Cross-cultural perspective: A thematic analysis of a music therapist’s experience providing treatment in a foreign country

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Abstract

As more music therapists are travelling and moving to different countries and little has been written about cross-cultural treatment, the researcher sought to answer the following two questions: (a) What is the experience of a music therapist treating clients in a different culture? and (b) What issues arise in cross-cultural music therapy treatment?

The research questions were explored using thematic analysis method. The experiences of a music therapist providing services in a different country were chronicled for one month. During the month of treatment, the participant wrote daily journal entries, processing her experience providing music therapy treatment in a foreign country and culture. Upon her return to the United States, the researcher interviewed the participant about her experience in Ecuador and her background prior to the trip. Data consisted of the therapist’s journal entries, responses to interview questions posed by the researcher, and responses to questions that arose during the coding of the data. Four overarching themes emerged from the data: allowing the music to facilitate, prominent role of drums, impact of differing views on therapy, and the music therapist’s uneasiness with the language barrier. Findings may assist other music therapists in their efforts to conduct cross-cultural treatment; results may also have implications for the training and education of music therapists.

Key words: cross-cultural, music therapy, cultural norms

Multicultural music therapy has been addressed in the literature in regard to education, training, and the nuances of services provided to diverse clients within one country. Yet, research is not available on the cross-cultural treatment of clients by a music therapist providing services in a foreign country. The likelihood that music therapists may provide music therapy services in a foreign country is increasing as individuals travel and
move to different countries. Also, not every country has music therapists residing in it at this point in time. According to the World Federation of Music Therapy (2013), music therapy is occurring in 53 countries; yet there are approximately 195 countries in our world (One World-Nations Online, 2014; World Atlas, 2014). As individuals within facilities and organisations learn of the potential of music therapy, music therapists may be asked to deliver services in a foreign country until native therapists are trained and educated.

When providing services in a different country, culture may become a central issue in treatment. In regard to culture itself, Stige (2002, p. 38) defined it as “…the accumulation of customs and technologies enabling and regulating human coexistence.” Another reference in his work points to a way of life that is transferred from generation to generation. In this study, differences in culture existed between the music therapist and her clients in regard to ethnicity, familial traditions, language, socio-economic status, educational attainment, disability and other cultural characteristics.

The therapist and the client(s) bring their own culture to the session as cultural learning begins with life and influences everything a person does (Stige, 2002). Thus as therapists, we need to view each person as a cultural individual and have goals for the individual, the group, and community (Stige, 2002). With a goal of increasing an individual’s participation and communication within the music therapy group, one will also increase the client’s quality of life (Stige, 2002). Participation in cultural experiences promotes socialisation which can assist with increasing one’s quality of life; and thus we can view music therapy as cultural engagement. A cultural community is created as each individual has a cultural identity (Stige, 2002). Stige claimed, “culture-centered music therapy may be understood as awareness about music therapy as culture” (2002, p. 42).

Ruud stated:

Music therapists...not only work with individual problems, but also focus on systemic interventions: how music can build networks, provide symbolic means for underprivileged individuals or be used to empower subordinated groups. Music has again become a social resource, a way to heal and strengthen communities as well as individuals. (2004, p. 13)

A current approach to music therapy that places emphasis on culture and community is Community Music Therapy. Stige (2004) proposed three tenets that make up Community Music Therapy: “that culture is central to music therapy theory and practice, that health is expressed as mutual care, and that mutual care is related to the issue
of human and social welfare” (p. 93). These propositions point to a focus on the well-being of the collective.

Within music therapy sessions, a circumstantial community is created (Ansdell, 2004) as individuals share the music space and come together with some commonalities—the need for music therapy being one of them. Communities do not need kinship; they are formed from shared experiences, interactions, and the feeling of belonging (Ansdell, 2004). Communities may include persons of different cultures; thus a music therapy session in which different cultures are represented may be a cross-cultural experience.

Cross-cultural music therapy is defined by Ip-Winfield & Grocke (2011, p. 61) as “music therapy practice in which important cultural differences exist between the therapist and client/s and/or among the clients themselves.” Valentino’s (2006, p. 109) definition is “therapeutic situations in which the client and therapist are from different ethnic groups.” Cross-cultural treatment could occur between persons of different cultures residing in the same country. Yet the situation detailed in this manuscript is that of a music therapist providing therapy in another country; thus both of the aforementioned definitions apply: the therapist and clients were of different cultural groups and ethnicities.

When such dramatic differences in culture exist, there may be factors that impact the therapy session and the therapeutic relationship. Yet we cannot foresee such potential issues, as there is a dearth of information available about cross-cultural treatment in music therapy. Thus, this study was undertaken to begin the examination of cross-cultural music therapy treatment. This initial look into the therapeutic experience is of the music therapist’s perspective as a starting point for the examination of cross-cultural music therapy; it may be useful to music therapists preparing to provide services in cross-cultural situations.

Method

The investigator explored music therapy treatment in a cross-cultural situation to yield insight into the experience. The researcher sought to answer the following two questions: (a) What is the experience of a music therapist treating clients in a different culture? and (b) What issues arise in cross-cultural music therapy treatment? The research questions were addressed via thematic analysis (Boyatzis, 1998; Braun, & Clarke, 2006).
Data Gathering and Analysis

The Institutional Review Board (IRB) of Marywood University approved this research study (board reference number 2012-E139). The participant, a board-certified music therapist, gave consent to take part in the study. She travelled from the United States of America to Ecuador and provided unpaid music therapy services for one month at a government-sponsored outpatient facility for children with developmental disabilities. During the month of treatment, the participant wrote daily journal entries, processing her experience of providing music therapy treatment in a foreign country and culture. Within a month of her return to the United States, the researcher interviewed the participant about her experience in Ecuador and her background prior to the trip. There was one initial interview and six follow-up discussions that occurred via telephone and electronic communication. For the initial interview, the researcher determined 23 questions for the interview schedule (see Appendix) that were reviewed by two music therapy researchers with cultural research experience. Data consisted of the journal entries, interview responses, and participant responses to questions that arose during the coding of the data. All data were made into a written record that was coded manually.

Thematic analysis was the method used to analyse the data. According to Boyatzis (1998), it is a process of analysing information into an organized form that is easily communicated to others. Thematic analysis involves developing codes, recognizing patterns and interpreting themes (Boyatzis, 1998). Braun & Clarke (2006) discussed thematic analysis as a flexible method that can deliver a meaningful interpretation of data. Within the same article, they identified six steps for conducting thematic analysis:

1. Familiarizing oneself with the data
2. Generating initial codes
3. Hunting for themes
4. Reviewing themes
5. Defining and naming themes
6. Constructing the report.

In this study, a semantic approach was utilised to describe, summarise, and interpret the data (Braun & Clarke, 2006). A semantic approach moves from description to analysis and interpretation; yet does not investigate underlying assumptions or ideologies beyond what is explicit in the data (Braun & Clarke, 2006).
Initial coding occurred in an inductive format (Boyatzis, 1998; Braun, & Clarke, 2006). The participant reviewed codes and themes for accuracy throughout the analysis process; she also clarified meaning and answered follow-up questions as the researcher synthesised the data. Themes were arranged in order according to how often they were identified (number of entries) and length of discourse in the data. A rich construction of meaning was obtained by intensive contact with the participant as she reviewed draft versions and the final manuscript.

**Participant**

A board-certified music therapist identified herself on a music therapy electronic mailing list as preparing for a trip to a foreign country to provide music therapy services. The researcher saw the post and thought the experience would be interesting to study. The researcher and the participant had no knowledge of each other prior to the post. After reading the post, the researcher searched for contact information for the music therapist. Once IRB approval was gained, the researcher contacted the music therapist regarding participation in the study. The participant happily gave consent for participation and publication.

The participant for this study had obtained her music therapy equivalency (entry level qualification) and master's degree. She had worked in the field a few years before engaging in this opportunity to provide music therapy services abroad. Prior to this therapeutic experience, the music therapist had exposure to Hispanic culture in America and also worked with Korean and Japanese staff. Thus she was accustomed to interacting with persons of different cultures than her own. She knew a few Spanish songs that she had learned from clients. Though she had some experience working with children, most of her professional music therapy experience was with adults and though she does not ascribe to one theoretical orientation, much of her work stems from a psychodynamic base. In this situation, the clientele was children and she adapted her treatment to meet their needs in the moment.

**Setting**

During this therapeutic experience, the music therapist provided services at a government-sponsored facility for children with special needs that utilised a team treatment model. In each session, there were three staff members present (in addition to the music therapist) and they interacted musically with the clients. Though no music
therapists had visited the facility prior to the arrival of the participant, the staff conducted group sessions using music for the benefit of the clientele for approximately ten months prior to the participant’s arrival. The staff recognized the power and influence of music for their clients, yet did not have access to education and training in music therapy. There are no music therapy education programs in Ecuador (World Federation of Music Therapy, 2013).

During the time of this study, eight sessions for groups of three to five children were conducted each day. Children ranging from two years old to twenty-one years old attended the music groups once a week. The majority of the children had autism; others had cerebral palsy, Down syndrome, or another developmental disability. Often the child’s parent(s) would attend the sessions as well, particularly if they needed physical assistance. Then the parent would hold the child during the session if the child had difficulty sitting on his/her own. As the facility is a government-sponsored treatment centre, services were free of charge to the clients and their families.

Results

All client names were changed within the journal citations to maintain confidentiality in this report. Predominant themes, listed in descending order of greatest influence on the therapeutic experience included (a) allowing the music to facilitate, (b) prominent role of drums, (c) impact of differing views on therapy, and (d) the music therapist’s uneasiness with the language barrier.

Allowing the Music to Facilitate

Allowing the music to facilitate interactions was the most prominent theme, as the participant discussed it the most in her journal entries and interview responses. The music facilitated engagement and client progress in spite of the cultural differences; it also served as a means of communication. The music therapist stated, “Through all the roles that I had, music was the guide, as well as my intuition.” The therapist admitted that prior to this experience, she relied primarily on intuition during music therapy sessions; yet this cultural experience shifted her focus to music guiding the session, with intuition playing a lesser role. “I learned I had to solely rely on music to support any clinical intervention I made, even in the times when I was co-facilitating/staff was translating.” She used music to provide the reinforcement she was not able to give through verbal communication. Being fully present in each moment of therapy and unable to communicate effectively by speech,
the music therapist concluded that improvisation was central to her work at the facility. Speaking of improvising, the music therapist stated, “It’s strengthened my confidence as well as discovering new communication and expression abilities in these children.”

The music provided structure, engaged the children, brought everyone together as a group, and facilitated progress. Structured songs, such as those with start/stop directions, were used to promote following directions, attention, and awareness/interaction. During the use of start/stop musical experiences, the rests in the music kept the children’s attention by building anticipation and facilitating a playful interaction.

A sense of play was present in the music and sessions. With this clientele, repetition was helpful as “The beauty of simple...repetitions offer musical engagement and connections.” Repeating musical phrases while changing other elements of the music, such as rhythm, helped engage children who were not participating with the group as identified by the therapist: “This song with repetition and change in rhythm begins to draw in the little boy who was wandering and exploring the room.”

Music also created the space for therapy to occur. As the therapist stated, “These first notes set the environment for welcome and greeting.” Throughout each session, the music served as a stabiliser and communicator. The therapist and staff utilised it to respond to and adjust the energy level and participation of the clients. As many of the playful interventions included energetic movement, a time for reflection and tranquil togetherness was also necessary: “We sit and take ‘physical’ breaks = letting the music sound the space and all present.”

In this culture, the music itself differed from the therapist’s expectations. She noticed that the majority of music was lively and upbeat in duple meter. She asked the staff members and they stated that they do not listen to sad, slow music. Then the staff and therapist discussed how even though many songs contain sad lyrical themes, the music itself is cheerful; thus the mood set by the rhythm and melody are not congruent with the lyrics. The therapist discussed the lack of minor keys, dissonant harmonies, and triple meter with the staff and they appeared to appreciate the new music experiences.

Yet, the music therapist did not use the culture’s music in the sessions. Being in the moment, she utilised what she was experienced with to produce therapeutic music: she improvised music without Latin influences, used standard American and Spanish children’s songs, and Nordoff-Robbins melodies.

When asked about not using the music of the culture, the music therapist said that the staff also did not use Latin music in the sessions; they used songs from Nordoff -
Robbins prior to her arrival. One staff member had discovered Nordoff-Robbins by searching the internet and later visited the Nordoff-Robbins Centre for Music Therapy in New York, USA to learn more about using music to help people. Thus, they had used this music while working at the treatment centre before the music therapist arrived. However, once the music therapist encouraged the staff to improvise more, some Latin idioms were naturally introduced into the sessions.

**Drums Serve a Prominent Role**

The use of drums was of great importance with this population. The therapist said drums were prominent in many sessions for several reasons: they attracted the children's attention, promoted engagement, and sparked curiosity. In one reflection the therapist wrote, “The drum remains throughout the whole session the ‘object’ of gathering and togetherness.” A gathering drum was often used to promote community and centre the clients in the session at the beginning of the session and throughout it. As the therapist stated, “The gathering drum is the musical object of introduction, while the keyboard provides supports to the environment and transition to music,” and “As a group we explore the gathering drum - the children rub it, tap it - sitting across from each other - more physically connected through space.”

For one client, “The ocean drum becomes his musical instrument of communication - he initiates movement on his own lifting his left arm up and slapping the drum - he awaits for our reactions – looking at both [the staff facilitator] and myself.” While reflecting on the impact of the drum on the therapeutic growth of the clients, the therapist mused, “I wonder how many children need a musical transition object to open their doorways to connecting with people.” In this case, the attractiveness of drums led to increased interaction and the opportunities for growth within the clientele.

**Different Views of Therapy**

One of the main cultural differences that impacted the therapist’s view of the sessions was the difference regarding therapeutic norms, such as respecting the therapeutic environment with timely arrivals and few interruptions. Alternatively, families often entered the therapeutic environment late and while conversing, which distracted those in the therapy space and impacted the energy and flow of the session. As sessions were only twenty minutes long, it was the therapist’s belief that these interruptions greatly affected client progress. Though the therapist was familiar with the cultural differences regarding
time management and scheduling, the therapist asked the staff about the pattern of interruptions and was told it was due to cultural norms and the "lack of education about what constitutes a therapy space". The music therapist and staff discussed boundaries and eventually set a limit that the door to the therapy room was locked five minutes after each session started.

Within this theme of family interaction and roles, the women are the primary caretakers for the children in the Ecuadorian culture. Yet occasionally during this experience, the music therapist and staff invited both mothers and fathers into the sessions. This was a new experience for the fathers, yet they seemed to appreciate it and benefited from the emotional interaction with their children through music, as recorded by the music therapist.

The therapeutic team often discussed the involvement of family members in the therapeutic process. Prior to the therapist’s arrival, the parents attending the sessions served as physical supports for their children; the team decided to assist the parents in becoming active music makers within each session. Thus, the parents were viewed as part of the team to improve the lives of their children. Several times the music therapist documented that she felt more as an observer to the mothers interacting with their children in the session or as a “holder of the musical object” as opposed to the primary influence on the therapeutic process. The therapist was pleased to facilitate interactions between the parents and their children as it improved the quality of life for the children and families, as evidenced by parent and staff feedback to the music therapist.

Quality of life was a frequent topic in staff discussions as the socio-economic conditions provided challenging circumstances. Access to resources and support was sparse, poverty and the lack of education impacted the children and families. The music therapist documented, “These social conditions are jarring and at times bring me down.” The team often discussed providing “new and pleasurable experiences” for the children they served. One such experience was the therapist’s introduction of a mirror into the sessions. “The mirror is utilized to invite the children to centre themselves in the room, and awareness of self.” It functioned to add playfulness and awareness to the sessions that strengthened the relationships between therapist and child. It was also helpful for a child who had limited vision – she smiled when she saw sunlight flicker off the mirror or her own reflection.

“Such simple movements seem to provide such pleasurable effects with Pablo and the others.” During her work at the treatment centre, the music therapist was drawn to the
concept of “less is more.” She recalled learning that in her music therapy training, yet she
did not fully understand the concept until this experience.

“I am struck by the simplicity yet meaningful intervention [of] human contact.” The music therapist encouraged the staff to “break free more and live in the moment-
utilizing improvisation, spontaneous play and interaction, and greater flexibility.” The staff
quickly adopted these new ways of interacting and in observing the shift in the staff’s
delivery, the music therapist also became more flexible in her interactions within the
sessions.

Language Barrier

The clients and their parents only spoke Spanish; the music therapist did not speak
Spanish. The music therapist was concerned about the language barrier; she recorded, “Of
course the language barrier was stinging me with anxiety” and “I could not communicate
with families and this caused me great sadness.” The music therapist did learn some
Spanish words such as basic body parts and action words to sing during some interventions.
Yet, she primarily used music and gestures to communicate with the group during therapy
sessions. The music therapist also stated once, “A language barrier moment that seems to
not frustrate the staff but I feel like I am interfering with the therapy process for the
children.” The music therapist often felt frustrated, inadequate, disconnected, and like an
outsider, as she was unable to communicate in the native language of the clients. To
circumvent the lack of language, she relied more on the music and observation of the group
members’ non-verbal communication. For instance, she wrote, “The children’s energy, the
children’s expression-non verbal, gestural, how the children communicated through music-
what instrument/voice/silence...all these components assisted me in understanding who
they are, and what they need.” She also learned to use her own body language and facial
expression to communicate with the clients more than if she had access to verbal language.

The staff members would translate for her, yet she still reported feeling “helpless”
and “lost.” The music therapist also felt a disconnection from the clients when the
translation occurred. The clients showed minimal discomfort with inability to
communicate verbally; this was only evidenced by reduced engagement from clients on a
couple of occasions. At the moments of reduced engagement with the music therapist, the
clients would engage with the staff, who were native speakers. Language was not a concern
within the therapeutic team as staff members spoke English.
Discussion

This study was undertaken to answer the following two questions: (a) What is the experience of a music therapist treating clients in a different culture? and (b) What issues arise in cross-cultural music therapy treatment? In so doing, the following themes resulted: (a) allowing the music to facilitate, (b) prominent role of drums (c), impact of differing views on therapy, and (d) the music therapist’s uneasiness with the language barrier.

Overall, the music therapist had a positive experience treating clients in a cross-cultural situation. This experience stretched the capability of the music therapist and allowed her to grow professionally and personally. “One of the greatest gifts this opportunity has given me is to be present in the here and now, let go, extend human contact.” Being present in the experience let the music therapist learn things that she believes she would not have understood from reading literature or listening to someone else’s experience. She had moments of self-doubt and stated “The challenges of adapting to a new environment, meeting new people, not speaking the language, being put on the spot to answer a thousand questions, being put in the ‘spotlight’... all of those experiences made me uncomfortable but greatly benefited me.” In addition to being more independent and confident, she said, “I returned home with a new sense of myself, calmness, answers about my clinical work direction that has been hovering over me, new questions about clinical work, and a deepened appreciation for music and the opportunities for music therapy.” As the music therapist said in one of her last correspondences, “All of that being said my life has been so much richer as a result of that visit and experience!”

Yet, there were some issues that were challenging for the music therapist in this situation. The therapist was uneasy with the language barrier; she was less confident in her delivery because of the inability to communicate through spoken word. This finding gives credence to more training in the language of the culture in which one will be providing services. Advanced training in the musical idioms of the foreign culture is also recommended to facilitate the feeling of belonging in the circumstantial community of the music therapy group. As Brown (2001) stated, music can transcend cultures yet one must take care with the extra-musical associations of the different cultures.

Allowing the music to facilitate and using drums served the therapist well in this situation. The music the therapist made engaged the clients throughout the sessions, even when she was unable to engage them with speech. Drums proved to be an attractive instrument to the clients, capturing their attention and serving as a means of interaction.
Utilising accessible instruments, such as drums, that are present in many cultures (Matney, 2007) is therefore recommended.

The therapist did abide by Chase’s (2003, p. 87) recommendations for multicultural treatment: (a) know yourself, (b) engage in new cultural experiences, (c) treat each person as an individual, (d) be musically flexible, and (e) ask for help if you need it. She also quickly learned to focus on the music and allow it to bridge the gaps in culture, while carefully observing the clients’ responses to the music and their own musical responses.

Similar to Stige’s (2011) documentation, music therapy functioned in this situation as collaboration among the parents, children, and staff as well as an intervention. The music therapist created resources for the clients and their families by welcoming parents into the therapy sessions and provided examples to them and the centre staff of how to use music to encourage interaction and facilitate therapeutic experiences.

As recommended by Valentino (2006), therapists in cross-cultural situations must (a) be aware of their own cultural identity, (b) know cultural attributes of clients, (c) use cognitive and affective empathy, and (d) communicate empathy effectively. Though the therapist did not speak the same language as the clients in this situation, she used non-verbal and musical means of communication to empathise with them. Her previous life experience gave her some familiarity with the culture and that may have helped her connect with the clients. In this case as in Ip-Winfield & Grocke’s 2011 study, personal experience with other cultures assisted in addressing the cultural aspects of working in a cross-cultural situation.

Limitations

As this study was limited to the therapist’s perspective of the experience, it did not give voice to the other persons who were affected by the experience: the staff, clients, and parents. One must also take into consideration that the themes presented were based on only one therapist’s perspective. A greater number of participants may yield different insights into cross-cultural music therapy treatment.

Conclusion

Although this one participant’s experience may not serve as an all-encompassing guide to cross-cultural treatment, it does provide insight into the experience and may assist other music therapists in their efforts to conduct cross-cultural treatment. One may facilitate cross-cultural experiences easier by learning the language and music of the
culture prior to conducting the therapeutic experience. It appears from the data that the music therapist was successful in her interactions with the clientele even with these two large barriers.

References


Appendix

Questions for Cross-cultural Study Interview with a Board-certified Music Therapist

- What languages, ethnic groups, races, and religions did the recipients of services represent?
- How was the language barrier addressed in sessions?
- If the therapist worked with an interpreter during the music therapy sessions, how did the involvement of the interpreter affect treatment? How did it affect the client-therapist relationship?
- Were you aware of culture differences during the sessions?
- At any point during the treatment process, were you uncomfortable due to cultural differences between yourself and the client?
- What cultural differences existed between the culture that the music you identify with and the culture the client identifies with in regard to the wellness model? Are there differences in view of health vs. illness? If so, please describe these differences.
- What cultural differences exist in each of the following: personal interactions, familial structure, social norms and mores, male/female roles and expectations, use of music, music instruments/style/function?
- How do the people of the foreign culture view therapists as professionals?
- How do the people of the foreign culture view music therapy?
- Did the cultural differences listed above impact treatment?
- If you were aware of cultural differences, such as those listed above, how did you modify treatment in regard to the differences?
- How do you feel the director of the centre perceived treatment?
- How do you feel treatment was perceived by clients/families?
• Did you feel the director’s perception of treatment was influenced by cross-culturalism (in contrast to music therapy services provided by a therapist within the same culture)?
• Did you feel the client/family’s perception was influenced by cross-culturalism (in contrast to music therapy services provided by a therapist within the same culture)?
• What types of interventions were used? Did these differ from what you would typically use with a client who’s culture is similar to/the same as the yours?
• What music did you use in the session? What informed your choice of music for the session?
• Were there any extra-musical associations that you did not foresee?
• What is your background/training/theoretical orientation?
• What type of cultural training did you have prior to this experience?
• Were you trained in the music of the foreign culture?
• Were you familiar with the music of the foreign culture?
• Describe your exposure to cultures other than your own prior to this experience.