The relentless roots of community music therapy

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Community Music Therapy?

In the recent World Congress of Music Therapy in Oxford, one of the comments I heard from several music therapists were: "I didn't know that I was working with community music therapy, but now I know that I do." They were responding to Gary Ansdell's (2002) article in *Voices*, 2(2), as well as to the many discussions about community music therapy in this congress.

The purpose of this essay is to put this new interest for community music therapy in context by reviewing some relevant literature that can give a historical backdrop as well as some directions for future developments of the field. A review like this is of course related to the question "what is community music therapy?," which is a question I consider impossible to ask in a completely innocent manner. As author of the essay I do not start from scratch, asking for instance "is community music therapy a model of practice, an area of practice, or a new paradigm for music therapy?" without having a preliminary understanding

I consider models of music therapy to be linked to specific originators and/or specific theoretical positions, to be shaped for specific client populations or clinical needs, and to be characterized by specific procedures and techniques (see for instance, Bruscia, 1987). This seems not to be the case with community music therapy, which - from the verbal and written accounts I have encountered - could rather be described as a range of related ways of working, relative to each community.

Neither have I chosen to discuss community music therapy as a new paradigm for music therapy. While paradigms[1], schools, or theoretical forces in music therapy are important to discuss (Bruscia, 2002), I consider community music therapy as a concern with real world challenges, related to questions such as "What is the relationship between music therapy, community, and society (and what do we want to do with it)?" While community music therapy by some scholars may be considered the theory and practice of an emerging paradigm, and while I think this is an interesting idea to consider, I have chosen not to treat community music therapy as a paradigm in itself.

Instead I am treating community music therapy as something that is closer to an area of practice, to use a term from the music therapy literature[2] Kenneth Bruscia (1998a, p. 157) defines an area of practice in the following way: "An area of practice is defined by what the primary clinical focus is, or what is the foreground of concern for the client, the therapist, and clinical agency," and he continues by specifying that of particular relevance are: the priority health concern of the client and of the agency serving the client, the goal of the music therapist, and the nature of the client-therapist relationship. This illuminates how I am starting with a pre-understanding of the concept and phenomenon I am exploring. The argument then goes in a circle, but I consider it a hermeneutic circle, a circle that may lead to deeper understanding.

For the purpose of clarifying my pre-understanding, I will present a definition taken from *Culture-Centered Music Therapy* (Stige, 2002b), a text that tries to clarify implications for practice, theory, and research of taking a culture-inclusive meta-perspective to music therapy:

**Community music therapy:** Music therapy practices that are linked to the local communities in which clients live and therapists work, and/or to communities of interest. Basically two main notions of community music therapy exist: a) music therapy in a community context, and b)
music therapy for change in a community. Both notions require that the therapist be sensitive to social and cultural contexts, but the latter notion to a more radical degree departs from conventional modern notions of therapy in that goals and interventions relate directly to the community in question. Music therapy, then, may be considered cultural and social engagement and may function as community action; the community is not only a context for work but also a context to be worked with. Both variants of community music therapy suggest the relevance of project-oriented approaches in which sometimes the therapy process of several groups or individuals may belong to the same community music project. Project-oriented approaches usually require untraditional therapist roles and tasks (including project coordination, interdisciplinary consultation, and local political information and action). Community music therapy requires a broad spectrum of inter-disciplinary theory in order to be well founded, and relevant models of research include ethnography and participatory action research (the latter being especially relevant for the more radical definition of community music therapy).

Community music therapy is necessarily ecological, since individuals, groups, and communities function in and as systems (Stige, 2002b, p. 328).

Purpose and Choice of Focus

As already stated, the purpose of this essay is to review some relevant literature that can give a historical backdrop as well as some future directions to the emerging interest for community music therapy. What is new about community music therapy, and what are possible roots of community music therapy?

This elaboration at times will be made in comparison with what I have chosen to label “conventional music therapy.” The term “conventional music therapy” is of course vague and somewhat problematic, given the fact that music therapy is practiced and discussed in a multitude of ways. The conventions that I refer to by using this term are: To examine symptoms and health problems at the level of the individual, to focus the interventions at the same level, and to work within the boundaries of a “therapeutic space” (a clinic, institution, or private office).

Because of place limitations I have decided not to include British literature in the literature review. This is in fact a paradoxical choice, since British music therapy is probably the context in which community music therapy currently is most discussed. Already in 1968, Juliette Alvin reflected upon the “Changing Patterns in Music Therapy - The Mental Patient and Community Care in England,” and in one of the more influential British textbooks in music therapy - *Music Therapy. An Art Beyond Words* - Leslie Bunt (1994) devotes one of eight chapters to a discussion of music therapy as a resource for the community. Also, one of the most influential scholars in the British music therapy discourse recently published a discussion paper about community music therapy (Ansdell, 2002) in this journal, and scholars such as Procter (2002) and Sutton (2002) have from different angles produced convincing arguments for a “new” music therapy, possibly one that could be labeled community music therapy. British music therapists therefore have contributed considerably to the current increase in interest for community music therapy. Another characteristic feature of the British situation is that music therapy has attracted interest among scholars of other disciplines, more so than in most countries. Four recent books that could count as examples of this are Gouk's (2000) discussion of music healing and music therapy in cultural contexts, Horden's (2000) discussion of the history of music therapy, DeNora's (2000) sociological treatment of music (including music therapy) in everyday life, and Boyce-Tillman's (2000) attempt to develop a general theory of music's relationship to health and therapy. All these recent texts demonstrate awareness of the role of music not only within healthcare and education, but also within society and community.

The exclusion of British literature in this review is therefore due to place limitations, and not to an evaluation of its value. On the contrary, the recent British contributions have been prominent and may be considered a very important context for the review to be made here. When closing the essay through an outline of what I have chosen to call “the relentless roots of community music therapy,” references to the British literature have been included.
Selection of Literature

Since the term community music therapy is not established in the literature, a search in electronic databases, through use of "community music therapy" as keyword, did provide me with only a few results and could not give me a representative starting point. A broadening of the search, by using "community" as keyword showed that there has, in fact, been considerable interest for and use of this term among music therapists. A term is not a concept, though, and there is a large range of foci in the music therapy texts that include the term "community." I do not find it relevant to try to give a comprehensive treatment of all articles and texts using this term. Instead, I have been searching for texts that go beyond the clinical and individual focus of conventional modern therapy and that include awareness about sociocultural processes. The result is that many of the texts to be discussed do not even use the term "community". Instead, some of the authors are use terms such as "social music therapy," "music environmental therapy," or "ecological music therapy."

I have ended up with the use if three main approaches when searching for and selecting literature: First, I have searched databases of literature, using a broad range of related keywords, such as milieu therapy, sociotherapy, and social therapy, as well as environment, context, and culture. Second, I have used my own knowledge of the field - gained from several years of working with, reading about, and discussing these issues - as a guide. I have followed clues I have had ("didn't someone write something about this in that journal sometime in the early 1990s," things like that). Then I have searched for information through indexes, reference lists, databases, and personal contacts. Third, I have asked colleagues for help. I have had a reasonably good international network of colleagues to ask, a network that has been growing rapidly due to the recent boom of interest for community music therapy, as evident both in recent congresses and from the contributions in Voices.

Because of language and space limitations I have decided to concentrate on literature from Germany, Norway, and the US. These contexts have been chosen because it was possible to find a tradition of relevant literature, that is, in these contexts there have been several authors writing about related issues over a number of years. As expressed above, the British literature would warrant an inclusion in the review, but has been excluded due to place problems and due to the fact that several of the British contributions are easy to get hold of since they are recently published. I hope that the reader will consider them as a context for this essay.

The choice of countries - which undeniably is "ethnocentric" in that no countries from Asia, Africa, Oceania, or South America have been included - is therefore a practical and technical one in relation to this study. It is not based upon a value judgment on which traditions of practice are more important. I will, for instance, underline that some South American music therapists demonstrate awareness of cultural and social issues in ways that would be relevant to the discussion (Barcellos, 2002; Schapira, 2002), but due to my own language limitations I have not been able to go deeply into the South American literature. My judgment is that for the development of a healthy scholarly discourse on community music therapy, contributions from more countries and continents must be included in the future.

The following is therefore in no way intended as a comprehensive presentation of literature on music therapy, community, and society. From the countries I have chosen to focus upon, I have selected authors that have approached these issues from different angles. In this way I have tried to draw out a sufficiently elaborated picture in order to be able to contextualize as well as focus this study. In presenting the authors I have tried to make their own voices perceptible through use of quotations. The degree to which this has been feasible has varied considerably, both because several of the texts to be presented are written in other languages than English and because some of the ideas to be presented are synopses of longer arguments.

German Literature

Some of the influential music therapists in Germany, such as Hans-Helmut Decker-Voigt (2001), started their careers as teachers in social education, and there is a relatively strong tradition for discussing social and political dimensions of music therapy in the German literature, including critical discussions of music, music therapy, and society (Geck, 1972/1977). In some
of the German literature there is also acknowledgement of the role of *culture* in music therapy. It is acknowledged that processes of music therapy do not develop in a culture-free space, and that the rules of the game, such as definitions of the roles of therapist and client, reflect sociocultural values in broader communities and societies (Allesch, 1996). This is not to say that there have been no controversies in German music therapy about what the relationships between clinical and social approaches could and should be (including debates on how to define music therapy and demarcate it from other fields). On the contrary, there have been many debates.

Until the unification of East and West Germany in 1990, there were of course two separate German traditions of scholarship in music therapy. I still choose to represent German texts under one heading, since the main text to be discussed here by the central pioneer of music therapy in former GDR, Christoph Schwabe, was published as late as in 1998, partly in response to changes in culture and society due to the unification process. In addition to Schwabe, I will discuss Almut Seidel and Isabelle Frohne-Hagemann, who have both contributed to social perspectives on music therapy.[6]

**Christoph Schwabe: Social Music Therapy**

Former East Germany (GDR) was one of few countries in Eastern Europe with a strong tradition of music therapy, and Christoph Schwabe must be considered a central pioneer of the discipline in this country. From 1960 to 1980 he worked as music therapist at “der Nervenklinik” (psychiatric clinic) at the University of Leipzig, and from 1980 to 1992 as “docent” (lecturer) in psychology at the Academy of Music in Dresden. In 1969 he was co-founder of the music therapy section of the East German Society for Arts Psychotherapies. Schwabe’s two most famous books are probably *Aktive Gruppenmusiktherapie für erwachsene Patienten* (1983) and *Regulative Musiktherapie* (1987), about active group music therapy and receptive music therapy respectively. The text that I have chosen to discuss here, and which is more central to the focus of this study, is *Sozialmusiktherapie* [Social Music Therapy](Schwabe & Haase, 1998).[7]

While this book - as well as the label Social Music Therapy - is relatively recent, Schwabe underlines that this is an approach with a history of about forty years of development.[8] The argument is based upon a discussion of the human condition and the notion of the *individual*, and Schwabe underlines that individuals are never single or isolated; they interact with, relate to, and are dependent on others.[9] A specific notion of the *social*, in which the individual and the collective reciprocally constitute each other, is used as the core theoretical notion in Social Music Therapy, and the argument is both local and general:

The local element is linked to how music therapy had to adjust to the social and cultural changes in former GDR, after the unification of the two German states. The roles, responsibilities, and possibilities of the music therapist changed, and some areas of practice that used to be accessible for music therapists, such as medical practices, were closed. Instead the application of music therapy was transferred to supportive work and welfare work in, for example, psychiatric departments. A tradition of music therapy in psychiatry already existed and could be expanded, and one of the challenges music therapists could work with, according to Schwabe, was the need among East German people to deal with the “destabilization of the Self,” that is, to develop self-competence and social competence in order to cope with the loss of economic and social security after the introduction of capitalism (Schwabe & Haase, 1996).

The more general argument is that *human existence basically is social*, that is, individuals develop in communities and societies. The collective and the individual levels of human existence make each other up. Schwabe’s notion of social existence is therefore not limited to social structure, but includes the domain of interpersonal communication. Based upon this premise Schwabe describes social life through use of the notions “proximity” and “distance” (Nähe und Distanz): Proximity is related to being open to others, to the experience of connection to others, and therefore also to a certain lack of protection. Distance is related to being different, to the establishment of boundaries, and therefore to self-protection. Taken together this illuminates how social contact is the path to liberation but at the same time represents hazards and risks. Social health is therefore the capacity for balancing proximity and distance in encounters with other persons as well as with one’s own inner life (Schwabe & Haase, 1998, p.
Indications for Social Music Therapy are linked to "social illness," as described by Schwabe and Haase. The authors underline that the biological, psychological, and social aspects of human life are inseparable, and they question the established convention within medicine to only acknowledge problems that have led to physical or psychological symptoms at the level of the individual. As a critique to this, they launch the term "social illness," which is a term not acknowledged by the medical and psychological establishment (a fact the authors discuss). They define social illness as an individual's lack of capacity for regulating proximity and distance in relation to other people, objects, and him-/herself, with a concurrent lack of balance that may ensure and enhance development (Schwabe & Haase, 1998, p. 20).

The development of social competency is then considered the main (meta)goal of music therapy. The second section of the book is devoted to the description of methodological principles based upon this assumption, and in the final section of this book several colleagues of Schwabe and Haase describe how these principles operate when working with children with learning problems, with students of a (community) music school, with patients with alcohol problems, with patients with psychiatric problems, with elderly patients, etc. One interesting characteristic of this section is that Schwabe clearly distinguishes between what he calls social (non-clinical) and clinical settings or areas. This is more than a practical division of working sites; it is based upon a discussion of clinics and health institutions as sites of power struggles in which representatives of some disciplines, such as medicine, have the power to neglect and reject other disciplines, such as music therapy.

A point of entry to this discussion is Schwabe and Haase's reasoning concerning Social Music Therapy as psychotherapy. Schwabe outlines a definition of psychotherapy in four points, and specifies that psychotherapy is the alleviation or treatment of physical, psychological, or social disorders through psychological interventions leading to mobilization of resources in the individual. He also states that psychotherapy is based upon specific diagnostics, and that psychotherapy is an interdisciplinary field linked to both medicine and psychology (Schwabe & Haase, pp. 42-43). Based upon this definition Schwabe advocates that Social Music Therapy satisfies the criteria he has defined and should be considered a form of psychotherapy. He then proceeds by discussing problems that arise because Social Music Therapy is not always acknowledged as such. In the school system, for instance, Schwabe considers Social Music Therapy helpful and relevant in many cases, but this is opposed by regulations that say that therapy should not be given as part of the services of German schools.

Similar debates concerning how to define and label music therapy in schools and other non-clinical settings are probably common in many countries. What distinguishes Schwabe's contribution is the clarification of how notions of therapy are institutionally and politically constituted, with the concurrent double edge to his conclusion: First, he criticizes medicine (and psychology) for neglecting a category of disorders, that is, a group of pathologies that he has labeled "social illness" (this argument also leads to a criticism of these disciplines' lack of acknowledgement of Social Music Therapy). Second, he suggests that due to this situation, and the institutionalized power-struggles among disciplines and professions, music therapists cannot restrict themselves to working in clinics and conventional health institutions. In order to serve people in need, music therapists must go beyond efforts of becoming recognized as psychotherapists in conventional clinics. They must "walk out on the streets" and offer their services in non-clinical settings.

What is proposed then, is that music therapists actively work against the limitations of institutional constraints and restraints. They should not restrict themselves to conventional therapy in conventional clinics, but should experiment with new ways of working in non-clinical contexts. The authors note that this requires awareness and careful reflection on the part of the music therapist, concerning several differences between working in clinical and non-clinical settings. In the latter, the conditions are less pre-structured and predictable (organizational frames are more open, indications for therapy less defined, etc.). Specifically the authors stress that the therapy process in non-clinical settings is not protected by the "safe space" that the walls and frames of an institution may constitute. This puts new demands on the music
One of the music therapy training courses in former West Germany has developed a unique profile, in stressing the social dimensions of music therapy. This is the Frankfurt-course, established in 1988 with Almut Seidel as head of studies. Two of Seidel's articles - who currently is an advocate for internalization of European music therapy training (Seidel, 2002) - will be discussed here, as they represent condensed and focused presentations of several years of practical experience, theory development, research, and teaching in relation to music therapy as social education and social work:

In a discussion of Sozialpädagogische Musiktherapie (social-educational music therapy) Seidel (1992) sums up twenty years of experience and advocates the integration of music therapy in the professional task of the social worker. The perspective is probably closer to music therapy in social work than to music therapy as social work, but the distinction is not easy to make as an integration of perspectives is involved. At the Fachhochschule Frankfurt social workers have been trained to become music therapists who then integrate music therapy as part of their repertoire of interventions in relation to a range of tasks and professional responsibilities. Seidel's article starts with five vignettes, which in an effective way demonstrate the dilemmas and real world challenges that suggest the relevance of social-educational approaches to music therapy. The first vignette, for instance, tells about Frau A., a social worker and music therapist who is responsible for a group of multiply handicapped children. She is critical of the fragmentation of these children's everyday lives due to the fact that they have several individual sessions of therapy every day (speech therapy, physical therapy, occupation therapy, hydro-therapy). Instead of adding music therapy to this list of individual therapy sessions, Frau A. tries to integrate music therapy elements in the everyday routines of the group. The focus is upon the development of healthy communication and relationships, and the work is based upon assessment of the needs of each child.

After these vignettes Seidel outlines some general principles for social-educational music therapy. This is an interdisciplinary and integrative approach, located at the "crossroads" of clinical music therapy and social education. An integration of systems perspectives with client-centered perspectives is also involved. The music therapist works with persons in context, that is, the focus is upon helping persons to grow and develop in their everyday life situations. The clients in question are suffering due to interpersonal, social, and cultural change and problems, but have not yet been hospitalized or diagnosed. Seidel underlines that social-educational music therapy is not operating on the basis of diagnosis-specific information, since this belongs to the clinical field. Instead it is operating on the basis of information about the person-in-context; the focus is not treatment of symptoms but the facilitation of processes that may enhance growth and development in both person and context (Seidel, 1992).

The theoretical foundation for this approach to music therapy is therefore not theories about disorders and psychopathology, but theories about socialization and health. In relation to this Seidel outlines some methodological principles. She stresses the value of working with communication and relationships through musical improvisation, and argues that social-educational music therapy in these respects can learn from more conventional and clinical approaches to music therapy. An important difference, at the practical level, relates to the boundaries each context of work afford, that is, social-educational music therapists usually work in a less protected space than clinical music therapists, and they need to negotiate boundaries very carefully (Seidel, 1992, pp. 301-303).

In another article, Seidel (1996) stresses that more than twenty years of work with the integration of music therapy in social work in Germany has led to a broader range of sites (social locations) for music therapy practice, as well as development and refinement of approaches, techniques, and relevant theories. She also underlines how music therapy's relationship to social work has shaped and has been shaped by debates within and between professional groups concerning professional identity, and questions of education and training, and so on. When music therapists relate to social work, they relate to a field in flux, growth, and
development, both because the profession is young and because society continuously is changing.

Seidel (1996) states that the focus of social work is the empowerment of marginalized groups in society, and also suggests that social work represents an important corrective and adjunct to conventional therapy in that preventative strategies more than reactive (curative) strategies are developed. A central notion in Seidel's discussion is everyday life, and she proposes that social work is everyday-oriented; it is based on an acknowledgement of the complexity of everyday situations and networks and aimed at supporting individuals, groups, and communities in their efforts to deal with the challenges of everyday life. Social work then is related to enabling and empowerment and is basically building on and strengthening the clients' own strategies for dealing with the tasks and situations of everyday life; the experience of deceit and deficit, of barriers and rejections, of protest and dissent, of ineffective processes of learning and dealing with problems, and so on. The goal is to help people to develop their capacity for self-help.

Therapy starts when the strategies chosen for dealing with everyday problems break down, and therapy is characterized by a certain distance to everyday life and by a reduction of the complexity of situation that characterizes everyday life. Seidel's (1996) argument then is that there is a continuum between everyday life and therapy. There is no clear line between the two fields. Individual needs and values, cultural patterns, and socioeconomic structures determine how separate or connected they will be and how they overlap. Seidel's argument, which also relates to the line of reasoning in the article from 1992 referred to above, is that music therapists with competency in social work will be able to deal with this continuum in a constructive way, and adapt their work to the needs and resources of each client. Both articles therefore advocate the importance of integration of professional competency in social work and music therapy.

Isabelle Frohne-Hagemann: Music as Experience of Solidarity

The third and last German author to discuss here is Isabelle Frohne-Hagemann, who has been a major contributor to the German literature on music therapy theory since the mid-1970s, and who consciously has integrated psychotherapeutic and sociotherapeutic perspectives in her discussions (Frohne, 1986; Frohne-Hagemann, 1998). In a recent book Frohne-Hagemann (2001) presents twenty-one selected articles and papers, and the chapters of this book deal with a broad range of topics. Frohne-Hagemann covers clinical areas such as addiction, depression, and psychosomatic problems, and she discusses theoretical models for the understanding of music therapy in different clinical settings. Issues such as supervision and interdisciplinary work are also covered, as well as more metatheoretical perspectives on music therapy, including a discussion of aesthetics in relation to body experience.

Frohne-Hagemann's work has for many years been inspired by Gestalt principles, as developed within the school of Integrative Therapy (with Hilarion Petzold at the Fritz Perls Institute in Berlin as the leading figure). A basic idea in Frohne-Hagemann's work has been the "rhythmic" principle (dialectic movement between polarities), which she has discussed concretely in relation to music, movement and body-work, and more metaphorically as the balancing of creation and integration, impression and expression, contact and withdrawal, symbiosis and individuality, etc. (Frohne-Hagemann, 1976/2001, 1981/2001, 1983/2001).

In a chapter of the above-mentioned book, Frohne-Hagemann (1990/2001) discusses the psychotherapeutic "self-understanding" of Integrative Music Therapy, that is, how this approach to music therapy defines and situates itself in the landscape of therapies. Referring to Petzold, Frohne-Hagemann argues that psychotherapy is a narrow conception and that one instead should speak of "human-therapy," that is, therapy devoted to the development of the whole person. Integrative Music Therapy therefore goes beyond conventional treatment. It is concerned with the enabling of human beings and with personality development. This includes sociocultural and political elements, and Frohne-Hagemann speaks for social criticism and against any devaluation of social and educational elements of therapy processes.

The argument is based on the anthropology of humans as fundamentally creative beings (Frohne-Hagemann, 2001, p. 98ff.). In this perspective it is not enough to treat or heal, it is also necessary to help the client to grow and develop. Based on this premise Frohne-Hagemann,
again with reference to Petzold, describes four "roads" to growth, health and healing: 1) Work with consciousness and the exploration of meaning, 2) Work with re-socialization and basic trust, 3) Activation of experience and work with personality development, and 4) Experience of solidarity, metaperspective, and engagement.[16]

The first road, work with consciousness and the exploration of meaning, is psychotherapy, as it first was conceptualized: to make what is unconscious conscious, to integrate thoughts and emotions, to process and work through experiences of intrapersonal conflicts, etc. This work is focused upon the client's development of increased understanding of his or her own inner life. What makes this achievable is not any readymade knowledge that the therapist could teach in any conventional sense. It is rather a question of insight growing out of the interpersonal relationship between client and therapist. Frohne-Hagemann (1990/2001, pp. 103-105) suggests that free improvisation (as "open experiment" and intersubjective practice) is an especially suitable approach to this kind of work in music therapy. Through improvisation and reflection new meaning may be negotiated between client and therapist. In contrast to the original (Freudian) conception of the role of the therapist as "neutral," this approach demands active and engaged participation from the therapist, of course without becoming private or unprofessional.

The second road, which is linked to the first and the third, is work with re-socialization and basic trust. This approach too is related to the exploration of meaning, but more as building of meaning than as disclosure. This is psychotherapy as it has been conceptualized in theories discussing the needs of clients suffering from traumata and deficits more than from intrapersonal conflicts. Usually this way of working requires long term therapy processes with a high responsibility on the therapist, who at times must take the role of a "father" or "mother" and try to offer the client the balanced measures of nurture and frustration that best can promote growth. Frohne-Hagemann (1990/2002, pp. 106-109) argues that often these clients initially lack the capacity for reflection through language, and that work through music and other expressive modalities may be helpful for the development of the needed identity and awareness of oneself in relation to others. In describing the music therapeutic approach, she stresses the constructive use of carefully managed countertransference as "substitute for (the client's) introspection."

The third road, activation of experience and work with personality development, is based upon the growth potential linked to positive emotions and experiences. This road to health has been explored by numerous approaches to self-help groups and self-experience groups, in which the participants work with their sensibility, expressiveness, fantasy, flexibility, and communicative capacity. These groups have the function of being a facilitating environment (as described by Carl Rogers). This third road to growth, health, and healing is situated on the borderline between education and therapy, according to Frohne-Hagemann (1990/2001, pp. 109-111), and could aim at counteracting the experience of "Entfremdung" (estrangement) that life in society may have created in the individual. She advocates that the importance of music for this way of working is related to its potential as communal and pleasurable activity and experience, and that this potential should be used much more actively among music therapists, for instance in the shape of working with rock bands with adolescents or arranging musical parties for elderly people. An example of a receptive approach is also given, in which clients in a group could bring their favorite music with them and share their experiences of it. This is not psychotherapy in the conventional sense of working with consciousness, meaning, re-socialization, and trust, but is still therapeutic in that basic human needs for growth, health, and healing are met. The clients may be helped to develop new perspectives on life and new creative capacities for expression and communication.

The fourth road described by Frohne-Hagemann is the experience of solidarity, metaperspective, and engagement. Solidarity, which is related to engagement and responsibility for the interests of the other, is seen in contrast to narcissistic and self-absorbed strategies of interaction as well as to self-effacing strategies. The fourth road is therefore not independent of the other three; self-awareness, tolerance, dignity, and identity are considered pre-requisites of true solidarity.[17] Frohne-Hagemann (1990/2001, pp. 112-113) stresses quite clearly the danger of becoming "ignoranten Weltverbesserer" (ignorant mendes of the world),
and advocates that determined attempts of developing metaperspectives are necessary in order to counteract this. Metaperspectives in this context means theories about society and about the cultural and social factors that lead to health problems in individuals, groups, and communities. Concrete aspects of this work in therapy could be the use of and reflection on several styles and genres of music, including functional music of the everyday world (such as the background music of the retail sector). In the "partial engagement"[18] of music as experience and expression of solidarity, Frohne-Hagemann suggests that possibilities for a better acknowledgment of oneself as a historically situated human being exist; one is given the possibility of exploring one's position in one's own subculture, and thus also of developing intercultural solidarity.

As we can see, Frohne-Hagemann places herself in a German tradition arguing for the value and relevance of social work to music therapy, and she does this through the development of an argument for an integrative approach. Frohne-Hagemann suggests psychotherapy and sociotherapy belong together and are dependent on each other in ways comparable with the relationship between our two hands, (1990/2001, p. 112) . For this author, therefore the notion of awareness includes social awareness and cultural critique.

Norwegian Literature

In a recent Danish textbook of music therapy, Bonde, Pedersen and Wigram (2001, p. 261), suggest that "music therapy as locally based milieu work and cultural work"[19] is a Norwegian specialty, and that this socially oriented practice contributed to Bruscia's (1998a) inclusion of ecological practices in the second version of Defining Music Therapy. This literature review should clearly demonstrate that similar ideas and practices have been cultivated in several countries, but it is probably correct to label this area as a Norwegian specialty in the meaning "a field that has been cultivated and given special attention."

When preparing this essay I originally planned to use the subheading "Nordic literature" for this section. Probably I felt that this would seem less pretentious than focusing upon the literature of my own country only. In considering the criteria for selection of literature, this would be less precise though. In all Nordic countries there has been important work informed by sociocultural perspectives,[20] but, as far as I can see, in no Nordic country except Norway has this been developed into a tradition of music therapy literature. I will concentrate on the contributions of Even Ruud, Brynjulf Stige, and Trygve Aasgaard. The inclusion of my own writing is of course problematic, since my relationship to it is rather different to that of the other literature discussed here. I have chosen to include it, however, since there has been a reciprocal influence between these three authors, and the presentation of the Norwegian tradition therefore would be a little "warped" without it.

Before presenting some relevant texts by these three authors, I want toemphasize that a much larger group of Norwegian music therapists have practiced these and similar ideas, and developed them within specific contexts and forms of activity, such as school settings (Byrkjedal, 1992); arenas for development of communal activities between children and elderly people (Skarpeid, 1993); leisure activities for mentally challenged people (Einbu, 1993; Fugle, 1999); leisure activities, rehabilitation, and re-integration of psychiatric clients (Skotheim, 1996; Oust, Gudmundsson & Skarvang, 1996); open groups in hospice care (Sjåsæt, 1998); re-integration of prison inmates into society (Ruud Nilsen, 1996); and inter-disciplinary community work (Aftret, 2002).

Even Ruud: Music Therapy as Social Field and Cultural Movement

To the international audience of music therapists Even Ruud is well known, through numerous articles, lectures, and congress presentations, and through his three books in the English language: Music Therapy and its Relationship to Current Treatment Theories (1973/1980),[21] Music and Health (1986), and Music Therapy: Improvisation, Communication and Culture (1998). These three books in themselves would clearly have warranted the inclusion of Ruud in this literature review, but to my judgment some of his most important contributions in relation to an emerging discourse on community music therapy have been published in Norwegian only (and will also be discussed below).
In *Music Therapy and its Relationship to Current Treatment Theories* Even Ruud (1973/1980) discusses music therapy's relationship to various traditions within medicine, psychology, and philosophy. He divides the field of psychiatry and psychological treatment into four general approaches, in line with what was common thinking in the 1970s: the biological, the behavioral, the psychodynamic, and the humanistic. The book is extraordinary in the history of music therapy literature, as it was among the first texts to include serious treatment of metatheoretical problems, such as the influence of philosophical dualism (Cartesian thought) on both behaviorism and humanism (which could be said to represent two sides of the "coin"). While some of the specific content of this book today may seem "out of date," the basic premises for the discussion as well as the conclusion of the text still represent a challenge. Ruud argues that the "schools" or approaches discussed are ways of understanding, that is, they represent "man's potential ways of regarding himself," and he proposes that:

> If one model of understanding ever comes to establish itself at the cost of all others it could mean that man's potential views of himself would be decreased. The field of music therapy, therefore, ought to be an open field where different models of understanding are given the possibilities to collaborate with each other (Ruud, 1973/1980, p. 71).

This discussion alone makes this book important for the discipline of music therapy, but what is its importance in relation to the issue under scrutiny in this essay? This is not so obvious at first glance. Discussions in this book focus on rationales behind conventional modern therapeutic practice. There is little discussion of social work, sociotherapeutic methods, or communal approaches. Still, I find it reasonable to count the book as an early example of a text to challenge the conventional individualistic focus in music therapy theory. I do this because Ruud to a large degree uses sociologically informed perspectives when discussing and evaluating the different approaches. He goes beyond discussing biological and psychological aspects of human life, and adds a third dimension to the discussion; humans as social beings and members of a society.

The sociological influence on Ruud's thinking is even more visible in a book published in 1980: *What is Music Therapy?* Already in the first few paragraphs of the preface, the agenda is defined: He suggests that music therapists work with marginalized groups in the society (he does not speak of clients with diseases and disorders), and he describes how his interest in society, social work and his strong love for music led him to music therapy. Also, in the same preface, he gives an argument for the relevance and importance of music therapy that goes beyond the scope of conventional individual and health-specific goals. He suggests that music therapy is important because it brings music, as cultural phenomenon and heritage, to people who have traditionally been excluded from the institutions of music in society.

In the second chapter of the same book Even Ruud (1980, pp. 41-43) presents some reflections around a definition of music therapy that has influenced most Norwegian music therapists throughout the 1980s and 1990s. The premise for Ruud's reflections is that the biomedical view on health problems neglects the social dimensions of human life, and that the limitations on possibilities for action experienced by a client in music therapy could be due to social and cultural conditions as well as to circumstances linked to the individual him/herself. Ruud therefore argues that therapy must be directed towards the context and milieu of the client, and that prophylactic and political dimensions become crucial. Interpersonal sensitivity is not always enough, Ruud (1980, p. 101) argues; the music therapist needs to be sensitive in relation to the "social field" that music therapy belongs to. Sometimes the therapist will need to deal with the political and social forces that shape this field and create the conditions within which people live, grow, and develop. This insight also leads Ruud to warn against possible negative sociocultural outcomes of an unreflective professionalization of music therapy; a new strong profession that "knows" what music is and what it is good for could lead to disempowerment of ordinary people.

This social and sociological edge was developed in Ruud's writings throughout the 1980s, for instance in an influential book on music education (Ruud, 1983) and in a collection of papers on music, health, and therapy (Ruud, 1986). In 1987 he finished his doctoral thesis; a discussion of music therapy theory called *Music as Communication and Interaction* (Ruud, 1987/1990).
To my judgment this is one of the most important texts on music therapy theory that have been published, but it is not widely read, since it is only available in Norwegian. It is beyond the scope of this essay to describe and discuss the contents of this volume. Here it suffices to mention that Ruud in this work situates contemporary music therapy in relation to history, to contemporary theories of science and research, and to contemporary musicology. One notable feature of this work is that an explicit theory about humankind is presented. Ruud contends that no theory about humans is complete unless biological as well as psychological and sociological dimensions have been included. Based upon this premise he develops a pluralistic or multi-factorial theory of conditions for communication in music. Ruud (1987/1990) thus argues that theories that reduce music to a (mechanistic) means are not sufficient; the acts of the improvising individual as well as processes of socialization and enculturation must be included in music therapy theory.

Ruud's (1987/1990) dissertation integrates and develops the sociological and musicological arguments that he had developed through ten years of writing about music therapy. An abbreviated and simplified version of these arguments were made available in English in Music Therapy: Improvisation, Communication and Culture (Ruud, 1998), where he discusses the individual as improviser, the concept of music in improvisational music therapy, and improvisation as social interaction, and so on. The book also includes some of the more anthropological arguments that Ruud had developed in Norwegian books and articles throughout the 1990s,[29] such as discussions of music and identity, music and the quality of life, the aesthetics of everyday life, and improvisation as a liminal experience.

The 1998-book then, in some ways, sums up two decades of writing where Ruud attempts to integrate musicological, sociological, and anthropological perspectives into the music therapy discourse. In Chapter 4 - "Music, Health, and Quality of Life" - Ruud comments upon his efforts, linking them to a conception of music therapy that is of direct relevance for the emerging discourse on community music therapy:

When I first attempted to define music therapy, I was concerned that I not create a definition placing the client in a "sick" role. In traditional medical thinking, therapy is connected to some kind of disease or illness, often related, in Western medicine, to our biology. In addition, there is also a tendency in our culture to regard disease as something that strikes the individual independent of society and culture. ...

Because music therapists work with a broad range of life problems and handicaps, this way of thinking about therapy is not adequate, of course, in many instances. Sometimes we work with clients whose problems may be deeply interwoven with the material and economic structure of society, or whose problems are shaped more by their own attitudes and reflections, as well as by the attitudes of others, rather than by their individual or objective biological constitution.

This is why I came up with the idea of defining music therapy as an effort to "increase the possibilities for action." To increase a person's possibilities for action would mean not only to empower her but also to alleviate - through changing the context of music therapy - some of the material or psychological forces that keep her in a handicapped role (Ruud, 1998, pp. 51-52).

In the same book, Ruud elaborates on the notion of music therapy as social field, a topic he touched upon already in 1980, this time by relating it to Bourdieu's notion of social field:

A field is an area in which a group of people and/or institutions struggle with something they have in common. We struggle with values, about the right to participate in the field, about the right to partake and to have influence, and to obtain dominant positions. A field is recognizable by its dynamics, ... Within a field, we find both orthodox and heterodox followers, the latter of whom challenge the dominant theory. ...

The concept of fields must be understood within Bourdieu's theory of "habitus" and "cultural capital."...

Bourdieu meant his concept of habitus to connote a "system of more or less endurable dispositions," a kind of social competence founded in the body that we acquire throughout childhood in relation to a certain class, gender, and so forth. By appropriation [off a certain
musical culture, we appropriate a bodily disposition, a way of being that seems natural. This knowledge is of consequence to music therapists in the sense that through our music choices and our ways of being in our bodies, we communicate values that are not always in accordance with the life views of our clients (Ruud, 1998, pp. 82-83).

Some of the continuing struggles in the field of music therapy, and which now have relevance for community music therapy, are struggles about how to define the discipline and the profession, how to understand knowledge and scholarship in music therapy, and how to relate to society and everyday life issues. In a text from the late 1980s Ruud discussed music therapy as cultural movement in a way that throws light on this:

From a point of view of sociology of knowledge, it is understandable that music therapy, when it first established itself among other university disciplines in the fifties, had to depart from all kinds of metaphysical or idealistic types of theory in order to gain respect in the prevailing scientific community. But in creating the science of music therapy, along with the profession of the music therapist, the question of the general role and value of music in everyday life was handed over to the music educator and the philosopher of music - as well as to the music industry. The concept of music as therapy won much scientific credibility but lost its historically important role as a field of knowledge seeking to utilize music as a prime source of information about how to live and relate to the universe (Ruud, 1988, p. 34).

Even though Ruud's ideas are fairly theoretical, developed in an interdisciplinary discourse and not directly linked to concrete clinical practice, his work has paved the way for music therapy practices that have taken the ecology of the sociocultural processes of communities into consideration. Ruud's work has, for instance, influenced the work of the next author to be discussed.

Brynjulf Stige: Community Music Therapy and the Ecology of Social Networks

I will not pretend that my relationship to this author is comparable to my relationship to the other authors presented in this essay, and will change the narrative style in two ways: I will use the first person singular pronoun in this sub-section, and I will restrict myself to brief presentations of a few ideas developed in my previous texts. I will to a lesser degree comment upon the contributions or contextualize them within the music therapy discourse, since I have the possibility in this and other texts to actively position myself in relation to the emerging discourse on community music therapy.

The first text of relevance is the thesis I wrote as a post-graduate student of music therapy, where I discussed the relevance of East African ngoma-traditions for contemporary music therapy. "Ngoma" is a polysemic word, used in Swahili and some other Bantu languages, and may for instance mean drum or the social activity of singing and dancing together. Ngoma is used as the name for a tradition of music healing as well, and when the East African countries gained independence from Britain, ngoma gradually also developed into folklore and a concert tradition, sometimes - maybe especially in Tanzania - linked to political commentary.[30] In my thesis I reflected upon this multitude of connotations and how this could challenge the rather restricted concept of music therapy in Western societies (Stige, 1983).

Some months after writing this thesis I started working as a music therapist, in a project that allowed me to develop a community perspective on music therapy. After some years of experimental work together with a group of colleagues, where we tried to develop ways of using music therapy to help handicapped people re-integrate into the wider community, I co-authored a book called With Longing, Life, and Song (Kleive & Stige, 1988).[31] The book describes the music therapy process of four different groups, of which Knut's group Upbeat is one. The other groups include a group of multiply handicapped children, a group of adolescents with learning problems as well as social and emotional problems, and a group of adults with occupational problems. This work is discussed in relation to the notions of integration, cultural work, music education, and music therapy. Possible roles of a music therapist in the community are discussed, and the whole project is seen in relation to sociocultural developments in the Norwegian society. The project was not officially conducted as a research project, but the method was informed by ethnographic literature on field studies and the tradition of action research, which is briefly described in the Appendix of the book.
As this project to a large degree still is a frame of reference for my thinking about community music therapy, I have included a description of it in *Culture-Centered Music Therapy* (Stige, 2002b). The reflections in that chapter represent both a summary of and elaborations on reflections that I made throughout the 1990s, since this decade gave me several opportunities to develop the ideas that first were shaped in the 1980s. Some of these opportunities were related to new avenues of communication (such as international congresses and journals of music therapy), others were related to engagement in new projects that in different ways were linked to the first project (such as a national project on the re-integration of handicapped people into the cultural life of Norwegian communities and a national project on culture and health). Some of the added dimensions in the texts from the 1990s, compared to the book of 1988, were discussions of the ecology of social networks in relationship to health issues, and the conscious introduction of the term community music therapy since 1993.

My engagement with this field has ranged over topics such as music, health, and everyday life (Stige, 1993a, 1996a, 2001a; Ruud & Stige, 1994), new sites for music therapy and new roles of the music therapist, including that of the consultant and supervisor (Kleive & Stige, 1988; Stige, 1992a, b, c, 1993b, 1993/1999, 2001b), ecological and transactional theory (Stige, 1995a, c, 1996b), music therapy's relationship to music education (Stige 1995b, d), perspectives on meaning and aesthetics in music therapy (Stige, 1998a, b, 1999), cultural meta-perspectives on music therapy practice (Stige, 2002; Stige & Kenny, 2002), as well as research implications (Stige, 2001c, 2002).

I will not reiterate the arguments developed in these texts. At this point it suffices to underline that since the first book (Kleive & Stige, 1988) I have argued for the need to examine how cultural and social changes in the society challenge music therapists to revise conventional conceptions of the discipline and of the professional role of the therapist. These are - as far as I can see - questions at the core of the emerging discourse on community music therapy. I communicated this argument in English for the first time at the 7th World Congress of Music Therapy, and later in the English summary of an article published in the *Nordic Journal of Music Therapy*:

To understand what music therapy is, we need both definitions of music therapy and reflections on music therapy practice. These reflections should be built on concepts that help to see how music therapy changes in time and in different societies. ... 

The article suggests a model based on the three concepts of problem, task and approach. The problems that music therapists work with cannot only be connected to the individual, but are also created in the relationship between the individual and the community he lives in. Working with these problems the music therapist may take on different tasks, like prophylactic work, treatment and rehabilitation. Other tasks, like education, consultation and research are also important. To take on a task, the music therapist chooses an approach, reflecting his values, theoretical knowledge and practical skills.

Problem, task and approach could be seen as three dimensions creating the "space" for the work of music therapist. In this "space," different combinations of problem, task and approach are possible. And the "space" will be changing, both because the categories of the three dimensions will change in time and because new combinations can be created.

A new and growing "space" is then presented and discussed: the community work, or cultural engagement in the local community (Stige, 1993b, pp. 20-21).

These ideas, developed 10-20 years ago, still color my way of thinking about community music therapy, while I now choose to use the term "social field" instead of "space."

Trygve Aasgaard: Music Therapy as Milieu and Environmental Therapy

In the 1960s and early 1970s Trygve Aasgaard was one of the early advocates of music therapy in the Norwegian context. He then left the field for a couple of decades, and worked as a psychiatric nurse and as an assistant professor at a university college, before he decided to "reconvert" to music therapy in 1994. For the last eight years he has been doing important work within the areas of hospice care and music therapy with children with cancer.
Aasgaard (1996a, b, 1999, 2001, 2002) has been concerned with music therapy as performance in context, that is, he has gone beyond the conventional individualized focus and examined how music therapy may contribute to the milieu of, for example, an oncology department. Aasgaard's descriptions of how he works in the palliative care context of a hospice and in the milieu of an oncology ward for children give clear examples of this. We understand how the posts are transformed - musicalized, so to say - by interventions of public musicking, including activities such as community singing, improvisation, and performance of songs composed by the children in collaboration with the music therapist.

Aasgaard (1999) discusses his work in relation to the notion of milieu therapy, which is well established, at least within psychiatry. Aasgaard uses the terms milieu and environment synonymously, and asks: "What can the role of music therapy be when it comes to creating favourable environments?" He argues that:

A modern paediatric oncology ward is ... permanently struggling between providing a milieu that facilitates the most effective, life saving, but very uncomfortable medical treatment and providing conditions for the best possible good life for patients/relatives during hospitalization. If the ultimate goals of any treatment are set with the patient's quality of life in mind, it might be wise to assess the realities of the environmental aspects of treatment and care, and not just consider each service or profession as an isolated entity (Aasgaard, 1999, p. 31).

Aasgaard then asks whether music therapists possess particular properties regarding the formation and maintenance of a therapeutic milieu, and answers positively through the presentation of vignettes from "music environmental therapy," which he defines as:

A systematic process of using music to promote health in a specified environment inside or outside of institutions (Aasgaard, 1999, p. 34).

This form of music therapy Aasgaard relates both to the history and future of music therapy, and he compares it to music therapy as cultural engagement in the local community,[34] which he calls "grand scale" music environmental therapy. Aasgaard proceeds by relating this area to a notion of health promotion and to identity development, and proposes that dominant values in a healthy environment are love, freedom, and respect for the individual, and that a healthy environment is one that fosters growth and creativity. Goals of music environmental therapy should, according to Aasgaard, encompass all present in a defined milieu, and in outlining therapeutic strategies he focuses upon three levels of the environment:

First, strategies may be related to the physical environment, which for some clients and in some cases may create sensory deprivation, in others overload. This is a matter of relationship, it depends upon the properties of the physical environment (which in an oncology ward, for instance, may be quite noisy due to a plethora of technical equipment), and it depends on the sensory needs and capacities of the patient. The task of the music therapist is to assess this relationship and suggest suitable interventions.

Second, strategies may be related to the social environment, through activities such as community singing, collective improvisation, or concerts and performances. Aasgaard gives several examples of this way of working, and he emphasizes the importance of establishing socially stimulating but secure environments in which music therapy sessions may be open meeting-points for social interaction. Related to this is his argument that many dying and seriously sick patients are not only looking back at what has been or forward towards an inevitable death and beyond. They also want to "seize the day," that is, to experience rich and enjoyable moments (Aasgaard, 1999, p. 31).

Third, strategies may be related to the symbolic (or cultural) environment, which, of course, is related to the social environment. Aasgaard argues that many patients are afraid of being looked upon merely as patients (and not as persons), and he suggests that opportunities where conventional social roles at the hospital could be overturned should be sought for, in order to help patients retain their experience of being valued as humans beings. He proposes that musical and cultural activities are precious in relation to this, and that new relations between
persons may be created. Examples are when the authorities of the hospital play new roles, for instance through getting involved in musical improvisation, or when young patients gain acknowledgement by the group through the performance of songs they have written. Aasgaard has given special attention to the potential of working with symbolic and cultural artifacts, such as songs, and has also examined the "geography of songs" (Aasgaard, 2000, 2002), that is, the range of contexts in which songs created in music therapy appear and have been used, and thus how links between contexts have been established. This important work therefore throws light on the ecology of contexts at the mesosystem level.

North American Literature

North American music therapy is in many ways the largest and most established tradition of modern music therapy. For instance, North America is the only region of the world that has developed a strong tradition of quantitative research in music therapy. While it may be argued that most research studies in this tradition have not been context-based but have taken the de-contextualized experiment of the natural sciences as the basic model, it is still not correct to assume that communal perspectives have been neglected in North American music therapy. In the pioneering years of music therapy in post-war USA a broad range of topics were examined and discussed. This is well documented in the yearly Books of Proceedings of the National Association of Music Therapy, published from the early 1950s and to the founding of Journal of Music Therapy in 1964. One example of this is the interest for ethnographic perspectives. For instance, Bruno Nettl, currently one of the grand old men of ethnomusicology, wrote a short piece published in Music Therapy 1955, the fifth book of these proceedings (Nettl, 1956). He described how music in primitive and simple cultures hardly is used for therapeutic purposes alone. Instead music is part of ritual and ceremony, with an integration of music, words, and movement. What he described, I will argue, is music as part of an ecology, and music as mode of communication rather than as separate stimuli. Nettl contrasted this to the more limited study of the direct effect of music upon behavior, which he understood was the focus of modern American music therapy.

Nettl was a guest visiting the North American discourse on music therapy only briefly, and for the most part, and for many years what was cultivated in this discourse was the more scientifically approachable focus upon music as a stimulus, as defined in the behavioral tradition, and not music as ecology and integrated element of social practices. Nevertheless, early in the tradition, North American music therapists tried to adopt their practices to the community mental health centers that started to become common in this country in the 1960s. Part IX of Gaston's (1968) influential textbook Music in Therapy is entitled "Development of Music Therapy in the Community." In a chapter called "The Developing Situation" Folsom (1968) argues that the growth of community health services will change music therapy practice, with implications such as more focus upon group activities, focus upon the interrelationships of group members, and the relevance of adaptable repertoires in open groups. Linked to this she argues that the "therapeutic community" will become more important:

A ... more recent trend combining sociology and psychology with psychiatry has been the systemization of "normal treatment" or "social treatment," based on interactions of groups living, working, and playing in a "therapeutic milieu," or beneficial environment. [This has( the advantage of better adaptation to mass application (Action for Mental Health (1961, p. 244), as quoted from Folsom (1968, p. 352)).

Folsom envisions a future of music therapists not only working in hospitals, but in community health centers, in clubs and community programs, in community day centers, in residential treatment centers, and suggests that this will change the approach to both practice and research. In relation to the challenge of developing high quality rehabilitation program she states: "... In some instances, the music therapist may help in the vocational rehabilitation of a patient who has been a professional musician. In most cases, however, the greatest need is to provide leisure-time pursuits that will help integrate the person into his community and provide him with emotional satisfaction" (Folsom, 1968, p. 257).

This could count as one example of an early awareness about the importance of the integration of community and therapy in North American music therapy. This was probably related to a
general awareness of the communal potential of music, as, for instance, described by William Sears (1968/1995) in his influential "Processes in Music Therapy," where he discusses the Experience of Relating to Others as one of three main "ways of experiencing" in music therapy. In summing up the reports on community-integrated music therapy in Music in Therapy, Charles Braswell argues that one of the future strategies for music therapists may be "to develop a social psychological program that defines basic social and interactional deficiencies and attempts to modify or correct them" (Braswell, 1968b, p. 402). The same chapter gives examples of how insular music therapy programs may be turned into community activities in a hospital, how hospital services may serve a community in informal and experimental ways, as well as how to work with outpatient choirs.

Currently there is a rapidly growing interest for community music therapy in the US, as demonstrated in a recent doctoral dissertation by David Ramsey (2002). Ramsey, by the way, did direct the Florence Tyson Musicale’s for 15 years and has continued the same sort of outside performances with patients ever since at Beth Abraham Health Services. Tyson will be the first North American author to review here.

Florence Tyson: The Community Music Therapy Center

One of the first music therapists to regularly use the term community music therapy was probably Florence Tyson. Whether or not her concept of community music therapy is comparable to the emerging concept in current music therapy is not so easy to decide, since she - to my knowledge - never defined or explained the notion in detail. She was, however, a persistent advocate of the development of music therapy programs in community contexts. Also considered as one of the pioneers of psychotherapeutic and psychodynamic music therapy in the US, Florence Tyson's work is currently met with new interest, as the forthcoming publication of a collection of her texts demonstrates (Tyson, in press).

Already in the late 1950s Tyson discussed what she called "out-patient music therapy," in response to the de-hospitalization of North American psychiatry (Tyson, 1959). In Gaston's (1968) Music in Therapy she wrote a short piece called "The Community Music Therapy Center," where she discusses the history, goals, and organization of a center she built up in New York.[36] The backdrop is the "reentry of psychiatry into the community," that is the development of community-based rehabilitative centers throughout the US in the 1960s. Tyson (1968, p. 382) characterizes the community music therapy center in New York as a pioneer program, and she describes the development of it with the explicit aim of providing guidance to similar efforts in other towns and cities.

Tyson describes how community-based services present the music therapist with new tasks, responsibilities, and challenges, since both patient and music therapist are more vulnerable in a community setting than in a hospital. Patients may need more support, and they may also be more upset and unpredictable than what they are within the walls and restrictions of a hospital, Tyson argues. The therapist may become more available to the patient, and the negotiation and maintenance of limits and boundaries therefore becomes an issue of utmost importance.

Simply transferring to the community the departmental operation as it is known in hospitals will not suffice.

Music therapy acquires different dimensions in community practice. The music therapist seems to become even more aware of the patient as a whole person and of the fact that each interpersonal contact may have immediate and crucial implications for the patient's total life situation. (It is not merely a question of his adjustment on a sheltered hospital ward.) The constant impinging of the entire community environment on the music therapy contact creates the necessity for a broad framework within which music therapy can serve the outpatient's needs (Tyson, 1968, p. 383).

Tyson argues that the main goal of community music therapy is the same as that of hospital music therapy, the resocialization of the patient. But she proposes that the possibilities for working with this are different, for instance because the community music therapy center is a milieu with a broader range of people walking in and out than in a hospital. She describes vividly how interaction among patients could grow out of informal conversations in the waiting
This opportunity for friendship expanded during preparations for the center's semiannual musicales. The musicales resulted in strikingly improved social interaction among new combinations of patients (Tyson, 1968, p. 383).

Tyson thus introduces community performances as part of the music therapy center's activities, and she argues for a range of positive outcomes from these performances, both for the development of individual clients, for the development of the milieu at the center, and for the development of positive relationships between the center and the community.

I will not go into detail in describing the rest of Tyson's argument from 1968. Most of the rest of the piece is concerned with discussions of the necessary qualifications for music therapists to work in a community music therapy center. She argues that a center will need therapists of both sexes and of various ages in order to meet the needs and wishes of various patients.[37] Also she argues that post-graduate qualifications will be needed for the music therapists in many cases, and that a community music center must develop close relations with other agencies and professions, including psychiatrists and social workers.

In 1973 Tyson developed the description and discussion of the community music therapy center in an article she called "Guidelines Toward the Organization of Clinical Music Therapy Programs in the Community." She starts this article by arguing that the notion of "therapeutic community" has spread beyond hospital walls, and that there is an increasing use and acknowledgement of environmental "vectors" in therapy and rehabilitation. The more practical aspects of the text (how to work with administrative and financial functions, etc.) are specific both to time and place and of less general relevance, but there are many aspects of this text that deserve consideration even today. For instance, Tyson carefully describes how she works in informing the community, and she gives an account of clinical considerations that negotiate between educational and psychotherapeutic aspects:

In attempting to meet the needs of patients in the community, it soon becomes very clear how indirectly the course of music therapy serves musical ends.

What are the needs that must be met? There is the patient's tenuous hold upon reality, which results in a precarious, unstable day-to-day situation; the inability to formulate goals or to apply oneself with sustained energy; low self-concept which perpetuates destructive and self-defeating tendencies; lack of satisfying experiences; denial of angry feelings; immobilization because of overwhelming anxieties and fears; profound misunderstandings and distortions of events and responses. Above all, there is the terrifying isolation which results from the inability to relate to others.

Nevertheless, in spite of and because of these functional approaches to patient's problems in the music therapy setting, because there is emotional and social growth of the patient at the Music Therapy Center, there is almost always musical growth (Tyson, 1973, pp. 120-122).

Tyson closes this article with an outline of future developmental prospects, including ideas about the development of community consultation (music therapists providing consultation to agencies and professionals in the community), and of research and postgraduate training in community music therapy (Tyson, 1973, p. 123).

Carolyn Kenny: Myths, Fields, Rituals, and Responsibilities

North American music therapy in the 1960s and 1970s to an increasing degree became behavioral in orientation, but there have been several divergent voices, advocating alternative and broader perspectives on music therapy. One of the more powerful voices has been that of Carolyn Kenny, who has been working partly in California, partly in Vancouver in Canada. The specific term community music therapy or closely related terms do not appear in Carolyn Kenny's writing, but several of her influential contributions to music therapy theory are of relevance to the present discussion.
In her first book, *The Mythic Artery*, Kenny (1982) advocates the value of "mystery, myth, and magic" in human lives generally and in music therapy specifically, through a discussion of music as part of a broader (cultural) system of health. Taking the work of Gregory Bateson as one of her points of departure, Kenny advocates relational definitions. She suggests that music in music therapy should not be considered a "medication" (a means in a restricted sense), but that music therapists should encourage and support people in taking responsibility for their health and their lives. Based upon these premises she proposes the following definition:

Music Therapy is 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 towards health and well-being (Kenny, 1982, p. 7).

The first part of the book is a cultural critique, with a discussion of the "dearth of creativity" in modern Western societies. She links creativity to growth and health, and suggests that some psychotherapists have been disguising moral and political conflicts as mere personal problems, and she also criticizes the medical profession for claiming "freedom" from the broad world of law and religion by reference to its scientific base (and therefore immunizing itself to criticism from society at large):

Value-free cure and care merely does not exist. Unfortunately, many health professionals have a deeper, culturally health-denying effect insofar as they destroy the potential of people to deal with their human weakness, vulnerability and uniqueness in a personal and autonomous way. We unnecessary become health care consumers (Kenny, 1982, pp. 20-21).

Related to this Kenny argues that the sociocultural function of therapy and therapists in the society must be examined:

Because treatments are decided through society's value system and the therapist at that moment, the values of the patient and rights to self-determination and self-actualization are greatly inhibited. As long as the patient is willing to conform to the prescribed code in varying degrees of strictness, he/she will become cured. If the patient has ways of being and speaking which fall outside the prescribed behavior for a particular social code, these strange "behaviors" are considered deviant and therefore symptoms of some illness (Kenny, 1982, p. 21).

Kenny acknowledges the role and importance of the humanistic school of therapist, as an "exception" illuminating the possibility of a different role for the therapist. In line with the thinking of humanistic therapists she advocates:

We need to reintroduce freedom, choice, responsibility into the conceptual framework and vocabulary of psychiatry and health care in general (Kenny, 1982, pp. 20-22).

Integrated in this sociocultural (self)critique Kenny reflects upon the role of science, as partly a liberating and partly a suppressing enterprise (through its establishment of itself as dominant knowledge), and she advocates that scientific knowledge needs to be balanced by the arts. However, the arts are also subject to a cultural criticism by Kenny, since she suggests that the arts in modern societies to a large degree have lost contact with the everyday life of ordinary people. This critique she then links to health and therapy:

One of the specific problems in treatment today is that we have lost the historical thread of the arts as healers for every man. Gradually, they are coming back. More and more people are taking up the arts and crafts. However, when the arts are applied to therapy, they are often justified and rationalized into distortions of the original benefits of the arts as healers.

In our attempts to become more and more civilized, we have stretched beyond the sacred limits of intellect and are only recently starting the journey back to center. On the one hand, we have the specialized artist, a person removed and excused from the conventions of society at large. The artist is free to dream dreams, see visions, hear voices and sounds of spheres and spirits, as long as he produces art. On the other hand, our clinics and institutions are filled with clients who are dreamers and ritualists and are denied the arts, as frills, because their results are empirically unobservable. ...
One of the threads from the past which must be connected to the present and the future is the concept of art as a preventative and curative resource. The most profound and immediate need for this change is felt in the therapeutic environment. Other areas in which the same principles apply are in formal educational settings and other places where the community comes together to share ritual (Kenny, 1982, p. 33-34).

A continuing thread in Kenny's argument is therefore the importance of a continuous search for a synthesis between traditional human wisdom and contemporary knowledge and practice. This could be read as a general argument against professional and scientific "isolationism" and for sociocultural awareness and participation. In addition, Kenny (1982) makes a specific case in *The Mythic Artery*, and that is for the value of working with and through myths and rituals in music therapy.

Three years later Kenny (1985) discusses the relevance of systems theory to music therapy, which is a theoretical perspective that has become increasingly relevant as socioecological perspectives to music therapy have gained foothold (see the sub-section about Bruscia below). In 1989 Kenny published her probably most renowned work, *The Field of Play*, a contribution to music therapy theory that to some degree integrates the argument of *The Mythic Artery* with systems theory.

In the *Field of Play* Kenny presents a theory of the music therapy process that is relational and context-sensitive. Her main question is: "Is it possible to formulate a language to describe the music therapy experience and create one of many possible general models which accurately reflect music therapy process, yet can be understood and used by professionals in other fields?" (Kenny, 1989, p. 7). This question is linked to what she considers a major responsibility of self-awareness for the discipline and profession of music therapy. Since the field of music therapy practices in the culture-at-large, it interplays with other fields, and music therapists must examine the influence we may have on the culture-at-large.

The theory that Kenny develops is based upon the premise that music therapy is a process-oriented art and science, and through a review of relevant literature she proposes that there are certain tendencies in the literature on music therapy theory: 1) to consider music therapy as a creative process; 2) to imagine this process in a field; 3) to appreciate the significance of relationships in the field; 4) to appreciate the power of organization and self-organization in the musical experience; 5) to consider the conditions of the field (Kenny, 1989, pp. 39-40). The notion of *field* developed by Kenny is related to an environmental approach and linked to the presence of sounds as well as of persons, symbols, and rituals. Her theory - the Field of Play - is an attempt of developing a language for description of this field, in a language that pays respect to the immediate and non-verbal elements of interpersonal encounters in music. Metaphors and poetic elements are therefore important in this theory.

Kenny (1989, pp. 71-89) describes the Field of Play as interplay of three primary and four secondary fields. The three primary fields she labels The Aesthetic, The Musical Space, and The Field of Play, the four secondary fields she labels Ritual, A Particular State of Consciousness, Power, and Creative Process. It is beyond the scope of this essay to describe these fields in detail. It suffices here to point to Kenny's careful attempts of describing the process of music therapy as interplay of contained and open spaces, and as interaction of creative, aesthetic, personal, interpersonal, and environmental elements. In this respect, it is an integrative theory that Kenny presents in this influential book.

More recently Kenny has been advocating the social responsibility of the music therapy researcher (Kenny, 1999), which is also relevant to the current discourse on community music therapy, as is her "turn" to a more explicit anthropological focus, with "the role of arts in the revitalization of Aboriginal societies" as her main research topic (Kenny, 2002a).

Kenneth Bruscia: Ecological Practices of Music Therapy

One of the more prolific authors in North American music therapy the last two decades have been Kenneth Bruscia at Temple University in Philadelphia. His own clinical work has focused...
upon clinical improvisations, psychotherapy, and Guided Imagery and Music (the Bonny Method), and in all these areas he has produced seminal books that have collected and compared the ideas of a broad range of music therapists (see for instance Bruscia, 1987, 1998b, and Bruscia & Grocke, 2002 respectively). His importance for the development of music therapy theory is beyond doubt. His importance in relation to the topic that is under scrutiny here is mainly related to his notion of areas of practice in music therapy, as developed in Defining Music Therapy (Bruscia, 1989, 1998a).

In the first edition of Defining Music Therapy, Bruscia (1989) argues that music therapy practice is too broad and complex to be defined by a single approach, model, method, or theoretical orientation:

Music therapy encompasses a wide range of clinical practices, depending upon the setting in which it is employed. In an educational setting, for example, music therapy is practiced quite differently than it would be within a rehabilitative, psychotherapeutic, or medical setting (Bruscia, 1989, p. 55).

Bruscia continued by arguing that these variations - which relate to theoretical and empirical foundations as well as to choice of procedures - have significant implications for achieving an overall identity of the field. He therefore sets out to define areas of practice, and suggests that in the late 1980s music therapy included or related to eleven main areas of practice. Each area, according to Bruscia, could be defined by a particular clinical setting, population, goal, and treatment approach. Using these criteria, he proposes the following eleven areas: Educational Practices, Instructional Practices, Behavioral Practices, Psychotherapeutic Practices, Pastoral Practices, Supervisory and Training Practices, Medical Practices, Healing Practices, Recreational Practices, Activity Practices, and Interrelated Arts Practices. Each area is defined and exemplified at four levels of practice: auxiliary, augmentative, intensive, and primary.

The system of terms Bruscia here establishes enables music therapists to describe connections between practices with different populations as well as to outline differences between practices with the same population. Bruscia categorizes music therapy practices on the basis of a review of the literature of music therapy as it exists at the time of writing. An interesting point is that in the second edition of Defining Music Therapy Bruscia reduces the number of areas from eleven to six. The areas of practice that now are included are Didactic Practices, Medical Practices, Healing Practices, Psychotherapeutic Practices, Recreational Practices, and Ecological Practices. The main criteria in this revised definition of areas is the primary clinical focus, as defined by the priority health concern of the client and the agency serving him, the goal of the music therapist, and the nature of the client-therapist relationship (Bruscia, 1998, pp. 157-158).

By reducing the number of areas from eleven to six, the descriptions proposed by Bruscia in the second edition of the book to some degree will fit music therapy practices of most modern countries. They relate to institutions - in the sociological meaning of that term - that have been developed in all modern cultures (such as education and medicine), and should therefore have something to offer outside the American context of the author, although, of course, some details are linked to this context. An interesting thing to note in relation to the subject investigated here, is that ecological practices have been added:

The ecological area of practice includes all applications of music and music therapy where the primary focus is in promoting health within and between various layers of the sociocultural community and/or physical environment. This includes all work which focuses on the family, workplace, community, society, culture, or physical environment, either because the health of the ecological unit itself is at risk and therefore in need of intervention, or because the unit in some way causes or contributes to the health problems of its members. Also included are any efforts to form, build or sustain communities through music therapy. This, area of practice expands the notion of “client” to include a community, environment, ecological context, or individual whose health problem is ecological in nature (Bruscia, 1998a, p. 229).

Bruscia links ecological therapy to systems theory, with reference to - among others - Carolyn Kenny’s (1985, 1989) work described above. He also refers to Even Ruud’s (1988, 1998) discussion of music therapy as cultural movement and social fields, as described above. Bruscia underlines
While the therapist may work to facilitate changes in the individual or the ecological context, the basic premise is that changes in one will ultimately lead to changes in the other. Thus, helping an individual to become healthier is not viewed as a separate enterprise from improving the health of the ecological context within which the individual lives; conversely, helping any ecological context to become healthier is not a separate enterprise from improving the health of its members; and helping individual and ecology to relate to one another harmoniously makes both healthier (Bruscia, 1998a, p. 229).

Before describing different sub-areas of ecological practice, Bruscia underlines the specific character of music therapy processes in this area:

... ecological practices are quite different from those in other areas, ... Not only does therapy extend beyond the treatment room, regardless of setting, it also extends beyond the client-therapist relationship to include many layers of relationship between client and community, therapist and community, members within a community, and between communities. Going even further, the process of intervention itself is different, sometimes not anything like traditional therapy (Bruscia, 1998a, p. 231).

Bruscia then proceeds by describing several sub-practices, at different levels, such as functional, ceremonial, and inspirational music as well as music therapy activism at the auxiliary level; arts outreach programs, organizational music therapy, healing music rituals, and music therapy in sensitivity training at the augmentative level, and family music therapy and community music therapy at the intensive level.

Bruscia (1998a) thus operates with a related but more restricted notion of community music therapy compared to the notion that I outlined in the beginning of this essay. Of related interest is also his discussion of recreational practices:

This area encompasses all applications of music, music activities, and music therapy where the focus is on diversion, play, recreation, activity, or entertainment. Music activity is broadly defined to include a host of related media and experiences, including the other arts, recreational games, educational exercises, and so forth. The primary aim, whether implemented in institutional or community settings, is to help individuals engage in music or the other arts as leisure time or social activities that will enhance the quality of life, while also serving as a vehicle for therapeutic change (Bruscia, 1998a, p. 225).

What Bruscia here describes is an established tradition of practice in North American music therapy. For instance, in most of the history of North American music therapy, recreational activities have been considered essential in relation to rehabilitation through music, as was demonstrated in the above presentation of Folsom's (1968, p. 357) argument concerning the development of music therapy in the community.

Benedikte Barth Scheiby: Transformation through Community Music Therapy Training

Originally from Denmark, Benedikte Barth Scheiby co-founded (with Inge Nygaard Pedersen) the music therapy MA course at Aalborg University in 1982, and she is a well-known advocate of Analytical Music Therapy (AMT), developed by Mary Priestley. Currently she is assistant director of music at a rehabilitation center and also teaches, for instance in the music therapy course at New York University. In her clinical work, Scheiby has integrated psychotherapeutic perspectives into the more functional approach typical of a rehabilitation facility.

In response to the terrorist attack on the World Trade Center in New York on September 11, 2001, and to the trauma experienced among caregivers and victims who lost their loved ones, Scheiby in collaboration with several other music therapists put up a series of workshops for a group of almost 50 participants. In defining her approach, Scheiby takes Ansdell's (2002) description of community music therapy as a point of departure. While Ansdell argues that community music therapy is incompatible with psychotherapeutically informed music therapy, Scheiby's own argument is that integration of analytical music therapy techniques into community music therapy enhances its value and relevance for the consumers.
therapy, and writes:

I have expanded on this concept to consider it as an approach to music therapy that provides services to a variety of subcultures that are defined by a common concern that would bring them to training/therapy. It offers musical and verbal communal collective processing and a context to work through political, social, and cultural issues that the group members have in common. The group is led by a music therapist or a group of music therapists. A common theme can be dealing with an ongoing war, terror, or natural disaster; a disease; political violence; or posttraumatic stress in relation to a particular event. The concern that brings the members of a subculture to therapy can be the issue that the community members need to deal with at a collective level (Scheiby, in press).

The double angle of this approach is quite clear from this definition: collective and communal aspects are stressed while at the same time notions from analytical music therapy, such as "to work through" have been retained. Also, Scheiby, in clear contrast to what Ansdell advocates, argues that verbal sharing and reflection is essential in community music therapy:

In this regard, the AMT model was particularly useful as it promotes the verbal integration of what has been experienced during the music. The music opens channels for verbal sharing. The model is based upon the idea of facilitating an integration of thinking, feeling, body awareness, and spirituality through active improvisation or composition (Scheiby, 2002, in press).

Of the series of workshops, Scheiby describes one workshop in detail in the article. The series was defined as training, not as therapy, and each workshop was followed by a lecture on pertinent topics. (After the workshop described in the article, a psychiatrist was lecturing on the topic “sharing each other’s stories.”) Scheiby argues, though, that these training workshops could be therapeutic in that they give room for therapeutic work.

Referring to Danieli, who has written about therapy with survivors, Scheiby suggests that victims of disaster trauma often experience silence and isolation, and that what community music therapy should offer, therefore, is possibilities of being listened to by others and of being connected to others. The workshop that she describes was set up with this as a goal. Her approach borrows, as mentioned, features from AMT, such as the focus upon process:

The music does not necessarily have to sound beautiful or aesthetically pleasing in order to function therapeutically, and often the group improvisations are atonal with few clear structures and forms (Scheiby, in press).

Scheiby uses silence consciously in the sessions, both initially at the beginning of a session and throughout. Referring to Winnicott’s theories, she emphasizes the importance of living with the empty space, that is, to get in touch with fear of emptiness after the loss, and to live through it. After the initial silence the group is led into free, collective improvisation. In the description of this, and of the verbal processing after the improvisation, Scheiby emphasizes the symbolic meaning of sounds, instruments, choices, and actions (in line with the analytical way of working).

The participants are encouraged to tell their own story in music, to express their emotions, to go to an "internal space" for reflection, and then to move to an "external space" and interacting with others. Scheiby's descriptions are woven together with participant reports, which include comments upon the value of honoring ones own emotions and responses to the tragedy, and of honoring the primitive and formless as profound. Throughout Scheiby's text the value of integration (of sensations, thoughts, and emotions, etc.) is stresses. Musically the workshop varied from "chaotic" free improvisation with voice and instruments to community singing of a slow and soft lullaby (initiated by the therapist as a closure). The nurturing qualities of this lullaby are discussed, and its possible qualities as "caring mother."

In sum, the argument in Scheiby's article is that community music therapy not only is compatible with a psychotherapeutic model of music therapy, but that analytical constructs - such as transference and countertransference - are essential in the interpretation of a community music therapy session.
The Emerging Discourse of Community Music Therapy

The authors above refer to notions and practices of music therapy that go beyond the conventional individual and clinical focus of modern therapy. To varying degrees the texts discussed transcend the established values and perspectives of the discipline and profession. These texts represent attempts of challenging recognized principles of practice, by adding social and cultural elements to the discussion of music therapy, sometimes through use of the term community music therapy, sometimes not.

I have made no attempt to give a comprehensive presentation of relevant authors. Instead I have tried to outline a breadth of ideas relevant for this inquiry. The reading of the texts has been limited to the focus of this study, and other interesting aspects of the texts have not been highlighted. This is why I have taken the liberty to treat authors rather differently. While I sometimes have discussed one short article in detail, I have at other times synthesized a series of important books in a couple of paragraphs.

What has been presented above then are precursors as well as a few glimpses into the current discourse on community music therapy. I want to emphasize that what has been given is not the history of community music therapy or the history of community music therapy ideas. The account does not represent an evaluation of who were the important pioneers, what the source and effect of their ideas have been, etc. Other scholars, with less invested positions in the field and through use of relevant methods, must write the history of community music therapy, if history suggests that such a thing will be relevant to do.

The authors I mention in this essay often belong to different discourses and the writings take quite different frames of reference. No attempts will be made here to evaluate these frames. While all texts represent a call for change in the theory and practice of music therapy, some authors advocate minor to moderate evolutions and other advocate more radical “revolutions.” The degree of change proposed and the authors’ need and wish to position themselves are probably two of the most seminal factors determining whether a specific label for the proposed “new music therapies” have been considered required or not. What we can see is that many new notions have been proposed, such as music sociotherapy, community music therapy, ecological music therapy, culture-centered music therapy, music milieu therapy, and music environmental therapy.

Any meaningful continued discussion will be hampered if these terms are treated as interchangeable. Some of the authors (for instance Schwabe) have argued for what could be called new models of music therapy, while others (for instance Ruud) have developed new metatheoretical perspectives. Some authors have taken new perspectives on music (Ramsey) or therapy (Frohne-Hagemann, Seidel) or music therapy theory (Kenny). Other texts represent more context-bound arguments for pragmatic adjustments of professional practice in response to change in society, which may be linked to gradual socio-cultural change (Tyson), war and conflict (Sutton), or sudden, dramatic events (Scheiby).

A direct comparison of these perspectives would not make sense, but I still find it meaningful to present them together, and in that way try to establish intertextual relations between them. This is because one perspective necessarily implies and interacts with other perspectives. When Schwabe, for instance, presents Social Music Therapy as a model of practice, he necessarily also touches upon metatheoretical and theoretical assumptions (about humankind, music, health, and therapy) and he relates his discussion to concrete socio-cultural changes in the German society. The texts referred to in this essay are hardly about the same phenomenon then, in any concrete or restricted way, but they could be read together in a search for family resemblances.[39] While I cannot take it for granted that all authors referred to would accept or appreciate community music therapy as family name. Yet the family relationships hopefully will be acknowledged.

The Relentless Roots of Community Music Therapy

If we search for the roots of the emerging discourse on community music therapy, one might ask
what traditions have informed the writings of the authors that have been referred in this essay. At a theoretical and metatheoretical level the range of influences obviously is very broad. Another way to ask the question would be to look at some related areas of practice that have lent discourse to the texts discussed, and I have chosen to take this entry.

Due to the fact that only very recently would it make sense to speak of an internationally shared scholarly discourse on community music therapy, I find it necessary to reflect upon the metaphor of "roots." In this context it is hardly sensible to think of roots as something given and stable, as shared origin and ancestry. Roots, as sources of nourishment, will still be necessary for community music therapy to grow. When using "roots" as metaphor, I therefore find it helpful to think of the Ficus benghalensis, the banyan tree in tropic Asia, notable for its "aerial roots." As the banyan tree grows, new roots descend from its branches, push into the ground, and form new trunks. The banyan tree roots grow relentlessly, and a single tree might have dozens of trunks. What from a distance looks like a group of trees could then be just one tree with several trunks, and it is often impossible to tell which is the original.[40]

This image suggests that new roots may develop as community music therapy develop, and the roots to be described in the following is a synthesis of the literature as I have used it in this essay, and nothing more than that. They are not necessarily given as stable roots for future developments of the field, but as a way of summarizing this literature review. I propose that the following domains will be relevant to consider when examining the influences that led to the development of the emerging discourse of community music therapy:

- community healing rituals of traditional cultures
- practices of conventional modern music therapy
- traditions and activities of community music
- models of sociotherapy and milieu therapy
- approaches to community work

These five domains represent the breadth of influence I can see behind the current interest for community music therapy. To be willing to learn from traditional healing rituals may mean to take a global (or glocal) perspective, while to focus upon traditions and activities of community music almost per definition means to take a local perspective. The intra-disciplinary perspective is ensured by the need to position oneself in relation to conventional modern music therapy, while inter-disciplinary perspectives are involved when learning from sociotherapy, milieu therapy, and approaches to community work.

Not every practice of community music therapy will claim to have roots in all five domains. Aasgaard (1999), for instance, concentrates on the relationship to milieu therapy, while Ansdell (2002) concentrates on conventional modern music therapy and the British community music tradition. I think, though, that in considering community music therapy as a movement, as a change of culture in contemporary music therapy, all these domains may be of relevance. In the following I will outline characteristics, and domains giving examples by referring back to the authors mentioned in my essay (including the British authors, as outlined above).

Community Healing Rituals of Traditional Cultures

Music therapy as we know it today in industrialized and post-industrialized countries is usually considered a modern enterprise, and relationships to traditional healing rituals have not always been considered relevant to examine. Contemporary music therapy has been seen as a modern breach, as a new direction, by not being based upon myth and tradition but upon rational and empirically tested theories. The theoretical "turn to culture" that many of the contributions in this essay represent[41] has changed the perspective somewhat, and it opens up for a new interest for traditional and heterodox healing rituals.

In my judgment, the potential lays not so much in transplanting these rituals into modern music therapy. To decontextualise practices is not necessarily to show respect, and they may be alien to modern therapists and clients. To learn from history and ethnography is not the same as
using other times and practices as recipes in one's own context, or as replacement for one's own tradition. I assume that music therapists may learn from traditional healing rituals in at least three ways: First, by examining unfamiliar practices one may discover biases and taken for granted assumptions in one's own theory and practice. Second, by comparative investigation of both traditional and modern practices one may discover patterns of similarities which then may suggest some of the shared biological roots for musicking and music therapy. Third, by developing knowledge about healing rituals of different cultural contexts one may develop one's own cultural sensitivity, which will be increasingly important as more and more music therapists are working in multicultural contexts.

Interest for traditional community healing rituals was taken by several of the authors referred to in this essay, for instance Kenny (1982, 1989, 2002) and Stige (1983, 2002b).

Models of Conventional Modern Music Therapy

Community music therapy obviously also is a development in continuation of and in contrast to conventional modern music therapy, as the epigraph to this essay suggests. Sometimes practices are so close that one is led to ask: "Is there anything new under the bonnet?" Other times the contrasts are greater, "sometimes not anything like traditional therapy," as (Bruscia, 1998a, p. 231) expressed it. In any case it makes sense to examine the relationships involved, as community music therapists usually are professional music therapists and have their identity and training linked to music therapy as it has developed as a modern discipline and profession.

There are some general attitudes linked to looking at music therapy as a discipline and profession; there is a concurrent ethos that most music therapists subscribe to. Part of this is the value of working methodically, of using scientific theory, and of doing research. Specific ideas, depending upon which model of music therapy the music therapist is influenced by, are of course also important. Some models stress systematic assessment and evaluation, others the dialogic character of music-making, others the need for verbal processing of experience, etc.

Almost all texts treated in this review of literature, discuss influences and differences from conventional music therapy practices. Some authors, such as Tyson (1973), Seidel (1992, 1996), Schwabe and Haase (1998), and Frohne-Hagemann (2001) develop arguments for the integration of psychotherapeutic and broader, more social and community-based approaches. Some authors, such as Ansdell (2002) take a music-centered perspective and argue that the psychotherapeutic tradition of music therapy is incompatible with the community perspective.

The differences outlined in the previous paragraph reflect general and theoretical differences among authors in notions of music, health, and therapy. Such basic assumptions will of course influence all texts, also in the cases where arguments for (or against) integration of perspectives are related directly to the specific needs of clients. This is for instance the case with Sutton's (2002) and Scheiby's (2002) contributions. Both authors take music psychotherapy as their point of departure when developing their approach to community music therapy, and both authors argue for the relevance of this seen in relation to the specific needs of persons who have suffered psychological trauma.

Taken together this all suggests that the relationship between community music therapy and conventional music therapy will be multifaceted, and also that there probably will be some intense debates on the identity of community music therapy going on in the years to come.

Traditions and Activities of Community Music

Gary Ansdell (2002) advocates that the two main roots of community music therapy are (conventional modern) music therapy and community music. He is then writing from the perspective of the British context, where community music is a separate tradition of music-making that goes back to the nineteenth century, with attempts of linking the social and the musical while building upon the rich amateur music-making tradition in this country. In the 1960s and 1970s this tradition defined itself as community music, making the link to community building more articulate. In contrast to the parallel development of music therapy in Britain, community musicians did not organize themselves with the ambition of establishing a discipline and profession.
To my knowledge, community music - as a semi-professional sociomusical tradition and movement - is rather unique to the British (and Irish) context. All music therapists moving into the field of community music therapy will have to consider carefully, though, that the amateur music-making traditions of the localities and communities they are about to work in and with. These traditions represent the cultural and social capital of the community. Traditions of community music do not only exist in relation to genres and forms of organized activities. They also link to values and social practices of a locality and community. This view is, for instance, strongly supported by the Norwegian tradition discussed above, where Ruud (1998), Stige (2002b), and Aasgaard (2002) underline the value of working with and through the musical and cultural tradition of the client. Some authors, such as Procter (2002) and Ramsey (2002) advocate the identity of the music therapists as a musician.

Models of Sociotherapy and Milieu Therapy

Community music therapy obviously also link to models of sociotherapy and milieu therapy, that is, approaches to therapy and social work that focus upon creating healthy environments, social support, and caring networks instead of just focusing upon the function of each individual client. The terms in use for describing this kind of work differ somewhat with time and place, and also from discipline to discipline, while the work is often inter-disciplinary.

In the music therapy literature discussed above articulations of this perspective are given for instance in Frohne-Hagemann's (1990/2001) discussion of music therapy as psychotherapy and sociotherapy, in Seidel's (1992, 1996) discussion of social-educational music therapy, in my own (Stige, 1993, 1996) references to the ecological approach of Bronfenbrenner and to the Scandinavian literature on health-work through social networks, and in Aasgaard's (1999) discussion of "music environmental therapy."

This domain is closely linked to the development of health services and social services in a country. In some periods hospitalization is seen as the key, in other periods de-hospitalization and the strengthening of communities is stressed. Milieu therapy is of course relevant in a hospital setting, in times of de-hospitalization the perspective is enlarged to the community. Music therapists need to relate to the changes in the delivery of services, which is underlined for instance in the arguments of Tyson (1968, 1973), Bunt (1994), and Schwabe and Haase (1998).

Approaches to Community Work

Community work is different from sociotherapy and milieu therapy in that it is usually more bottom-up (based in people's own aims more than in aims as formulated by professionals) and in that it is more concerned with community development than with the needs of individual clients (or groups of clients). The starting points and the traditions of community work may differ somewhat from country to country. In Britain, for instance, community work may be said to have some of its roots in the colonial period, where the authorities stimulated community development to adjust indigenous communities to the needs of the state (Hydle, 1991, p. 16).

This British example should illustrate very well one of the dilemmas often encountered in community work: What is the relationship to political authorities: collaboration or confrontation? In the 1960s and 1970s community work was radicalized in many Western countries, while some radical roots also go back to for instance Saul Alinsky's work with community organization in Chicago in the 1930s (Alinsky, 1971). The last couple of decades have seen less radicalism and more professionalism in community work. Contemporary community work therefore includes a broad range of approaches and attitudes, but most of it is based on subscription to values related to social justice (Twelvetrees, 1991).

This perspective is not explicitly visible in very many of the texts discussed in this essay, although it could be said to be implied in Ruud's (1988) discussion of music therapy as cultural movement and in my own discussion of music therapy as cultural engagement in the community (Kleive & Stige, 1988; Stige, 1993). This then, is one of the "weaker" roots of community music therapy, but is possibly one that will grow stronger.

Conclusion and Future Directions

Three traditions of music therapy literature were examined; the German, the Norwegian, and the
North American, with the recent British contributions as a context. Arguments for a “new” music therapy have been delivered in all four traditions. This, combined with the fact that only in the the last few years have cross-references between these traditions become common, suggests at least two possibilities: First, a sociocultural approach as it relates to the “ontology” of music, so that communal aspects will tend to be part of many approaches to music therapy and healing as they develop in different cultures. Second, the literature proposing new perspectives on music therapy could reflect specific sociocultural developments in late modern societies, which then represent situated conditions that need to be examined as such.

The term community music therapy was in use in the literature already in the 1960s. Florence Tyson (1968, 1973), for instance, discussed practical challenges in the establishment of music therapy as part of community health services. The context of her discussion was the de-institutionalization of health services that started to evolve in many industrialized countries in this decade (and which evolved further in the subsequent decade). While Tyson clearly communicated how new contexts affect the roles and responsibilities of the therapist, it remains unclear to me to what degree her discussion challenged the conventional conception of modern music therapy.

Several of the texts in this essay, however, express more radical challenges to conventional music therapy. If we look at the beginning of the 21st century, it is quite obvious that something has happened to the discipline and profession and that many music therapists have started to use the term community music therapy in ways that more fundamentally suggest a change in the conception and practice of music therapy, community in many cases no longer being just a context to work in but also a context to work with.

Part of this new picture is a growing debate on what community music therapy is and is not, which roots are more relevant and important, etc., as, for instance, evident in the differences between Ansdell (2002) and Scheiby (2002) concerning community music therapy's relationship to music psychotherapy. I acknowledge this debate as crucial, but I am not sure that it is on the right track, since the generic term psychotherapy is sometimes used synonymously with the more specific term psychoanalysis or psychodynamic therapy. This confuses the discussion, as other approaches to psychotherapy - such as the humanistic, the cognitive-behavioral, the interpersonal, or the narrative approach - imply other rules and ways of working, and therefore would relate differently to the challenges of community music therapy. Community music therapy for or against Freud and his followers is therefore not a focus I suggest following explicitly. But - I would like to use, as a rhetorical device, the title of one of Freud's more interesting books when summing up the discussion in order to see how it will influence the focus of this study. Freud's (1904/1968) title *Psychopathology of Everyday Life* provides me with three terms that I think could be used for this:

**Psycho:** Several of the authors presented in this essay argue that the psychological and the social are two sides of the same coin, or more dynamically expressed: that they constitute each other. Other authors polarize these two levels of organization and suggest that community music therapy is basically a social and cultural enterprise in contrast to individual therapies.

**Pathology:** Some authors advocate an extension of the notion of pathology, to include social and cultural processes. Others suggest that community music therapy is about working with potentials and positive emotions.

**Everyday Life:** Some authors accept the conventional definition of music therapy as separated from everyday life, and emphasize the potentials in the communal aspects of music in a safe therapeutic space. Others more radically suggest that community music therapists leave the clinics and walk out on the streets, that is, that it is an activity integrated in the everyday life of a community.

These three terms then suggest three unresolved areas, or at least three areas to examine in an elaboration toward a notion and theory of community music therapy.

Notes
The term paradigm is used in many ways and thus extremely vague, as is well known. Kuhn (1970) is said to have been using it in at least a dozen different ways himself. Here I use it broadly, to denote the basic premises (including metatheoretical assumptions) of a theory or approach.

I write "closer to" in order to communicate that I have some reservations concerning the term "area of practice," as defined by Bruscia. This could be clarified through discussion of community music therapy as social field, which is a topic I will discuss in other contexts.

Thanks to Trygve Aasgaard, Leslie Bunt, Peter Jampel, David Ramsey, Even Ruud, Benedikte Barth Scheiby, Almut Seidel, Julie Sutton, and Alan Turry for willingness to help with information from their contexts.

Very interesting community music therapy projects are already being carried out in many countries, such as in Israel and South Africa. There is therefore undeniably a need for compilation and comparison of these international initiatives. A forthcoming book, Community Music Therapy - International Initiatives, edited by Mercédès Pavlicevic and Gary Ansdell, addresses this challenge.

Geck's (1972/1977) argument is that if therapists uncritically try to normalize individuals with no awareness of the possibility of "collective abnormality," that is, with no sociocultural consciousness concerning problems of social power and interpersonal estrangement, therapy easily becomes suppressive. In such cases, Geck argues, music therapy represents and creates apathy rather than remedy.

While these three authors represent three different "schools" of German music therapy, and while other schools advocate quite different and more conventional psychotherapeutic perspectives, Schwabe, Seidel, and Frohne-Hagemann could still be said to belong to "mainstream" music therapy in this country. Another, and less mainstream, school is the tradition of anthroposophical music therapy. As Trygve Aasgaard comments (personal communication), aspects of their approach to music therapy could be said to be milieu oriented; music, art, design, etc. contribute to the establishment of a rich aesthetic and healthy milieu of a clinic or hospital. In some respects we may compare this to the use of "music as milieu medicine" in the Arabian middle ages (which could be seen as a development of the dietetics of the Antiquity), where musicians were hired in order to enhance the health promoting qualities of the milieu surrounding the patient (Kümmel, 1977).

Schwabe and Haase (1996) also presented some of their perspectives in a paper called "Social Music Therapy in Response to the Changes of Social Conditions" at the 8th World Congress of Music Therapy in Hamburg.

Schwabe and Haase (1998, p. 54) describe Social Music Therapy as a development of Schwabe's earlier published works.

"Der Individuumsbegriff darf hier nicht unmittelbar gleichgesetzt werden mit dem Singlebegriff. Es geht hier zunächst nicht um die Beschreibung einer wie auch immer Idealform eines Seinzustandes, sondern um die Charakterisierung der Abhängigkeitsbeziehung zwischen den einzelnen Menschen und anderen" (Schwabe & Haase, 1998, p. 13).

"Soziale Gesundheit ... bedeutet das Vorhandensein eines Ausgewogensein von Nähe- und Distanzfähigkeiten, verbunden mit der bewussten, auf eigener Entscheidung beruhenden Handhabung von Selbstöffnung und Abgrenzung im Vorgang Begegnung mit anderen und mit Ich selbst."

"Soziale Krankheit ist also das Unvermögen des Individuums, Nähe und Distanz in der Beziehung zu anderen Menschen, zu Objekten und zu sich selbst in einer lebensfördernden Balance zu gestalten."

The authors try to avoid a polarized position though: when possible and necessary Social Music Therapy should be an integrated element of conventional clinics and institutions (Schwabe & Haase, 1998).
Sometimes called "clinical" and "sociocultural" music therapy.

The German language operates with compound nouns, and the original German term is "Humantherapie." I have translated this to the somewhat awkward "human-therapy" in order to try to communicate that the issue here is not human(istic) therapy in a narrow sense, but holistic therapy, including sociocultural aspects.

The term "anthropology" is in this context used in the meaning of "theory about humankind" or "the study of the nature and essence of humankind" (sometimes called "philosophical anthropology").

The original German terms are: 1) Bewusstseinsarbeit/Sinnfindung. 2) Nachsozialisation - Grundvertrauen. 3) Erlebnisaktivierung - Persönlichkeitsentfaltung. 4) Solidaritätserfahrung - Metaperspektive und Engagement.


The engagement for others that does not imply self-effacement.

In Danish: "Musikterapi som lokalt funderet miljø- og kulturarbejde."

In the Danish context, for instance, Jensen et al. (1993) have focused upon their multi-handicapped clients as "whole persons." They have concentrated on their resources and possibilities and on giving them "their place in society as a person." Another example, from the same country, is Sten Roer's work with rock bands and performance for psychiatric patients, with exchange of experiences with - and partly in collaboration with - the two American music therapists Dan Gormley and Peter Jampel (personal communication).

This book was first published in 1980, but is based upon Ruud's Master Thesis at Florida State University from 1973, which is evident in the text itself, where the scholarly discourse of the late 1960s is the main context.

The last three approaches have often been labeled the three forces in psychology. Throughout the 1980s and 1990s the transpersonal perspective gained strength, so that it became common - at least in parts of the American context - to speak of four forces. This has also been transferred to music therapy theory. Recently, culture-centered perspectives have been heralded by several authors and have been labeled the "fifth force" in music therapy theory (Bruscia, 2002).

This is also noticeable in a book Ruud (1979) published about music education theory at about the same time, where he included a chapter on music therapy and included such aspects as music as social education and the integration (mainstreaming) of handicapped students in normal schools.

My translation of the original Norwegian title: Hva er musikkterapi?

The "vernacular" Norwegian phrase he uses is: "mindre heldige grupper i samfunnet."

While the definition in fact was first published in an article (Ruud, 1979b), most Norwegian music therapists have used the discussion in What is Music Therapy? (Ruud, 1980) as the frame of reference when using the definition, at least this was the case until the publication of his doctoral thesis in 1990, where the definition was included. The definition, and the metatheoretical assumptions behind it, was - to my knowledge - not presented in English before it was included in Music Therapy: Improvisation, Communication and Culture (Ruud, 1998).

This book is a volume of papers from a conference arranged with the explicit intention of bringing "music therapy back into mainstream thinking not only about music but also about the issue of health in society in general" (Ruud, 1986, p. 3).

My translation of the Norwegian original title: Musikk som kommunikasjon og samhandling.

In ritual form, this political tradition of ngoma may in Tanzania at least be traced back to 1905-1907, where specific forms called “likinda” were used in the “maji-maji-revolt” to communicate and developed the techniques to be used against the Germans, who were the colonial masters of he country at that time (Malm, 1974).

My translation of the Original title in New Norwegian, which is Med lengting, liv og song. This title is taken from a famous Norwegian spring song, and was meant to connote to the dreams and capacities of handicapped and marginalized members of the society.

This was inspired by my discussions with Kenneth Bruscia and Leslie Bunt at the 7th World Congress of Music Therapy in 1993. The fact that it took me 10 years since the start of my work with this field in 1983 before I found a English term that I was satisfied with, is partly related to the differences between the Norwegian and English languages.

As illustration it may be noticed that the scholar that usually is considered the “father of Norwegian music therapy,” Even Ruud, writes in his doctoral dissertation that he first heard about music therapy around 1968, from Trygve Aasgaard who had encountered the concept in anthroposophical contexts (Ruud, 1987/1990, p. 107).

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As described by the present author (Stige, 1993b).

We will have to excuse him for using such derogatory terms, still common in the scholarship of the 1950s.

As Tyson (1973) explains in a later publication, the center was - for technical reasons - named “Creative Arts Rehabilitation Center, Inc.”, but continued to be known popularly as a music therapy center.

Cultural and multicultural concerns are not communicated clearly in this text, except indirectly through Tyson's argument that patients will have different backgrounds and needs.

While ecological music therapy is a relatively new development (Bruscia, 1998, p. 231).

I am referring to Wittgenstein's (1953/1967) notion, originally developed in relation to language games. Games (and practices) are similar in ways similar to how family members are similar: There may be some common features within one sub-group, other common features within another sub-group, but we have no guarantee that there is any shared essence.

Or - as my wife reminded me when I told her about the banyan tree - I could have used as metaphor a bush in my backyard where I cultivate black currants; they too may grow new roots from already established branches.

See also Stige and Kenny (2002).

See for instance Dissanayake (2000a, b; 2001).

References


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