out to address this challenge. It was a community music therapy project with people living with neurological disability, and it offered a range of music therapy formats for people at diverse stages of recovery or rehabilitation. The individuals involved were mostly people who had been patients in the medical setting, but in time their carers, other staff and interested professionals also became participants in the work. This article will use as illustration the experience of one participant, 'Pam'.

Pam had participated in each stage of the work, starting as a client in individual music therapy,

joining a small group at the medical setting, and then joining a workshop course in a community setting and ultimately leading a large performance project. She was a bright, intelligent lady in her mid-fifties who had developed unusual neurological phenomena late in life. She suffered particularly from migraine, double vision and a tremor in her right side, all of which were a puzzle to her neurologists. She remained 'undiagnosed' for the duration of her time on the project. In contrast with her medical status, Pam achieved a personal transformation from being a patient in the hospital into being a creative participant in the local community.

To help me monitor this work, the project needed a model of music therapy that would provide an overview for planning purposes, and also enable detailed analysis for evaluation at all stages. I will bring examples from Pam's music therapy experience to illustrate the development of the broader model and the evaluation tool that followed.

Pam introduced herself to me during a lunchtime improvisation session at a conference:

> "I want to know what I can still do"

With her right hand in a dramatic tremor she proceeded to play drums, gongs, congas and even piano, in a large room of people milling by. She was hooked immediately. A period of two years followed, in which Pam attended individual sessions in the rehabilitation unit. This was a rich, intense experience in which she made core discoveries about her self, her potential and her musicianship. Pam was particularly reflective about her experiences in music therapy, making detailed, insightful comments about the process as we went along. It emerged that Pam had been trained in her youth on the violin and piano. She did not consider herself to be a 'proper musician' because she could not play repertoire. Consequently she did not consider improvised and contemporary music to be 'proper music'. As time went by, Pam came to hear all of her playing as music, to understand her own unique musical organisation, and to let music draw together the parts of her that she felt to be irreconcilable.

She began to pursue musical interests outside of sessions in addition to her work with me. This led her to attend drumming workshops and vocal classes independently, although with my knowledge and after consulting me. She also began to attend concerts and buy recordings of a diverse range of music, learning diligently about certain African musicians and western composers. In all, Pam became an independent, active music lover.

Workshops and SCRAP METAL

During one reflection on her process in individual music therapy Pam said this:

"When something like this [the onset of tremor] happens to you it can feel like you have been thrown on the scrap heap of life. Music makes you feel beautiful again."

We began to talk about how music was bringing her back "off the scrap heap", and whether other people felt the same. She felt certain that they would. During her brief group music therapy stage she raised this with the other members of the group, all of whom identified at once with the feelings she described. They had a brilliant idea.

The group knew that their workshop stage was approaching, and decided that the scrap heap would figure heavily in their plans for the workshops. With me, they would visit the local scrap heap, in search of metal that had been discarded and left to rust. They would seek out the music in the scrap metal, retrieving whatever objects they could from the scrap heap and transforming them into instruments that would be played in a public concert. Between these visits to the scrap heap, they would have workshops in styles and aspects of music which were of interest, and which may help them find more music in the discarded metal they were collecting.

Early one misty morning we joined the crows and the dump trucks at the scrap yard and began our workshop course. Ten weeks later we had built an ensemble that contained amongst other things a plough, an old washing machine wheel, a bicycle, three metal buckets and some chains, a collection of wine glasses, and the front of a car. Pam had helped to organise visits, she had consistently heard tone and timbre in items which nobody else would value, she had planned and participated in workshops, and she went on to help organise and perform in a public performance of the 'scrap metal ensemble' before an audience of 120 people.

Pam's musical work had gone far beyond the individual inner structures that had been the focus of our early 'individual' sessions. She was reconciling elements of physical coordination, cognitive organisation, self-knowledge, emotional response and social agency through her experience of herself in the varying states of independence and interdependence that music

provided. These realms of experience stayed with Pam through joining a group, into the social and creative organisation of a large public workshop course and concert. Music had been the constant organising medium whether that was within her own inner life, or in the public sphere as part of a musical community.

An Example: The Theremin Workshop

One workshop we arranged during this period was a theremin workshop on 21st May 2004. Led by Larry Smith, a local rock musician, this workshop theme had arisen from the group's interest in theremins and electronic music. A theremin is a unique musical instrument comprising antennae and electrical circuitry creating radio frequencies. The player moves their hands next to the antennae and through variation in distance creates changes in pitch and volume. The sound is a haunting, pure radio frequency which does not emulate other sounds, as in the case of Soundbeam, but has a distinct electronic quality.

Present at the workshop were three former patients including Pam, two carers and two music therapists. We were using a church ante-room, which was open to the main church but closed on two sides by a large curtain and a wall. People visited the church while we had the session, and the caretaker was setting up chairs for the weekend services. I noticed first what an unusual scene this was for a modern music therapy programme. Rather than being in a hospital or rehabilitation unit, we were working in a parish church, not only a 'community' venue but also one with a religious function. The workshop had a clear agenda: to play the theremin, to learn its musical uses, and to develop skills in playing it.

In the theremin workshop I noticed particularly how the participants were an interdependent unit in the way they organised the structure of the session and the arrangement of the instruments. I also noticed the influence of my playing on the piano both to provide a musical form and to focus on individual people. The workshop leader was treated as a welcome member of the group from the beginning, being invited to improvise with everyone first, perhaps creating a certain sense of being in the group - listening and valuing - before moving on to his specialism. This invitation came from the group, rather than from me. I was also amused at the end of the first improvisation to hear the group respond to the caretaker's noisy trolley by inviting him over to play it in their ensemble!

Most workshops were videoed for research purposes. In my notes from the analysis of the tapes I described how the group was utilising musical structures in different ways during a workshop. This is an example of my notes from that stage of research:

Fig 2: Example of notes from viewing video footage.

1.0	participants organising the first distribution of instruments, making an initial organisation - trying out new sounds on the scrap metal instruments, hearing musical structure in 'non-musical' objects agreeing on structure, choosing an instrument → organising the improv
5.40	Piano (SW) starts, gospel / jazzy style. Participants joining independently and don't need direct individual attention to maintain playing
7.50	pulse removed on piano - leads to shakes, tremolos and more careful listening among group. note eye contact and gesture at this point. Focus on melody on Swannee Whistle.
9.0	pulse returns, and focus on Glockenspiel. This is the workshop leader playing - he has been given a place within the group through this.
10.30	improv ends, without my prompting; shared ending. Caretaker rolls trolley across floor - makes interesting sound, and group remarks that he should join them and play it - a shared musical perception.

Further into the session, Larry demonstrated the theremin, showed how it works and invited participants to come and try. They asked questions, eager to learn about its sounds, gaining knowledge and skills as a natural result of their interest and confidence. I noticed that at this point I suggested an exercise between two participants. I suggested that one participant played the theremin, and another played the footpedal that changes the sound effects. Larry remained as the expert and organised with the participants how to set up the experiment. I was interested to see how easily a musical exercise can become a musical piece, changed from one to the other simply by the quality of attention of the players.

The group then decided to have a teabreak, in which they made drinks and ate cakes one member had brought. Here are my comments from my notes:

Fig 3: Extract from tea break notes.

Tea break	
40.0	tea. What happens during this break? Is the conversation different? It is specific - about music. They ask questions and make remarks which are related to what they have been doing. They give more time, perhaps listening more? And there is more calmness. Sound of children in the church. We can hear them - so they can hear us playing. Reminds us we are in an open environment. They discuss what they might play next: perhaps a "Fantasia on Happy Birthday" for one participant...

After the teabreak, a further two improvisations followed, including different participants playing the theremin and others on different instruments. Here the group incorporated what it had learnt into the existing body of experience and knowledge. It had a musical vocabulary and thus a boldness to embrace new sounds, challenging techniques or strange musical references into its experience.

In workshops like this, music afforded a vast range of actions. My video analysis brought out a list of things which music seemed to be making possible in those times. The list contains features of independent and interdependent structure:

Fig 4: List of actions from workshop analysis.

- a reason to meet
- a medium of organising socially
- a framework for structuring interaction from moment to moment
- a mode of paying attention
- a different way for participants to listen to themselves, each other and the world around them
- a means of welcoming and drawing people into the group
- a social form which allows independence and dependence to balance - ie, interdependence
- a social form which both values and demystifies musical skill
- a social form which is both specialist and normal
- a form of learning
- a source of pleasure and motivation
- a mode of equality between 'consumers' (clients, learners) and 'providers' (therapists, experts)
- a matrix for accessing functional ability and skill
- a source of confidence
- a new way of listening to themselves, each other and the world
- a different forum for verbal interaction.

In addition to video analysis, the research included interviews with participants. In interviews I was interested in what participants thought about what they were doing, and how they benefited from doing it. I asked whether Pam felt she was in a learning situation or not, and whether the role of workshop leader contributed to that. In individual interviews Pam said, "The workshop leaders don't feel at all like teachers. It doesn't feel patronising, and it feels like we are bringing our own things, and it doesn't matter what role."

I wondered also whether the 'public' status of the workshops inhibited a personal involvement for participants. Pam described how the workshops had a 'social' aspect, but this concerned its role in the town. Its status as a 'community' venue contributed to its effectiveness. Still, Pam felt she was also using the groups for personal growth within a fairly 'public' situation, and confirmed that "We could express our 'inner voice' in a social event".

I was also interested to hear her speak of the social or political nature of a group like this, in which music is the reason people meet. The workshops had a 'normal' but 'specialist' nature, catering for people with certain limitations but also being something that could compete with the cinema on a rainy afternoon! She told me "There are so many groups that you can't belong to because you're disabled. Most things, still, you can't do."

In addition to having workshops that held their own against other social activities in the town, an important concern for me was whether the participants themselves felt there was a 'therapeutic' benefit to the workshops. What good did they do? Clearly participants felt that this was something they could attend with confidence and also benefit from individually. Her final comment reflects the overall aim of the community music therapy programme: "The workshop feels like moving back into the world."

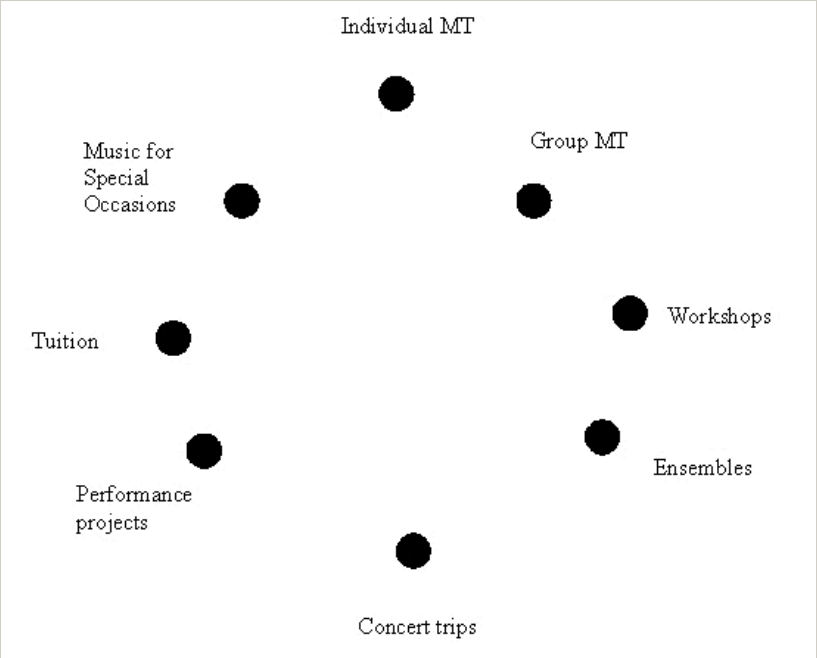
Part 3 explores how participants' experience links with the matrix model. The process of "moving back into the world" began for Pam in individual music therapy and moved between formats of music-making held together by the practical and theoretical possibilities of the matrix arrangement. Her reflections upon this process contributed to my thinking about the matrix principally because she did not discriminate between forms of music-making. For Pam, music is music. I was aware that my own preconceptions could interfere with her musical development if I were not open to change. By following where music led us both, we were brought into new territory. The prime consideration during this process was to ensure that the pathways were safe for all participants. To keep an overview of this experience, I felt I had to use a new approach to evaluation. I could not rely on traditional models that did not include the formats we now included, and I could not take a model from one theoretical background (such

as biomedical theory or psychoanalytic theory) without precluding change and development in another area of experience. I had to take a 'matrix view' of Pam's musical experience in the evaluation.

A 'Matrix View' of Evaluation

Across the range of work included in these projects, all of music's properties were of potential therapeutic use within sessions. Equally, all of its formats were potential therapy situations within the programme as a whole. How was I to think about this diverse work? How should I plan a programme out of all this potential activity? And how would I evaluate it to ensure it was effective? I found it helpful to focus on the formats in which music therapy happened, and draw them like locations on a map:

Fig 5: The formats in which music therapy was organised



In this diagram each dot or 'node' is a 'format' in which music therapy took place. Already I noticed that I had not listed formats in a pre-decided order of priority but I had spread them equally in a circle.

My research had suggested that all formats of work carried therapeutic impact, but that this took different qualities for different people and in different contexts. It suggested that the essence of what music does in individual sessions is carried over into workshop courses or performance projects, in that it draws people together within themselves and then works to draw them together among one another. From my perspective, the only available evidence of effectiveness was in the quality of musical structures we created, whether they were as small as a drumbeat or as vast as a public concert. I could be sure, given my concept of music, that our work itself would draw together the diverse areas of experience within and between the participants. My role was to create and protect useful formats for making music.

In practice, three principles became central to the way I created and monitored the work. These were:

1. All music therapy formats make use of the properties of music, which are common to all music-making.
2. Participants do not necessarily follow a single linear route from one format to the next, and some participants can be engaged with several formats in the same programme.
3. The music therapist needs to oversee all the formats in music therapy programme whether or not he is delivering them all himself directly.

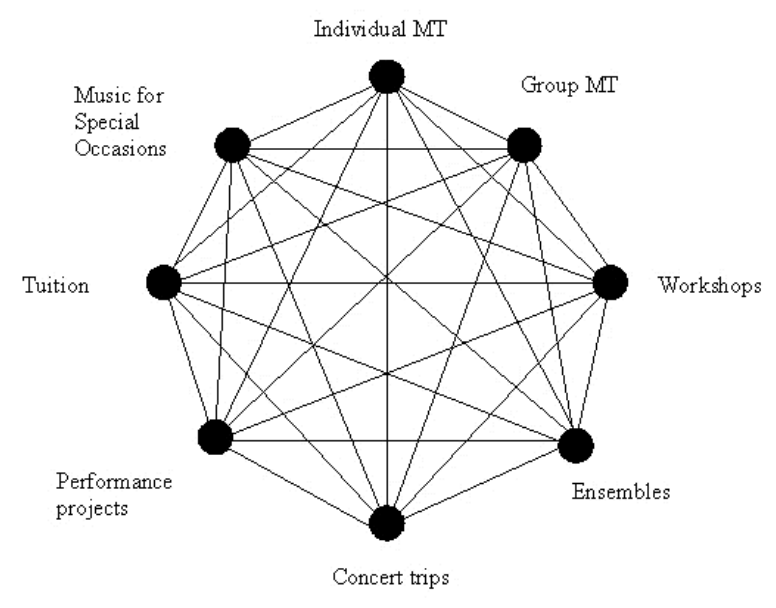
For the purposes of planning a programme, the matrix model offered conceptual possibilities which other models did not, and could accommodate these principles easily. First, there is no centre or hierarchy to the matrix. Just as neuromusicology shows that music has no 'centre' in the brain, but relies on a network of relationships and modules, so the matrix allows us to conceive of a music therapy programme in which there is no 'centre', or vertical hierarchy of formats. Instead of a hierarchy there is what Schrag (1997) refers to as a "transversal unity" (p.

133). He describes this as "an achievement of communication as it visits a multiplicity of viewpoints, perspectives, belief systems, and regions of concern." (p. 133). He suggests:

> ...this harmony and unity cannot be achieved via a vertically ordered and hegemonic decision-making arrangement that simply subordinates the lower to the higher. Nor can, of course, decision-making be left to the autonomy of horizontally serialized groups...what is required is a transversal ordering and communication that is achieved through a diagonal movement across the groups, acknowledging the otherness and integrity of each while making the requisite accommodations and adjustments along the way (Schrag, 1997, p. 132).

In this project the idea of transversal unity relates first to the practical formats of music-making but also to the need for multidisciplinary work, multi-agency networks, and for theoretical integration. The matrix model enables a 'bird's eye view' for the purposes of evaluation, service development, and theory. It meant that one person's movement from individual music therapy to a choir and then to a workshop course represented development and progress, but that for another person progress might be represented by the opposite. All would depend on the relationships between the aspects of music experience being drawn together along the way. In a final working diagram I joined all the nodes together in a web of optimal interconnecting relationships:

Fig 6: The 'Matrix model'



In this final working model all the nodes are connected. This reflects the many possibilities for participants to make their own progress in music therapy, from one format to another. It also reflects the idea that music is the unifying, organisational principle within and among us in these contexts. Both the connections, and the nodes on the matrix, are the music.

While the matrix model gave perspective to the overview of the community music therapy programme, there was a need to integrate the independent and interdependent categories of musical experience into an evaluation tool. The project needed a model that was based on the same concept of music: that could identify both an individual's experience in a group situation, and also interdependent experiences in individual sessions.

There are shades of this approach in the original Nordoff-Robbins rating scales. The 'Musical Communicativeness' scale for example refers to a "Commitment to musical objectives in group work" in which the participant no longer needs the musical connection of individual music therapy but may still use group music for "individual creative expression":

> The child has outgrown the need for, or scope of the particular kind of musical interactivity that individual therapy provides; occasionally he may use a musical situation which lends itself to individual creative expression. When appropriate, formal individual musical instruction can take over...Any personal dependence upon the therapists an individual child might still have diminishes under these conditions. He becomes an independently contributing member of a working group, sharing pleasure and interest with others and feeling pride in his own accomplishments (Nordoff-Robbins, 1977, p. 187).

In this level of work the participant's therapy occurs in their independent contribution to an interdependently held objective; and often in their experience of making that contribution. This led me to think of evaluating the work in the two modes of being: independence and interdependence. When this view is used to structure the elements of musical experience in an evaluation tool, it creates a list with two categories of criteria. Each category could be of application in many different formats of music therapy:

Fig 7: Working list for Community Music Therapy rating

Independence

- Physical:
  - organisation,
  - flexibility,
  - continuity,
  - strength.
- Cognitive:
  - awareness,
  - responsiveness,
  - organisation,
  - initiation.
- Communicative.

Interdependence

- Role.
  - Shared interpersonal goals.
- Musical interests pursued outside sessions.
  - Participant values opportunities for independent music-making outside sessions.
- Composition and public performance.
  - Participant has new confidence and a new role which enables public performance or composition.
- Motivation and framework to meet in social formats.

This emerging evaluation tool relies on the concepts and values of the traditional Nordoff-Robbins Rating Scales (1977) in which the individual and group settings are explored with compelling insight. My concern was to examine aspects of the interdependent mode more carefully, particularly for situations in which adults met in community settings. In Appendix A the implications of this for a rating tool for workshop sessions, or other such community structures, are explored. How this structure works for the daily practice of charting a participant's music therapy will be explored in future publications.

Does this approach require us to change as music therapists? Does it demand an expansion of music therapy skills? Or are people doing this already? In the research periods, I identified a list of skills that had become important to the work. I suspected that they are in fact common among music therapists, but that some are perhaps less valued or practised. The list is as follows:

Fig 8: Emerging list of skills and competencies

- Using improvisation, and repertoire with an improvisational attitude.
- Accompanying.
- Working with a learning focus.
- Thinking ahead into the programme: planning courses, etc.
- Facilitating a workshop led by someone else.
- Training / choosing workshop leaders.
- Structuring sessions.
- Creating appropriate performance opportunities.
- Collaborating with other agencies eg media, social services, local arts bodies, churches, community venues.

I expand on this list in Appendix B.

Many music therapists use these skills and more every day in their work, but sometimes without recognition. For some music therapists there is a level of anxiety about the use of musical skills that do not figure in the classic model of their training, and for which there is no existing evaluation to ensure safety. This is my response to these anxieties and to the everyday issues that arise from them. I hope it shows that the scope of music work is something to embrace, and our musicianship something to unleash.

Notes

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APPENDIX A

There is a level of interdependent work that is not elucidated in music therapy literature. This refers mostly to work that goes on within tuition, instrumental groups, or workshop settings. The specific challenge here is to address levels of development in this area of work. This "Interdependence List" is a working attempt to include the range of development in workshops or similar activities. It draws heavily on the Nordoff-Robbins Rating Scales, which formed the basis of my own music therapy training.

- Motivation and framework to meet in social formats.
    - Participant prefers or is able to meet in a social setting.
    - Participant agrees to meet in a social setting.
    - Participant takes responsibility to meet in a social setting.
- Role.
    - Participant acknowledges shared musical objectives.
    - Participant takes responsibility for shared musical objectives.
    - Participant becomes fully collaborative in initiating and realising shared musical objectives.
- Musical interests pursued outside sessions.
    - Participant sees opportunities for independent music-making.
    - Participant seeks out opportunities for independent music-making, and takes opportunities with support of therapist.
    - Participant develops an ongoing musical life without support of therapist.
- Public musical performance.
    - Participant has confidence to join a musical structure which works towards public musical performance.
    - Participant takes responsibility for musical structure which works towards public musical performance.
    - Participant is fully collaborative in initiating and realising public musical performance.

These criteria could be scaled as follows:

1. **Willingness to work in a social setting**.
   The participant prefers or is able to meet in a social setting, acknowledges shared musical objectives, sees opportunities for independent music-making, and has confidence to join a musical structure which works towards public musical performance.
2. **Responsibility for shared musical work**.
   The participant agrees to meet in a social setting, takes responsibility for shared musical objectives, seeks out opportunities for independent music-making, and takes opportunities with support of therapist, and takes responsibility for musical structure which works towards public musical performance.
3. **Full collaboration**.
   The participant takes responsibility to meet in a social setting, becomes fully collaborative in initiating and realising shared musical objectives, develops an ongoing musical life without support of therapist and is fully collaborative in initiating and realising public musical performance.

APPENDIX B

A Community Music Therapist's Skills and Competencies: the wish list

- **Clinical thinking**.
    - Identifying therapeutic change in any mode of experience
- **Using improvisation, and repertoire with an improvisational attitude**.
    - Clinical Improvisation with individuals and with groups of people;
    - Clinical use of repertoire with improvisational attitude - allowing the music to form, and be formed by, the interdependent structures of the session;
    - Clinical use of musical formats to create opportunities for social organisation or action
- **Accompanying**.
    - Accompanying people in a variety of formats, eg Learning solo songs, working in a choir, in performance, in workshop settings

- **Working with a learning focus**.
  - Enabling participants to acquire specific musical skills
  - Responding to intellectual interest appropriately
- **Thinking ahead into the programme: planning courses, etc**.
  - Identifying musical styles, interests or skills which can be developed in further stages
  - Identifying new formats of work which will fit the context and specific needs of participants
- **Facilitating a workshop led by someone else**.
  - Training / choosing workshop leaders
  - Keeping a helpful distance, being in and out of the session
  - Intervening collaboratively
  - Ensuring safety of participants
- **Structuring sessions**.
  - Responding to needs of participants in structure and management of sessions
  - Being open to change and opportunities when they arise
- **Creating appropriate performance opportunities**.
  - Setting performance as part of the music therapy programme, not the end of it
  - Ensuring performance is manageable and has a therapeutic goal
  - Setting up expectations of performers and audience
- **Collaborating with other agencies e.g. arts bodies, churches, community venues**.
  - Setting realistic budgets
  - Maintaining communications
  - Valuing other agencies' language and norms
  - Seeing potential in collaboration
  - Informing other agencies of clinical considerations responsibly

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