Methods used in cross-cultural music therapy in aged care in Australia

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Thesis submitted in partial fulfilment of the requirements for the degree of Master of Music Therapy.

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June, 2010
For baby Felix
The University of Melbourne
School of Music

TO WHOM IT MAY CONCERN

I declare that this thesis, submitted for the degree of Master of Music, comprises only my original work and that due acknowledgement has been made in the text to all other material.

Signature: ______________________________
Date: 14 /6 /2010

Vannie Ip-Winfield
ABSTRACT

Aged care clients in Australia come from increasingly diverse cultural and linguistic backgrounds. Music therapists are being called upon to work with this changing population, an area in which both training and research are still developing, according to current literature. Music therapists have written about cross-cultural practice; yet most of these studies concern individual clients, not the group approach that is most commonly used in aged care. This study therefore addresses the shortage of research in these areas: 1) cross-cultural music therapy methods, 2) aged CALD clients and 3) group situations.

The Australian Music Therapy Association (AMTA) was contacted to circulate an online questionnaire to 88 practising registered music therapists (RMTs) identified as working in aged care. A thirty-three percent response rate (30 respondents) was achieved. Data was gathered on frequently used methods (listening to music, singing and movement to music), music repertoire, genre and styles, and utilisation of cultural specific music idioms.

The results suggest that cross-cultural music therapy practice in aged care is influenced by various factors, including personal experience and professional training, as well as the client’s background, abilities, level of acculturation and musical preference. Most respondents were confident in providing music therapy to CALD clients, who enjoyed an equal amount of service as non-CALD clients. However, a number of respondents expressed reservations about the level of preparedness for cross-cultural work provided by university training, preferring to emphasise the importance of personal (rather than professional) experience and interests. This study thus concludes with recommendations for training music therapists in future.
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CHAPTER ONE

INTRODUCTION

Elderly Australians in the twenty-first century represent an ever-increasing diversity of ethnic, cultural and religious backgrounds. For health professionals of all fields, especially music therapists, this changing population provides unique challenges in both preparation and practice. In the past, the notion of ‘cross-cultural music therapy’ might have been considered the domain of ethnomusicology, yet now it is an everyday reality in working with aged care clients from culturally and linguistically diverse (CALD) backgrounds.

The researcher is an Australian music therapist of Hong Kong Chinese background. So far, her cultural background has been different from the clients she has worked with in Australia. Thus, music therapy practice has been an entirely cross-cultural experience for her. When she started aged care music therapy practice, she worked at several aged care facilities in Victoria. Of particular interest is a facility founded by Dutch migrants, with great ethnic and linguistic diversity, including people from the Netherlands (about 50%), Mauritius, Sri Lanka, South Africa, India, the UK and New Zealand. Initially, she had trouble with group work, as many participants were unfamiliar with much of the music she played. She was faced with the reality that her training had not addressed the important issue of cross-cultural practice, which music therapists will certainly need to utilise now and in the future. Indeed, in Baker and Grocke’s 2009 survey of music therapists, several respondents expressed difficulties in developing relationships with CALD clients. Faced with this understanding, the researcher became interested in cross-cultural music therapy methods. Over time, the researcher has found ways to foster social cultural integration and she believes that other music therapists, with different clients and
different theoretical orientations, training or personal style will also develop their own cross-cultural music therapy methods.

Over the last decade, a great number of studies have shown the effectiveness of music therapy as a psychosocial intervention for the elderly. Research addressing multicultural practice in music therapy, however, is far less comprehensive. Some music therapists have written about their personal experiences in this area (Amir, 1998; Dos Santos, 2005; Forrest, 2000; Ikuno, 2005; Yehuda, 2002) and about ethical considerations in cross-cultural practice (F. Baker & Grocke, 2009; Bright, 1993; Dileo, 2000; Estrella, 2001; Kenny & Stige, 2002; Ruud, 1998) yet little is known about the practical details – most particularly, the methods used.

It was this experience that inspired the present study. It is the purpose of this study to provide a survey of cross-cultural methods used by Australian music therapists, with particular focus on the methods used in group therapy involving CALD participants, and to assess how their education and their experience inform their practice.

This thesis will begin with a literature review (chapter two) of studies that have focussed on the CALD population aged 65 and over in Australia, the influence of culture and music in general, and finally cross-cultural music therapy illustrating case examples from around the world. The method chapter (chapter three) will discuss recruitment of participants, ethics approval for the study, the creation, implementation and analysis of the web-based questionnaire, the pilot study with Registered Music Therapists (RMTs) at the National Music Therapy Research Unit (NaMTRU) seminars, and other related protocol. Results of the survey will then be presented (chapter four), detailing both quantitative (descriptive statistics of survey results) and qualitative data (thematic analysis of the respondent’s written comments) collected from the survey. The final chapter (chapter five) will discuss the findings in detail, drawing on personal accounts published in Voices: the world music therapy forum online as well as other relevant literature. Chapter five will conclude with recommendation on cross-cultural competencies for music therapists and recommendation for further studies.
It is hoped that this study will inform music therapists about current aged care cross-cultural practice, and will become the basis for future clinical application and multicultural investigation in Australia.

**Stance of the researcher**

Despite best effort to remain neutral, the researcher’s personal and professional backgrounds have exerted influence on the questions asked in this study as well as the interpretation of data. By articulating the stance of the researcher, it is hoped that readers can see the result of this study in consideration of the factors relating to the researcher’s background and experiences, also to generalise the result in a way that is relevant to the readers. Within this stance of the researcher, the first person ‘I’ will be used, as referred to the researcher.

These are possible influences that have been exerted over this study:

I am bi-lingual - both English and Cantonese are my first languages. I migrated to Australia from Hong Kong in my adolescence in 1996. This year, I have lived in these two countries for as long as each other – 15 years in each country. Hong Kong is known for its ‘East meets West’ character, as is manifested in its government systems and my formal education. Despite its close proximity to the Chinese mainland and the predominant Chinese population, the Hong Kong government and its systems were British before 1997; despite my Cantonese native tongue, all my formal schooling in Hong Kong was completed in English, apart from the study of Chinese. The last two years of high school and my tertiary education was completed in Melbourne. I had a traditional Chinese upbringing. My family observes collectivist values of harmony and hierarchy in family, yet these values are fused with the individualist values of competitiveness and achievement that are also cultural norms in Hong Kong. I married an Australian, who is also British in nationality. My personal background (migration and intercultural marriage) has inspired me greatly to investigate cross-cultural issues.
Western culture and the English language have fascinated me since I was a child. American and British mass media that were popular during my childhood (in Hong Kong) have influenced my cultural values and beliefs significantly. This fascination with the ‘West’ was further reinforced in my adolescence around the time of and after my migration. In many ways, I have stronger identification with general Western cultures than that of Eastern, to the extent that I might even assume what goes on in the Western society is natural and correct. For example, I have doubts about family values in Collectivist cultures (e.g.: extreme pressure on filial piety and the diminished role of women), as well as the use of traditional/ folk medicine. On the other hand, I sometimes assume everyone like music and the elements of Classical music may appeal to all people, and that Western medicine is applicable to all cultures. This might have led to my belief in the existence of ‘cross-cultural music therapy methods’ – the context for this study. Certainly the reference made of ‘Eastern’ and ‘Western’ cultures in this section are broad generalisations only. This will be discussed in Literature Review.

The reason for the particular focus of this study stems from my professional life as a Registered Music Therapist (RMT). The majority of my clients are older adults who come from CALD background. For four years, I have worked in a multicultural aged care facility established by the Dutch Reformed church in the outer South Eastern suburb in Victoria. A year prior to this study, I presented my own cross-cultural music therapy methods at the 7th European Music Therapy Congress in the Netherlands. My presentation was titled ‘Culturally responsive methods – fostering socio-cultural integration in a music therapy group in Melbourne, Australia.’

Personally, I strongly believe in reverence for my elders and I share with my older multicultural clients similar migration experience. I found connecting with this particular population comfortable and rewarding. Hence, both personally and professionally I have the following preconceived expectations as well as ideas about the probable result of this study. These include:
• RMTs enjoy working with older adults from CALD backgrounds, in which positive experiences outweigh negative ones.
• RMTs have developed their cross-cultural music therapy methods.
• RMTs appreciate cultural diversity in their work.
• RMTs are willing to share their knowledge and experience openly.
• CALD clients in an aged care facility have access to music therapy services.
• Music therapy benefits aged clients of CALD backgrounds.
CHAPTER TWO

LITERATURE REVIEW

1. Overview of the culturally and linguistically diverse (CALD) population aged 65 years and over in Australia

1.1 Demographics

Australia is a multicultural society. One quarter of Australians are overseas-born and almost half (43%) have one or both parent born overseas (ABS - The Australian Bureau of Statistics, 2007). Australia is home to people who come from different cultures around the world, as well as the earliest culture of the Indigenous people, which is one of the oldest known. Almost 200 different languages are spoken in Australia, and a wide range of diversity exists within each linguistic group. In the Australian Indigenous community alone, there are about 250 dialects spoken today.

Early settlement from Europe began in the late 18th century. Most came from Britain and Ireland, and these cultures maintain a strong presence in Australian society to this day. Residents born in the United Kingdom still account for 5.5% of the total Australian population (ABS - The Australian Bureau of Statistics, 2004). However, Australian past relationship with the Indigenous people has not been a comfortable one. For almost a century (~1869-1969), previous governments practiced a policy of assimilation, in which generations of Aboriginal children were forcibly taken from their family to be integrated into European Australian family. Significantly, in 2008 the prime minister of Australia offered a historic apology to these “Stolen Generations.”

Apart from the Anglo-Saxon population, further cultural diversity was introduced following World War II, when a migrant boom occured from various European countries.
In recent years, immigration from Asia has become dominant, with 40% of migrants coming to Australia from that region (Walmsley, Rolly, Rajaratnam, & McIntosh, 2007).

**Languages spoken in Australia**

The official language in Australia is English, the next most common languages are Italian (1.6%), Greek (1.3%), Cantonese (1.2%) and Arabic (1.2%) (ABS - The Australian Bureau of Statistics, 2006). Much of Australia’s linguistic diversity has been brought through migrations, rather than its educational systems, but this situation is changing.

The Australian government policy on language learning is linked to the nation changing self-perception. For much of the 19th and 20th centuries, the school curriculum followed the British models. Language teaching did have a place, but it was at secondary education levels particularly in private schools. The choices for a second language were limited to European languages: Latin, French and German (Ozolins, 2004). Much of the emphasis was on English literary. With assimilation – linguistically and culturally - being the prevailing policy, Indigenous people and migrants were expected to acquire English and to abandon their first language (Department of Education, Employment and Workplace Relations, & Commonwealth of Australia, 2002).

The situation regarding Australia’s language education has improved since the 1990s. Considerations of its geographical position (in the Asia-Pacific), and the reality of multiculturalism and economic strategies, have resulted in greater recognition of second languages (particularly Asian ones) in society and schooling. Today, all states have introduced a study of Languages Other Than English (LOTE) in many primary schools and the compulsory years of secondary schooling. Younger Australians who received their formal schooling in the 1990s are more likely to have learnt an Asian language than previous generations. This has implications for the abilities of the younger health care professionals to communicate in a multilingual capacity with their clients to whom English is not their first language.
An aging society

People in Australia are increasingly living to an older age. The percentage of the population aged 65 years and over is rising. This is a global phenomenon, particularly in developed countries. Better healthcare systems and advance medical technologies, such as pace makers, allow people to live to an older age. Furthermore, declining fertility rates, and shifts in the composition of migration, mean that the rate of aging in Australian population will grow quickly. As mentioned earlier, Australian society has become increasingly diverse and the aged population is no exception.

CALD

The term Culturally and Linguistically Diverse (CALD) has been recently introduced to replace its predecessor ‘NESB’ (Non English Speaking Background). The term CALD is used to describe people who were born overseas and for whom English is not their first language. Thus, people from English speaking countries (the UK, the USA and New Zealand) are excluded from this category. The older term was replaced in recognition of the fact that cultural difference is distinct from linguistic difference – people from many cultures, including Malaysians, Germans, French and Dutch, speak English well despite the fact that it is not their first language.

Older adults from CALD backgrounds are an important component of the aged population. Throughout this review, the term ‘older adults’ applies to those aged 65 and over unless otherwise stated. Older adults constitute 18% of all overseas-born Australian residents, while the Australian-born residents in this age group constitute only 11% of the total Australian-born population. (ABS - The Australian Bureau of Statistics, 2004) This figure indicates that there is a larger number of older adults in the CALD community than in the Australian-born community.

Aging in CALD communities

In addition, older adults from CALD backgrounds are increasing in number. It is projected that more than one in five (22.5%) older adults will be from a CALD
background in 2011 in Australia, an increase from 17.8% in 1996 (Gibson, Braun P, C, & F., 2001). This growth is more rapid than for their Australian-born counterparts; the growth rate for the CALD population over the period from 1996 to 2011 is 66%, compared with only 23% for the Australian-born population (See table 1.1).

Table 1.1 Projected growth rate for CALD population over the period 1996 to 2011

<table>
<thead>
<tr>
<th>Birthplaces</th>
<th>1996</th>
<th>2011</th>
<th>Growth rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALD – non English speaking countries</td>
<td>17.8%</td>
<td>22.5%</td>
<td>66%</td>
</tr>
<tr>
<td>Australian-born</td>
<td>64.1%</td>
<td>69.1%</td>
<td>23%</td>
</tr>
<tr>
<td>Main English speaking countries (The UK, US and New Zealand)</td>
<td>13.1%</td>
<td>13.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: (Gibson et al., 2001)

Notably, figures from the ‘Projection of older immigrants’ (Gibson et al., 2001) show that aging in CALD communities is greater than for the older Australian-born. In 1996, only 16.3% of people from CALD backgrounds were 80 and over, compared with 22.9% for the Australian-born in the same age group. In 2026, while the percentage of Australian-born population aged 80 and over will remain more or less the same (22.4%), the proportion of people from CALD backgrounds of the same age group will increase to 28.7%. This means one in four older adults over 80 will be from a CALD background in 2026.

1.2 Cultural diversity amongst Australian older population - countries of birth

This section will explore cultural diversity in Australia’s older population. Over the past two decades, patterns of migration have changed and the diversity of countries of birth has increased (See table 1.2). First of all, given the post-war migration boom after WWII, it is not surprising that people from European countries ranked the highest in the list of top ten countries of birth for older Australians in 1996. People born in Italy, Poland, Germany, Greece and the Netherlands were the most prominent, accounting for 69.7% of the migrant intake before 1986 (Walmsley et al., 2007). People born in these countries
are considered as the old migrant streams, because together they form the first waves of migration after WWII.

In the sixty years since the end of WWII, these migrants have aged and their numbers have declined (ABS - The Australian Bureau of Statistics, 2007). It is expected that migrants from countries like China, India and Vietnam will overtake them in numbers by 2011. (Gibson et al., 2001) (See table 1.2). Notably, the number of older adults from Vietnam is projected to expand rapidly, moving from 10th place in 2011 to 3rd place in 2026 in top ten countries of birth for people aged 65 and over (table 1.2). Immigration from China, Vietnam and India has proliferated since the 1980s. According to the Australian Bureau of Statistics, from the period 1981 to 2005, the China-born population increased nearly eightfold, making up 4% of the overseas-born population, while the Vietnam-born population increased fourfold, also making up 4% of the overseas-born population (ABS - The Australian Bureau of Statistics, 2007).

**Table 1.2 Top ten countries of birth for persons aged 65+ from CALD backgrounds, ranked in order of size, in 1996 and projected for 2011 and 2026**

<table>
<thead>
<tr>
<th></th>
<th>1996</th>
<th>2011</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Italy</td>
<td>Italy</td>
<td>Italy</td>
</tr>
<tr>
<td>2</td>
<td>Poland</td>
<td>Greece</td>
<td>Greece</td>
</tr>
<tr>
<td>3</td>
<td>Germany</td>
<td>Germany</td>
<td>Vietnam</td>
</tr>
<tr>
<td>4</td>
<td>Greece</td>
<td>Netherlands</td>
<td>China</td>
</tr>
<tr>
<td>5</td>
<td>Netherlands</td>
<td>China</td>
<td>Germany</td>
</tr>
<tr>
<td>6</td>
<td>China</td>
<td>Malta</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>India</td>
<td>Croatia</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Former Yugoslavia</td>
<td>Former Yugoslavia</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Hungary</td>
<td>India</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Malta</td>
<td>Vietnam</td>
<td></td>
</tr>
</tbody>
</table>

Source: (Gibson et al., 2001)

Note: ‘CALD’ excludes main English speaking countries – the UK, US and New Zealand
Distribution of CALD population

The figures presented above are national, whereas at state and territory levels, CALD demographics indicate some remarkable trends. ACT and Victoria have the highest number of CALD adults over 65 year-old: 24.8% in ACT and 23.1% in Victoria. Queensland (10.4%) and Tasmania (7.3%) have lower than average proportions (Gibson et al., 2001). Howe (2006), in her Department of Human Service report “Diversity, aging and HACC (Home and Community Care): Trends in Victoria in the next 15 years” shows that the CALD population in Victoria will grow by 71% to reach 31% of the total aged population, making it the most culturally and linguistically diverse of all the states (Howe, 2006). She also pointed out the need to consider the different rate of aging occurring in different CALD communities. In Victoria, the Dutch community is the ‘oldest’ (40% of Dutch-born residents are over 65), followed by the German and Polish communities. The number of older adults in Dutch, German and Polish communities has already peaked, while it is projected that the Italian communities will peak in 2011, followed by the Greek communities in 2016. In 2026, it is estimated that the proportion of the CALD older adults (aged 65+) will remain at 22.5%, however, the number of those aged 80 and over are projected to increase to 25.2% from 21.8% in 2011. By 2026, then, one in every four people aged 80 and over will be from CALD backgrounds. These are important considerations for any aged care service delivery.

1.3 Aged care services delivery for people from CALD backgrounds.

Figures from the Australian Institutes of Health and Welfare (AIHW) show a significant number of CALD people are consumers of Australia residential aged care services. They represent over one quarter (27%) of permanent residents, with 11% of CALD residents born in the United Kingdom and Ireland and another 11% born in other areas of Europe (AIHW, 2007). A remarkable increase in CALD permanent residents was recorded between 1999 and 2006. It has increased by 63.3% across Australia, while the total number of permanent residents has only increased by 14.6% nationally (Hugh, 2008).

Hugh (2008) in his investigation into the experience of CALD residents living in Commonwealth funded residential care found that some of these residents have
experienced inappropriate care, neglect, isolation, aggression, anger and withdrawal. While language barrier seems to be the principle contributing factor, there are indications that CALD residents and their family /representatives under-use the measures established in *Aged Care Act 1997* to obtain the services and care that they are entitled to. Complaints were withheld in fear of retribution. However, there were also reports of satisfaction from some CALD clients (Hugh, 2008).

To conclude this section, Australia is a multicultural society. A quarter of Australians are overseas-born and almost one in five (18%) older Australians were overseas-born. Significant historical events of the 20th century have led to waves of immigration. After WWII, a large number of European migrants arrived in Australia. People from Italy, Greece, Germany, Poland, and the Netherlands become prominent groups of the Australian nation. They also form the bases of the Australia CALD population. Asian communities, whose migration occurred more recently in the 1980s, will become prominent in the near future. Recent demographic data indicates that the aged CALD population is growing in number at a much faster rate than their Australian counterpart. This is also reflected in the numbers of CALD people residing in Australian residential care facilities. With growing numbers, increasingly diverse countries of birth, it can be said that the CALD population can now exert considerable influence over service delivery in their facilities.

2. Culture

The first part of this section will explore the meaning of culture using sources predominantly from music therapy publications. This will be followed by a discussion on aspects of culture, in which values will be discussed, with emphasis on individualism/collectivism and power distance. The second part of this section will take a more clinical view of the issue of culture, focusing on problems that may arise from cross-cultural encounters.
2.1 What is culture?

Culture is part of what makes us human. Stige (2002) remarked that ‘in the case of [the evolution of] the human species, nature has chosen culture’ (p.38). In other words, humans need to live together and living within a culture makes it possible. Culture, in sociological term, involves ‘shared meaning’ (Ruud, 1998) within groups of people. The understanding, or the assumption of such ‘shared meaning’ allows us to communicate, to work and to interpret other people’s behaviours and motives. The languages or any ‘symbolic tools’ (Stige, 2002) we use, like music and arts, are part of culture, through which we seek meaning.

Culture influences our lives, yet we are so immersed in it that we are generally unaware of it. It is not like clothing that can be taken off and discarded. Often it is only when we are confronted by a different culture that we become aware of our own. This may be a daily encounter for some Australian health care professionals who work with an increasing number of clients from different cultures.

However, ‘different culture’ does not necessarily refer to difference in ethnicity only. Ethnicity is a self defined term (Andary, Stolk, & Klimidis, 2003). Self-perception can influence one’s definition of ethnicity, as evident in some migrant groups. Some migrants maintain their original ethnicity even after settling into their new country, while some adopt their new nationality. Various motives can influence ethnicity, for example, ‘Hong Kong Chinese’ prefer that term to just ‘Chinese’ as that is a term associated with the Chinese mainland. Other examples where people are specific about their origin include ‘Macedonian Greek’ and ‘Palestinian’ for people coming from Israel.

These simple examples suggest that culture is more than ‘ethnicity.’ The meaning of ‘culture’ can range from gender, age, social class, educational status and professional role to one’s sexual orientation. Consider a young person with acquired brain injury living in a nursing home with a number of elderly residents (assuming all residents are Australians), great cultural differences exist between the young person and the older
residents, due to his/her age, educational background, his/her disability and lifestyle. All of the above contribute to his/her cultural differences.

The term culture, when used in different contexts, means different things. Culture is a concept well known to everyone, yet there is no consensus on a definition. The following are some of the definitions used in music therapy research. (See Box 1)

**Box 1. Definitions from music therapy research.**

<table>
<thead>
<tr>
<th>Definitions of Culture:</th>
</tr>
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<tbody>
<tr>
<td>• “Culture is the accumulation of customs and technologies enabling and regulating human coexistence.” (Stige, 2002, p.38)</td>
</tr>
<tr>
<td>• “Culture could be seen as a certain strategy for interpreting symbols or signs, a way to give meaning to the world around us.” (Ruud, 1998, p.54)</td>
</tr>
<tr>
<td>• “Culture is an inevitable backdrop for therapeutic communication and [musical] improvisation.” (Ruud, 1998, p.54)</td>
</tr>
<tr>
<td>• “Culture provides us with the tools we need in order to construct our personal narratives and to link them to the more public one.” (Kenny &amp; Stige, 2002, p.14)</td>
</tr>
<tr>
<td>• “Culture…is an extremely complex phenomenon. In relation to the evolution of our species it is possible to say that culture is part of what makes us human, that is culture is a shared characteristic of the human species.” (Kenny &amp; Stige, 2002, p.19)</td>
</tr>
<tr>
<td>• “Culture is a primary defining characteristic of basic group identity, articulating ‘a particular people’s values, value systems, beliefs and ideologies which give meaning, logic, worth, and significance to their existence and experience, within a particular context.’” (Kanitsaki, cited in Forrest, 2000 p.24)</td>
</tr>
<tr>
<td>• “Culture, when defined broadly, includes a constellation of factors, each of which interacts with the others. These factors include: age, religion/spiritual orientation, ethnicity, socio-economic status, sexual orientation, indigenous heritage, national origin and genders.” (Dileo, 2005 p.85)</td>
</tr>
<tr>
<td>• “Culture is actually a principle guiding element in evolution.” (Yehuda, 2006, “on culture” para 1).</td>
</tr>
</tbody>
</table>
From the above definitions two conclusions can be made: that culture is an important consideration for music therapists and that culture is a multifaceted concept. Definitions of culture vary according to the context in which it was used. However, if any one meaning of ‘culture’ is singled out, the concept will be inappropriately defined. Generally speaking, many authors in music therapy literature agree that culture is embedded with shared symbols and meanings, which shape our systems of values and beliefs (Dileo, 2000; Kenny & Stige, 2002; Ruud, 1998; Yehuda, 2002).

There are various aspects of culture that are used to distinguish one group from another and include language, religion, values, rules, meanings, knowledge and beliefs (Andary et al., 2003). These aspects are often reflections of each other. For example, religion and beliefs are reflected in a culture’s values (see Figure 1).

---

**Aspects of Culture**

- **Religion**
  - Governs one’s thoughts and attitude in life. In some religion, it governs even the way one dresses.

- **Meanings**
  - of illness: Punishment from God (some Christian sects), inescapable part of existence (Buddhism)… Depression is seen as a mental illness (Western cultures). It could be manifested as ‘tired nerves’ (some Asian cultures) and/or part of the broader experiences of human suffering.

- **Knowledge**
  - e.g. DSM-IV vs traditional folk medicine. In music, the diatonic scale vs Pentatonic scale

- **Rules**
  - e.g. Moral judgment, social hierarchy

- **Beliefs**
  - e.g. superstitious beliefs, Confucianism vs Ten commandments.

- **Values**
  - e.g. Collectivist/Individualist, masculinity/femininity

- **Language**

---

Figure 1: Aspect of culture based on Andary et al., 2003
Individualism and collectivism

Values stand for what is considered important or desirable in a culture. They represent one’s moral standards. At the most fundamental level, cultural values can be classified as either ‘individualistic’ or ‘collectivistic.’ Individualistic values are often found in Western society, where individuals are encouraged to be independent. Everyone is expected to look after him or herself and his or her immediate family. Self-actualisation and autonomy are the developmental goals for people in individualist cultures (Andary et al., 2003). Offspring are encouraged to be self-reliant and to leave home as soon as they are able to support themselves.

Collectivistic values, on the other hand, emphasise cohesiveness and the interdependence of all within the group (Dileo, 2000). Collectivism is often associated with Eastern societies. Throughout life people within the collectivist group continue to be protected and assisted by a selected network of members in exchange for unquestionable loyalty (Andary et al., 2003; Dileo, 2000). Good social relationship is imperative to a meaningful and complete self.

People from collectivist Eastern culture tend to think in terms of ‘we,’ and personal worth is measured by the degree to which the person complements the goals of others (Andary et al., 2003). This particular cultural value is reflected in language used in collectivist culture. For example, in Vietnamese and Burmese, there are no words for ‘I.’ Also, in Chinese (the first language of the author), others are often addressed in term of their relationships, such as ‘uncle,’ ‘aunt,’ and ‘elder brother,’ rather than the person’s own name. This is of particular importance when an older person is concerned. Personal address such as ‘grandma’ and ‘grandpa’ denote respect for the person who may not necessarily be related to the speaker.

Power distance

In relation to the individualism-collectivism dimension, power distance is another significant dimension in cultural values. Power distance refers to ‘the extent to which societies are structured hierarchically’ (Andary, et al., 2003, p40). Low power distance is
associated with Western individualist culture, in which hierarchy is viewed unfavourably. Low power distance culture emphasises egalitarian values, equal rights and responsibilities. On the contrary, in high power distance culture, those in powers are respected and obeyed, and those not in power can expect the powerful to protect them and to look after their interests.

As noted, those in positions of status such as doctors or teachers, and music therapists (especially those who are in a medical position), are high in the societal hierarchy, and thus carry power. They are authority figures in high power distance cultures, and are expected to impart knowledge and personal wisdom. Subordinates expect to be told what to do. This sets the tone of the relationship between teacher-children, parent-child and clinician-client.

**Balanced view in cultural understanding**

It is extremely important to realise that ‘individualism’ and ‘collectivism,’ as well as the distinction between ‘East’ or ‘West,’ are broad generalizations of cultural information (Dileo, 2000). Brown (2001), a Canadian music therapist, stressed that cultural understanding should be a balanced consideration of both nomothetic and idiographic categories. ‘Nomothetic’ refers to cultural norms in one particular group; ‘Idiographic’ refers to one’s individual cultural experience and his/ her personal uniqueness. It should not be assumed that cultural norms, such as ‘individualism’ and ‘collectivism’ characterise any single individual, rather these represent general tendencies within cultures. As highlighted by Dileo, in *Ethical Thinking in Music Therapy*, ‘each person within each culture is an individual with a blend of many cultural factors, and must be approached as such rather than through any artificial or over-generalized “category” system’ (Dileo, 2000, p.156)

**2.2 Cross-cultural issues**

This section will discuss the impact of various cultural factors on the relationship between people who come from different cultural backgrounds. This situation is described as a ‘cross-cultural’ relationship in this study. As discussed in previous
sections, culture intervenes in all aspects of life, from the most basic level to the most complex. The effect of cultural factors is an important consideration in any interpersonal relationship, especially a cross-cultural relationship.

An international study of values by Hofstede (1980), aimed to find difference and similarities in national patterns through surveying 88000 IBM employees across 50 countries. Hofstede’s study founded that values vary greatly across cultures (Hofstede, 1980). The value categories ‘collectivist’ and ‘individualist’ are idealised extremes along a continuum. These categories, as mentioned above, only illustrate certain tendencies, but not the complete picture. For example, the United States, Australia, and Great Britain scored high on individualism but relatively low on power distance. These countries value egalitarian relationship, but the degrees of such tendencies are different. The United States is the highest scoring of the 50 countries studied in terms of individualism. Notably, next in the ranking is Australia. On the contrary, Pakistan and Indonesia scored amongst the lowest on the individualism and high on power distance. With increased migration around the world and changing economic situations, various cultures have crossed boundaries, so that the values of our society are evolving and changing.

The influence of age and gender on older CALD adults

Age and gender exert considerable influence on the basis of power status. In collectivist societies, older members of the community possess high power in the group (e.g. family) than a person in the same position in individualist societies. Elders are revered and consulted over important decisions. In contrast, some western societies value youth over maturity. Youthful images of energy, adventure and agility are aspired to (Andary et al., 2003), as evident in substantial amount of commercial advertisements in Australian society. This can lead to pressure for adults to remain youthful in order to maintain their status in society, as well as diminished self-esteem because of community or family attitudes (Bright, 1996). In high power distance cultures, however, older members are to be cared for at home, even when they suffer from long-term illnesses such as dementia. Sending the respected older member to a nursing home can be seen as immoral and the older member may feel betrayed.
Cultural values also influence gender roles in society. Cultural norms and expectations about man and woman’s roles exist in most societies (Western and Eastern), as evident in the clear patterns of ‘men’s work’ and ‘woman’s work,’ along with cultural explanations of why it should be so. Although the role of woman is changing in many societies around the world, Schalkwyk (2000) cautioned against applying ‘Western’ values of gender equality to other cultures without balanced assessment of its cultural context. Passing judgement on the role of woman from another culture based on value standards of our culture may be unfair and potentially offensive to these women. In a clinical situation, the therapist should refrain from taking action based on their cultural assumptions, for example, encouraging woman to assert their rights (as defined by therapist’s culture) or encouraging teenagers to challenge the authority of their parents. This may result in more harm than good to the clients (Andary et al., 2003).

**Ethnocentrism**

Ethnocentrism is described as the automatic assumption that values from other cultures are dysfunctional, compounded with an over-strict adherence to one’s own ethnic values (Dokter, 1998). Ethnocentrism is evident when cultural values are so ingrained that its impact may be unnoticed (Brown, 2001). Hence, we have a natural tendency to assume that what goes on in our culture is ‘normal’ and ‘correct.’ As a result, we tend to judge other cultures by our ‘standards.’ Such an attitude is an impediment to any kind of meaningful interaction with CALD individuals and should be overcome. Cultural understanding, particularly an awareness of cultural context, is key to this (Stige, 2002).

**Culture and mental illness – cultural-bound syndromes**

Cultural beliefs and values are integral to the ways in which illness – particularly mental illness – is experienced, perceived and managed (Minas & McKendrick, 2007). Modern psychiatry, for example, was born in the West, and was shaped by specifically Western traditions. Its most influential diagnostic classification system is the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV] (American Psychiatric Association, 1994). However, despite its assumed universality, it is not excluded from this cultural

Not only do different cultures possess different perspectives on mental illness, but these distinct milieus also give rise to unique mental illnesses (Hughes & Simons, 1985). Disorders that are specific to particular cultural contexts are called culture-bound syndromes; for decades, these mental illnesses have fascinated anthropologists (Castillo, 1997). In modern psychiatry, culture-bound syndromes are seen as idioms of distress and many are misdiagnosed in the Western terms used in DSM-IV systems (Andary et al., 2003). An example of this is neurasthenia, which is a disorder prevalent in East-Asian countries. Neurasthenia is thought to be caused by “tired nerves” or inadequate physical energy. Symptoms include fatigue, anxiety, and various somatic complaints (Castillo, 1997). It bears more than a passing similarity to the Western syndromes of depression, anxiety and somatoform disorders, but such a diagnosis is not congruent to the patient’s cultural understanding of the illness – one is a physical cause (tired nerves), and the other indicates a mental illness, to which a stigma is attached. Neurasthenia is consistent with the Eastern belief about the indivisible connection between the body and mind. Hence, the appropriate diagnosis of a culture-bound syndrome is important, as it offers validation to the subjective experience of the patient (Andary et al., 2003; Castillo, 1997; Hughes & Simons, 1985). Bright (1993) pointed out that music therapists must also be aware of culture-bound syndrome; she writes that ‘all these matters are part of our sensitivity to cultural influences in the life of our clients’ (1993, p199), and should not be overlooked.

**Conclusion**

Culture is a multifaceted concept. It involves shared symbols and meanings that shape our systems of values and beliefs. As social creatures, humans need to live together and culture makes this possible. Aspects of culture can include language, religion, values, rules, meanings, knowledge and belief. Cultural values such as the concepts of ‘collectivism,’ ‘individualism’ and ‘power distance’ are extremely important in any
cross-cultural relationship, especially between therapists and clients. These concepts can also influence how illnesses are perceived and managed. Therefore, the most important first step in studying culture and culture-bound syndromes is to be aware of our own personal assumptions and our own cultural worldview. It is naturally beneficial to the therapeutic relationship if the therapist shows interest and respect for the client’s values and beliefs without passing judgement.

3. Music and culture

Music and culture are inseparable. The ‘function’ of music is like that of culture as defined above: music makes us human. The purposeful involvement in, and the creation of music differentiates human beings from other higher vertebrates of the animal kingdom (Davis, Gfeller, & Thaut, 1999), and music making is a fundamental attribute of the human species (Blacking, 1976).

Throughout history, the relationship of music and culture has been evident in most aspects of human life: the religious and healing rites of preliterate cultures, the singing of carols at Christmas, and, even the social influence of hip-hop. In religious and healing rites, music validates cultural values and beliefs. In preliterate cultures, music is often associated with supernatural forces. Certain songs were said to have come from supernatural sources (Merriam 1964, Sachs 1965, cited in Davis, et al., 1999) and were performed only in important rituals. Christmas carols have been sung for generations in the West. Their spiritual and celebratory qualities arguably contribute to the continuity of the Christian culture. Nowadays, ‘hip-hop’ encompasses much more than music. It has been understood as a style (musical, visual arts and fashion) and attitudes. It denotes a society (originated by young African-American of certain socio-economic status) and an art form. Hip-hop has become a profitable music and fashion industry around the world, crossing certain social barriers and diminishing racial differences between people of different backgrounds (Walker, 2006), and so music potentially provides a valuable tool for cross-cultural music therapists.
In *How Musical is Man* (1976), Blacking attempted to document the ways in which music-making expresses the human condition as well as how it can be used to improve the quality of human life. More recently, music therapists Kenny (1989), Stige (2002) and Ruud (1998) have also followed similar anthropological / ethnomusicological approaches in their teaching of music therapy. Stige (2002) asserts that music must be considered within its context, that it is more than a stimulus, and is embedded in culture and vice versa. By considering music-in-context, music is no longer an abstract term, rather music(s) is plural (Stige, 2002). Examples include music in a prestigious concert event, music in one’s wedding, and music in a fitness class. The same piece of music can be applied to the above examples, yet it evokes completely different feelings. Examples from other cultures can be music in harvest festivals such as Thanksgiving (American), Pongal (Indian), and the lunar new year (Chinese). Associated with the music are a series of cultural rituals. By considering the plurality of music(s), music and its meaning are no longer separated. This leads to the daily working questions for music therapists: What does this song mean to the person? How does this song represent the person’s cultural belief and background? As Stige has articulated,

‘Music therapists need to be able to relate to a plurality of musics in order to meet the individual needs of clients coming from different backgrounds with different histories of music use’ (2002, p.93).

### 3.1 Is music a universal language?

The question ‘is music a universal language?’ is a truly debatable one. Music is inherent in human life (Blacking, 1976; Kenny & Stige, 2002) and is found in every culture known to us (Nettl, cited in Gfeller, et al, 1999). Yet, musical symbols are very specific to each culture. The use of the major scale and the ‘positive’ mood associated with it is not necessarily present or understood in non-western cultures (Bright, 1993). Conversely, people from Western cultures may have trouble understanding the sentiments expressed in non-Western music, such as the Indian microtone scales. Bright (1993) conducted research on the perception of moods in music. The subjects were people from European backgrounds. The result showed that less than half of the subjects were able to
distinguish different moods in Asian music, yet the subjects performed the same test a lot better when European music was used. It can be said that the role of music may be universal, but specific meanings are bound by different cultural beliefs and norms.

Ruud (1998) stated that music should not be considered a language because music is perceived symbolically. Its content is not passed on through music, but rather it is the listener who attaches a symbolic meaning to what they hear. The symbolic uses of music denote shared meanings to people within the same culture (Stige, 2002).

Forrest (2002) also sees music as possessing communicative power. In her investigation into the use of culturally specific music (Russian folk songs) with a palliative care client, she asserted that music transcends language barriers and reaffirms cultural identity. Her study showed that music is an effective medium to use for both client and family, to explore and resolve past conflicts. Through the sensitive use of music, the client’s cultural identity was reaffirmed. This kind of music therapy intervention will be further discussed in section 4: ‘cross-cultural music therapy.’

Bright’s (1993) quotation summarises this discussion well: ‘Music is universal but there is no universal music (p.196).’ While humans are inherently musical, we do not share the same musical understanding or appreciation. Cultural characteristics and individual unique experiences are important factors to be considered.

3.2 Music: Repertoire used for older adults

The choice of repertoire in music therapy for older adults – especially those who suffer from dementia – has been informed by literature that is empirically based, aimed at stimulating long-term memories. In various studies, older adults were found to respond most positively to repertoire that was popular when they were in their early 20s - 30s (F. Baker & Grocke, 2009; Bright, 1991; Moore, Staum, & Brotons, 1992; Vanweelden & Cevasco, 2009). Research indicates that singing and instrument playing are the preferred
activities for older adults (Clair, 2000), so this section will mainly look at songs for these activities.

In Australia, the two editions of the Ulverscroft Large Print Song Books (K. Baker, 1981; Donald & Lehmann, 1987) have been an invaluable resource for music therapists since the 1980s. They are used extensively in hospitals, aged care facilities and rehabilitation centres and are still recommended to music therapy students today. Ulverscroft Song Books are published in England and are intended for an Anglo-Celtic audience and population. Songs specific to the Anglo-Celtic cultures are easily found in these books, for example ‘on Ilkla Moor Baht’at’ (Yorkshire) and ‘An Eriskay Love Lilt’ (Scotland). Despite their usefulness, it has been 20 years since their publication and these books are now becoming out of date. Furthermore, according to the abovementioned model of geriatric music preference, these books are suitable only for those aged 80 -100 years (Baker & Grocke, 2009).

Table 1.3 below shows the content of the Ulverscroft Song Books according to the following categories. (In recognition of the fact that songs often span more than one musical style, these categories are designed to give a general but clear idea of the content of the book.)

‘Popular songs’ – include songs from musicals and folksongs in English; excluding hymns and carols.

‘Songs with cross-cultural appeal’ – include songs known by more than one cultural group, excluding anthems.

‘Culturally specific songs’ – sung in LOTE, known by one specific culture only; including songs sung in Aboriginal language.

‘Religious songs’ – songs with religious content from any faith, include hymns.

Table 1.3: Number of songs from Ulverscroft Song Books according to style categories:

<table>
<thead>
<tr>
<th></th>
<th>Book 1</th>
<th>Book 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Popular songs</td>
<td>106</td>
<td>181*</td>
</tr>
<tr>
<td>Songs with cross cultural appeal</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Culturally specific songs</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Religious songs</td>
<td>22</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>136</strong></td>
<td><strong>240</strong></td>
</tr>
</tbody>
</table>

*Please note that in book 2, four non-religious carols are counted as popular songs, rather than religious songs. These carols are ‘Jingle Bells,’ ‘We Wish You A Merry Christmas,’ ‘Carol Of The Birds,’ and ‘Christmas Is Coming.’*

It is not surprising to find that the majority are popular songs, because this category encompasses three well-liked styles (popular, musicals and folk songs). Nonetheless, the number of both ‘songs with cross-cultural appeal’ and ‘culturally specific songs’ is under represented (0.06%). Although the Ulverscroft Song Books are excellent reference tools for music therapists working with older adults aged 80 and over, the current situation calls for extra effort from music therapists to acquire multicultural repertoire through other avenues.

According to the model of geriatric music preference, most songs suitable for adults aged 60 - 80 would be composed between 1940s and 1960s. Questions have been raised about this principle (Vanweelden & Cevasco, 2007, 2009): First, there are a number of pre - 1925 songs such as ‘Let Me Call You Sweetheart (1910)’ and ‘Waltzing Matilda (late 19\textsuperscript{th} century)’ that have stood the test of time and are still enjoyed by all ages within our cultures. Time of composition alone is insufficient to determine the suitability of a song and should not override individual preference (in consideration of context and meaning).

Repertoire in music therapy for older adults has been further investigated in Vanweelden and Cevasco’s study (2007), in which 151 American music therapists were asked to list the ten most frequently used songs for geriatric clients under five ‘style categories.’ The results showed that ‘popular music’ is the most frequently used category, followed by folk, musicals, hymns and patriotic songs. This is consistent with the content of the Ulverscroft Song Books. Unfortunately, the validity of the survey design was negatively
affected by a large amount of overlapping within categories due to its unclear definitions. Consequently, survey respondents placed the same songs in more than one category. Hence, conclusions about the rank order of these styles are not reliable.

Interestingly, another study by Baker and Grocke (2009) utilised the same survey design to investigate repertoire used by Australian music therapists, particularly repertoire for CALD older adults, and the music therapy approaches employed. A comparison of the top five most recommended popular songs from both the US and the Australian studies are shown in table 1.4 below.

**Table 1.4: Top five popular music recommended by music therapists for older adults in US and Australia.**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Australia (Baker and Grocke, 2009)</th>
<th>US (VanWeelden and Cevasco, 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Que Sera Sera (1955)</td>
<td>Let Me Call You Sweetheart (1910)</td>
</tr>
<tr>
<td>2.*</td>
<td>Love Me Tender (1956)</td>
<td>Five Foot Two, Eyes Of Blue (1925)</td>
</tr>
<tr>
<td></td>
<td>You Are My Sunshine (1940)</td>
<td></td>
</tr>
<tr>
<td>3.*</td>
<td>It’s a Long Way To Tipperary (1912)</td>
<td>Take Me Out To The Ballgame (1908)</td>
</tr>
<tr>
<td></td>
<td>When Irish Eyes Are Smiling (1912)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Edelweiss (1959)</td>
<td></td>
</tr>
<tr>
<td>4.*</td>
<td>Daisy (1892)</td>
<td>In The Good Old Summertime (1902)</td>
</tr>
<tr>
<td></td>
<td>Show Me The Way To Go Home (1959)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Country Roads (1971)</td>
<td></td>
</tr>
<tr>
<td>5.*</td>
<td>Blue Moon (1934)</td>
<td>Daisy (1892)</td>
</tr>
<tr>
<td></td>
<td>Danny Boy (1913)</td>
<td>You Are My Sunshine (1931)</td>
</tr>
<tr>
<td></td>
<td>I Did It My Way (1967)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pack Up Your Troubles (1915)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What a Wonderful World (1935)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wish Me Luck (1939)</td>
<td></td>
</tr>
</tbody>
</table>

*Songs that were recommended the same number of times result in a tied rank.*
According to table 1.4, nearly half (47%) of the top five popular song recommendations by Australian music therapists are composed after 1940s, but all US’s top five selections were pre-1940s. Two songs – ‘You Are My Sunshine,’ and ‘Daisy’ are in common with the Australian recommendations. Overall, it appears that Australian music therapists may be more likely to utilise newer and a larger variety of songs during music therapy work with older adults than their American counterparts. However, it must be noted that the sample size of the Australian studies is much smaller - 24 Australian respondents compared to 151 American respondents. Thus, conclusions made on this small comparison are board generalisations only.

3.3 Repertoire for older adults who come from CALD backgrounds.

Song repertoire for older adults is best if it is familiar to the clients. For music therapists who work with CALD clients, this involves familiarity with music from diverse cultures. Culture specific music, if played in an ‘authentic’ manner can facilitate trusted relationships with clients, even when this relationship is hindered by language barriers (Bright, 1993), however, the music should be carefully and thoughtfully chosen. Moreno (1988) warned that in many cultures, music is associated strongly with religions and rituals, and, it may elicit powerful emotions in the client that may be difficult to resolve due to language and cultural barriers (Moreno, 1988). Alarmingly, in a survey conducted by Valentino (2006), a majority (82%) of music therapists claimed that they use ‘any song in the client’s primary language.’ Only 11% believed that awareness of the role of music in a client’s culture is necessary. Thoughtlessly chosen songs can be counterproductive to any therapy outcome, and unethical on the therapist’s part (Grocke, personal communication, March 12, 2008). Therefore, therapists must seek knowledge of both cultural context and the emotional content of the music before using it with a client (Bright, 1993; Brown, 2001).

Despite apparent difficulties, there are many cases in which culturally specific music has been used successfully in music therapy work. Forrest (2000) has used traditional Russian folk songs to trigger memories and to assist her client in resolving past conflicts.
Likewise, traditional Israeli folksongs were utilised in Amir (1998)’s case study with a group of bereaved women of Jewish backgrounds, all of whom had experienced loss from the death of family members. Israeli folksongs chosen by the clients were used in group singing and discussion to address ‘unresolved issues concerning identity, interpersonal relationships, death, bereavement, grief, ageing, past history, present and future (Amir, 1998, p223).’

Conversely, Moreno (1988) suggested the use of unfamiliar music (‘multicultural music’ for ‘Western’ clients) to evoke interest and to motivate participation for those who seem disinterested in a particular music therapy activity. While acknowledging that association with the music is beneficial, Moreno warned that familiarity might inhibit ‘spontaneous musical and emotional responses’ (Moreno, 1988 p.20) in improvisation.

In Australia, culturally specific music is utilised by almost one quarter (23%) of all aged care music therapists (Baker & Grocke, 2009). In the same national survey mentioned above, Australian music therapists recommended a total of 103 culturally specific songs; predominantly Italian and German, followed by Polish, Dutch, Greek, Spanish, Chinese, French and Yugoslavian (in order of frequency). These songs represented 25% of all repertoire recommendations by Australian aged care music therapists, compared to 2% in the corresponding US study. This result reflects the increasingly diverse clientele in Australia, yet the gap of missing repertoire in important Australian cultural groups such as Aboriginal, African, and Middle Eastern, and some Eastern European nations, is notable (Baker & Grocke, 2009).

In comparing the two surveys mentioned above, Baker and Grocke (2009) pointed out the different perceptions of American and Australian music therapists on music styles, despite their similarities in culture and language. For instance, under the ‘patriotic’ category, American respondents (Vanweelden, 2007) selected mostly American songs, while Australian music therapists seem less nationalistic in their choices - only three Australian songs were chosen under the ‘patriotic’ category. Moreover, half (52%) of the patriotic songs chosen by Australian music therapists are in LOTE (Baker & Grocke,
On the other hand, it must be noted that questions asked in Baker & Grocke’s (2009) survey have an emphasis on cross-cultural issues, which may have influenced the response.

Use of English songs in cross-cultural music therapy.

Kenny & Stige (2002) on cultural homogenisation comment that:

‘Through the process of urbanisation and globalisation, Western and American values and traditions are invading the life-worlds of more and more people. In other words, we are today witnessing a complex mixture of process of heterogenisation and homogenisation. (p.18)’

These processes, and the technological advances that have accompanied their rise, have meant that music from the dominant Anglophone cultures of America and Britain have exerted great influence around the world. Popular songs from musicals and movies, for example, are often familiar to CALD clients, though individual circumstances such as the level of acculturation and personal taste are obviously important (Amir, 1998). This is evident in Baker and Grocke (2009)’s survey, which found that a number of English songs were used for CALD clients.

The aforementioned music preference model, which is based on English songs and English speaking clients, should be observed with cultural sensitivity. Music that is regarded as out-of-date by Anglo-Celtic clients may not be inappropriate for a person from a CALD background, depending on his/her level of acculturation, or how, when and where he/she learnt this music. Two elderly clients who share the same cultural background can have varied preferences. It is important to note that the model of music preference, similar to cultural norms, indicates a general tendency only. It should not override an individual’s unique cultural experience and their association with particular types of music.
Conclusion
Humans are inherently musical, but we do not necessarily share the same musical understanding or appreciation. This section looked at music as more than a stimulus, rather it considered music and its association with culture as one entity – ‘music-in-context’ (Stige, 2002). Songs sung without consideration of context may be meaningless and expressionless. Cultural characteristics and individual unique experiences are imperative in music experience. As all music therapists would agree that choosing the right repertoire is crucial to the success of therapeutic relationship (rapport) and ultimately, a positive therapy outcome. The right repertoire should be based on client’s preference. Both cultural norms and individual cultural experience should be considered when choosing and performing music for CALD clients.

4. Cross-cultural music therapy
Definition
The inseparable association between music and culture makes music therapy an effective and natural intervention for CALD clients. Cross-cultural music therapy is defined by the author in this study as

‘music therapy practice in which important cultural (racial and ethnic) differences exist between the therapist and clients and/or among the clients themselves.’

The concept of ‘music healing’ is deep rooted in many cultures (Pavlicevic, 2005), although this in itself can pose problems to therapists. In the word of Pavlicevic’s African acquaintance: ‘what is music therapy other than some colonial import? Why is it calling itself thus in South Africa, instead of imbibing African music-healing tradition (Pavlicevic, 2005, para. 1)?’ A professional music therapist may argue that the two are totally different, but it could be argued that music therapy should never be an import, ignoring the cultural contexts of the host country. Similarly, it is important for music therapists to adapt to cultural change and to face the challenge of multiculturalism.
Hence, in this final section of literature review, cross-cultural music therapy encounters, its challenges, cross-cultural skills, education and training will be discussed in length. Previous topics on ‘culture,’ and ‘music and culture’ will be consolidated into the existing knowledge base of music therapy, using various anecdotal accounts from Voices: the World Forum for Music Therapy as well as other academic sources. The following discussion will illuminate some of the methods used by cross-cultural music therapists working around the world – some are pioneering music therapists in countries previously uncharted.

4.1 Cross-cultural music therapy encounters, challenges and skills

To many music therapists, the ever-increasing demand for knowledge of foreign music presents a unique challenge. A range of experiences was identified in Yehuda (2002)’s phenomenological study, through interviews with six Israeli music therapists. These experiences include mystical attraction to foreign music, feelings of revulsion (toward certain music instruments, Arab language and music), and feelings of rejection (Jewish ultra-orthodox society rejects non-religious therapists). Cultural and political tension in Israel is constantly high. Working in such environment can evoke strong emotion (e.g. revulsion) even in therapists. In the word of one of Yehuda’s interviewees, ‘social stereotypes toward Arab people affect [my] relationship to Arab music (Yehuda, 2002, research result, para 4).’ Yehuda claimed that this difficulty could be overcome by a shift of focus. Instead of concentrating on the foreign musical element, therapists should look for the common features in human experiences, such as thoughts, feelings and social identity, and focus on them, with the aim to create ‘a special third space’ where the client and the therapist of different cultural backgrounds could meet and share intimate musical moment together.

This notion is not dissimilar to that of Kenny’s field theory for music therapy (1989). Kenny, of anthropological and ethnographical background, states that clinicians have an unfortunate tendency to focus on symptoms of illness or disability, and in the case of
cross-cultural issues – differences in values and beliefs. Rather, the person should be seen as an aesthetic being, which she describes as ‘a field of beauty’ (Kenny, 1989, p.75). Simplistically speaking, Kenny’s field theory reflects the music therapy process, in which the therapist helps the client to elaborate his/ her inner beauty, and as such engages in a process of healing (Kenny, 1989). This is a useful reminder of the fact that music therapy, clinical nature aside, is all but an art form. Its aesthetic values might be overlooked sometimes. Despite all the striking cultural differences that we may encounter daily, the beauty of music and humanity is something we can elaborate on, whether it is through improvisation or songs sharing and singing. In fact, music is an invaluable tool for communication, linguistic and cultural diversity aside. Music allows differences between the therapist and the client to be addressed in a peaceful and creative manner (Kenny & Stige, 2002; Stige, 2002; Yehuda, 2002).

For further example, a personal account from German music therapist Weber (2000) described the use of folksongs from England, Wales, Scotland and Ireland for her German patients. Weber (2000) recalled that: ‘Most of my patients say that [the English folksongs] sound vaguely familiar but they seldom bring up any concrete memories… This music allows me an initial contact that is non-threatening.’ (Weber, 2000 p189) In this case example, Weber utilised English folksongs as an element that she and her patients had in common, as well as a familiar and secure object to build a trusting relationship with them.

Knowledge of cultural factors
This is by no means dismissive of cultural difference. The concept of culturally sensitive practice is based on the recognition of various cultural factors, as discussed in section 2. These include language, religion, values, rules, meanings, knowledge and belief. Knowledge of these factors are very important in cross-cultural relationship (Brown, 2001), as they may impact on the effectiveness of the intervention. For example, CALD clients from a ‘collectivist’ background may respond better to community orientated approach as demonstrated by Williams and Abad (2008) in their first Australian Aboriginal music therapy group and Dos Santos (2005) in her group music therapy work
in Africa. In both cases, group music therapy approach is utilised. Both Aboriginal and traditional African culture emphasise the value of family/community and group cohesiveness. “Individual suffering impacts the well-being of many others and group empathy is compelled in the search for a remedy (Dos Santos, 2005, The ‘Individual Level,’ para. 5),” – hence to approach an individual problem through group work is more culturally sensitive in this case.

**An open-minded attitude and active acquisition of cultural knowledge**

Music therapists who work in aged care facilities are likely to encounter a number of CALD clients every day, as discussed in section 1 of this chapter. It seems somehow idealistic to expect therapists to acquire specific cultural knowledge for all clients, however, according to Brown (2001) and Dileo (2000) what is more important is to maintain (or to develop) an open-minded attitude to other cultures, and to actively pursue additional training or research to improve the understanding of other cultures (Dileo, 2000). Even though some multicultural music may appear unappealing to the music therapist, who as a musician as well as a health professional must refrain from any ethnocentric judgements and ‘must realize that the openness to entering into the client’s musical expression will serve to establish the initial components of a trusting relationship.’ (Dileo, 2000, p155) Active exploration with the client and/ or family member will minimise possibility of stereotyping.

**Cultural empathy**

Empathy is understood to be a perceptual-affective-cognitive-communicative process (Goldstein & Michaels, cited in Brown 2001) – in other words, by responding to our clients’ action, we go through the process of intellectually perceiving meanings, resonating in their experience, and eventually communicating or conveying such understanding (Brown, 2001; Dileo, 2000; Valentino, 2006). Furthermore, cultural empathy is ‘the process of gaining an understanding of the client’s personal cultural experiences with the aim of conveying this understanding (Brown, 2001, ‘Cultural empathy,’ para.2).’
In Valentino’s (2006) survey of music therapists’ attitudes toward cross-cultural empathy, Australian music therapists received slightly higher scores than their American counterparts. Overall, music therapists from both countries have higher scores than a group of undergraduate students, according to the Scale of Ethno-cultural Empathy (Wang, et al., 2003, cited in Valentino 2006), suggesting that music therapists, either by personality type or the nature of music therapy training, demonstrate better ability to empathise with people from multicultural backgrounds (Valentino, 2006).

Cultural empathy can also be transmitted through sensitive use of music therapy techniques demonstrated by the music therapists mentioned in the above section. Brown (2001) and Bright (1993) refer to the practice of direct eye-contact and sitting in close proximity as an example of cultural dis-empathy. This therapeutic action may seem natural to Western music therapists, but is to be avoided in most Asian cultures as well as Aboriginal culture. Direct eye contact denotes disrespect, and even confrontation in these and other cultures. However, eye-contact is usual practice in Western society in order to communicate, and ironically, to convey empathy.

**Self-cultural awareness**

Dileo (2000) and Valentino (2006) urge music therapists to be, first and foremost, aware of our own cultural identity and its influence on values and beliefs. This understanding contributes to an awareness of our tendency towards ethnocentrism. The collective knowledge acquired from professional training and research over the years seems unquestionable. It might be seen as the natural and the only way to provide treatment for the clients. However if we don’t reflect on practice, our knowledge does not develop. Music therapy methods developed in the West may have no relevance to multicultural clients, therefore, are ultimately unhelpful. For example, in parts of Africa, music healing is a recognised and established practice in traditional culture. Western trained music therapists are required to adapt and to learn from traditional African music-making and their world-view, for the intervention to be beneficial to its population (Dos Santos, 2005; Pavlicevic, 2005).
4.2 Music therapy methods used in multicultural literatures

Music therapy methods discussed in multicultural literatures include ‘singing with reminiscence’ (Amir, 1998; Forrest, 2000; Orth & Verburgt, 1998), ‘instrumental improvisation’ (Amir, 1998, Elwafi, 2005, Moreno, 1988), ‘instrumental playing along to music’ (Orth and Verburgt, 1998), ‘listening to music that the therapist plays/ sing’ (Forrest, 2000, Orth and Verburgt, 1998) and ‘vocal improvisation,’ specifically vocal holding technique (Orth, 2005) which employed a two chords improvisational structure in combination with the therapists’ voice ‘in order to establish a predictable, secure musical and psychological container that facilitates improvised singing.’ (Orth, 2005, ‘Vocal Holding Techniques’ para 1)

When working with a refugee group in the Netherlands, Orth and Verburgt (1998) employed a combination of several abovementioned techniques,

‘Starting point: Songbooks and rhythm instruments from foreign countries together with ‘universal’ instruments such as the guitar and the piano…we try to play it together accompanied by rhythmic instruments, the therapist adds cohesion by means of the electric guitar, bass guitar or the electric piano. We then try to continue from this structured process by creating the opportunity for improvisation: vocal improvisation through a microphone, dancing to the reggae accompaniment, trying out other instruments (p.86-87)’

Neither activity is language dependent or difficult to understand. Both have therapeutic implications – reaffirming cultural identity through the use of cultural specific music, facilitating self-expression and creativity through improvisation, and promoting positive self-esteem through emotional support of group members.

Incorporation of culturally specific idioms

Other culturally sensitive approaches used by music therapists around the world include the incorporation of culturally specific idioms in therapy session. Aluede & Lyeh (2008), Guvenc (2006), Sabbatella (2004), from Nigeria, Turkey and Spain respectively indicated the inseparable relationship of music and dance in their countries. Aluede and Lyeh
(2008) wrote that, ‘in most cases in Nigeria, music and dance are closely knit. This is so because dance is rarely ever performed without music and music in very many instances calls for dance. (Aluede & Lyeh 2008, “Definition of music therapy,” para 2).’ Hence dance is an important inclusion in many multicultural practices.

Other idioms mentioned in literature are culturally specific instruments and traditional songs from the client’s culture. Amir (1998) described the singing of Israeli folksongs with her clients, ‘introducing specific songs when I feel that they can be a vehicle to work on specific issues.’ Sometimes it involves avoiding certain instruments altogether. Elwafi (2005) from Qatar mentioned her restriction in using strings or wind instrument such as the guitar, oud (Arabic guitar), piano, and flute in her music therapy session with the children she works with, because some interpretations of Islam do not allow music that uses these types of instruments. In that case, the voice and drums were used instead.

To conclude this section, music therapy models are based upon Western psychology, with all the cultural limitations that implies. It is vital to acknowledge these limitations and constantly question the suitability of our methods, rather than transplanting Western models of music therapy to the non-Western context.

4.3 Education and training

CALD music therapists

Up to now, this literature review has viewed CALD client’s music and culture as ‘foreign.’ Consider the reverse situation: music therapists of non-Western heritage, who have received their music therapy training in ‘the West’ and have returned to work in their countries of origin. Ikuno (2005), of Japanese heritage, discussed the effects of Western education (from the US) on her personal view of Japanese music therapy, which values group over individual therapy, especially in aged care. Despite this, attitudes among the younger Japanese generation in particular now recognise the value of ‘self-expression’ and ‘self-actualisation’ (Ikuno, 2005). Japanese culture is evolving – terms such as ‘collectivist’ and ‘individualist’ are no longer adequate or relevant to such
changing cultural environment. A dilemma was raised about group versus individual approach in her therapy work. Ikuno (2005) stated,

‘the individual orientation of today's Japanese people is not separated from the traditional culture of group orientation, but is strongly grounded by it. On the other hand, a calm united group at first sight conceives the covert and nameless movements of self-actualization underneath. The people who live in well-being seem to be those who can feel a good balance between the two orientations, one way or another. In contrast, confusion, such as when a group oppresses an individual or when unhealthy individualism breaks human-relationships, often becomes the themes of therapies (Ikuno, 2005, ‘Clinical Perspectives on Music Therapy in Japan,’ para.3).’

It must be reiterated that, in working cross-culturally, therapists must have self-awareness, be clear of his or her own cultural baggage and must be able to articulate, as Ikuno (2005) did, the influences of cultural teaching to his/ her own belief and values. On training, Forinash (2001) commented on the phenomenon of the large number of international students in the US, which provide opportunities for local students to experience other cultures. Again, cultural self-awareness on the part of both international and local students would ensure exciting cultural exchange and deeper understanding of various cultural issues, thus better prepare students for today’s multicultural society.

According to a US survey by Darrow & Molloy (1998), only 13% of music therapists felt that their cross-cultural training was adequate, while another survey conducted in both Australia and the US found a positive correlation between cross-cultural training and high cross-cultural empathy score (Valentino, 2006). Cultural and linguistic difference can certainly place a barrier between clinicians and clients and this is not restricted to music therapy. In a 1998 survey of Victorian mental health professionals, 55% acknowledged that their clinical skills were poorer when assessing mood and affect in clients of non-English speaking background than in clients of English speaking background (Stolk, cited in Andary et al., 2002). The difficulty is compounded for music therapists because
cultural diversity means that we can no longer rely on a single source for the acquisition of scores and other musical resources (Baker & Grocke, 2009; Valentino, 2006). Respondents from Baker and Grocke’s study (2009) expressed that the lack of knowledge regarding contexts of specific music as one of their main challenge. Therefore, the need for organised and comprehensive cross-cultural training and preparation is clear (F. Baker & Grocke, 2009; Bright, 1993; Brown, 2001; Darrow & Molloy, 1998; Dileo, 2000; Forinash, 2001; Valentino, 2006).

Several authors have called for the establishment of multicultural competencies by professional associations (Dileo, 2000; Estrella, 2001; Kenny & Stige, 2002; Valentino, 2006), both on entry and advanced levels to serve as a foundation for education and training. In terms of repertoire, Stige (2002), Vanweelden and Cevasco (2007) have suggested a collective approach to develop multicultural music resources, including the sharing of experiences and knowledge through individual case examples, opinions and research. Internet ‘headquarters’ like Voices: The World Forum for Music Therapy have been set up by music therapists and students to face this changing clinical demand, yet there remains much work to be done.

**Conclusion**

Multiculturalism is an everyday reality for Australian music therapists. In 2007, almost one in four of their aged clients came from a CALD background (Baker & Grocke, 2009) and this figure is expected to increase in the near future, as CALD communities are growing and ageing more rapidly than their Australian-born counterparts (Gibson, Braun, Benham & Mason 2001).

The following reasons have been advocated as to why music is a potentially valuable tool for cross-cultural therapy. Blacking (1976), Davis, Gfeller and Thaut (1999), Kenny & Stige (2002) asserted that music is inherent in human life and differentiates us from other higher vertebrates of the animal kingdoms. Every culture known to us has music (Nettl, cited in Gfeller, et al, 1999) and the relationship between music and culture is close, yet wide-ranging: from religious rites and nationalistic parades to lullabies. Additionally, this
chapter has discussed how certain music can cross cultural barriers, connecting people of diverse backgrounds.

The field of music therapy is expanding geographically, yet despite the proliferation of case studies and ethical considerations in multicultural music therapy literature, integrated analysis of practical methods and techniques are rarely investigated. Little is known about the extent to which therapists apply various techniques, and to what extent culturally specific idioms are used. There is no study so far that gives insight into the actual practice of music therapists working with CALD aged clients in group therapy, the most common approach in aged care. Unsurprisingly, studies have concluded that at present, music therapy training provides inadequate preparation for cross-cultural work.

In reviewing the literature for this topic, the researcher was compelled to use sources more than ten years old and from other disciplines such as ethnomusicology, psychology and counseling. While this reflects the multidisciplinary nature of music therapy, the deficiency in this area is also indicative of the paucity of contemporary research.

With these issues in mind, the present survey will provide an overview of cross-cultural music therapy practice in Australia through identifying common experiences amongst practicing Australian RMT and the answer for the following the research questions:

In cross cultural music therapy in aged care in Australia:
1. Which music therapy methods are used a) the most and b) the least, by RMTs?
2. Which music therapy methods are perceived by RMTs as a) effective, b) difficult to implement, or c) culturally insensitive/ inappropriate?
3. What musical styles are used by RMTs?
4. What culturally specific music idioms are used by RMTs, if at all?
5. What are the concerns or challenges experienced by RMTs in conducting cross-cultural practice?
The research will also collect demographic information regarding Australian RMTs practising cross-cultural group therapy in aged care, with the aim to verify the results from a previous survey (Baker & Grocke, 2009) and to extend their scope. Finally, on the issues of training, the researcher would like to examine therapists’ strategies in coping with cultural barriers and concerns that therapists may have when working with CALD clients. The results of this will hopefully contribute to multicultural competency in music therapy training in Australia.
CHAPTER THREE

METHOD

1. Method

1.1 Context for study
This research seeks to examine music therapy methods and approaches used by Australian Registered Music Therapists (RMTs) who work with aged CALD clients, specifically in a multicultural music therapy group situation.

In previous chapters, the phenomenon of ever-increasing cultural diversity in aged care and its impact on music therapy service delivery has been discussed. In Australia, 18% of the population aged 65 and over, are overseas-born (ABS, 2004), and 23% RMTs working in aged care utilize multicultural music at their work (Baker & Grocke, 2009). Multiculturalism is also a global phenomenon. It has interested many music therapists over the last decade, as shown in the increased amount of relevant music therapy journal articles, independent publications and discussion on the Internet forum (i.e., Voices: The World Forum for Music Therapy).

However, research addressing the practical aspects of cross-cultural music therapy is limited at the present. Many music therapists have written about their personal experiences and ethical considerations in cross-cultural practice; yet most of these studies concern individual clients, rather than the group approach, which is most commonly used in aged care. This study was designed to address the shortage of research in these areas: 1) music therapy methods, 2) aged CALD clients and 3) group situations.
1.2 Ethics approval
This research is in partial fulfilment of a Master degree from the School of Music at the University of Melbourne. In September 2008, ethics approval (project number: 0829905.1) was sought through the Music Human Ethics Advisory Group at the University of Melbourne and was successfully granted. The ethics application included research aims, methods, details on data management and method of analysis.

An anonymous survey was designed to capture information of practising RMT in Australia. The web sites containing the questionnaire was hosted by a web survey company ‘surveymethods.com’ for three months from September to December 2008 and were then automatically disassembled upon completion of the survey.

1.3 Participants – sample population
A small and specific sample population was selected to reflect the aims of this study. According to the 2008 AMTA membership directory, 88 RMTs (not including the author) were identified as practicing in ‘aged care/ old age care/ dementia/ community aged care/ aged psychiatry.’ Although it was impossible to determine the number of those who practice cross-culturally at the time of the survey, it was likely that most practicing RMTs would have multicultural encounters in their work. Therefore these 88 aged care RMTs formed the pool of participants, from which a 30% to 60% response rate was expected. This would be consistent with another Australian study – the study by Baker and Grocke (2009), which also targeted aged care RMTs and achieved a 33% response rate. It is worth noting that the population sample of that study was not restricted to cross-cultural RMTs.

The inclusion criteria for the present study were as follow:
1. Participants must have been registered with the AMTA as practicing members, as this study looks at the current practice of Australian RMTs.
2. At the time of the survey (September-November 2008), participants must have been practicing music therapy with older adults who come from CALD backgrounds.
3. Participants must have experience in conducting group music therapy. More than three CALD older adults in a group qualified as a group situation.

1.4 Research method – survey design

Survey design was the research method selected for this study. It is a common approach used by health care researchers especially in the field of music therapy. It involves the collection of information from a large group of people using a specially devised interviews or questionnaire, in order to describe an overall picture of that group ‘in any characteristics that are of interest to the researcher.’ (Hicks, 2004)

Many music therapy surveys explore attitude and perceptions of music therapists (Wigram, 2005). Survey research is often utilized to present demographic data and to provide supportive evidence to underpin the current and future deployment of music therapy services (Wigram, 2005). This study planned to collect demographic data and explore the practical details of cross-cultural music therapy in aged care in Australia, at the same time, comparing the result to the available literature. Hence, the survey research method was most suitable for the purpose of this study.

A web-based questionnaire was used instead of the traditional postal survey because the targeted participants were presumed to be computer literate and were expected to find completing a web-based questionnaire easier than the traditional postal survey. Other benefits included the immediacy of responses and reduced human error in data entry and processing, while ensuring all participants were unidentifiable. Lastly, the cost of a web survey was significantly lower than that of a paper survey with less printing cost and zero postage fees.

Survey design

After comparing a number of web survey tools over the Internet, the researcher found the independent contractor ‘Surveymethods.com’ to be the most professional in appearance with a wide range of question types (from simple choice questions to rating scales) for
the researcher to choose from. Also, its ‘skip logic’ function allowed respondents to be routed around questions that they didn’t need to answer.

The researcher devised a total number of 27 questions reflecting the four key research questions mentioned in the previous chapter (See appendix A):

In cross-cultural music therapy in aged care,

1) Which methods are frequently or less frequently used?
2) Which methods are perceived as working well, difficult to implement, or culturally inappropriate/ insensitive by RMTs?
3) Which cultural specific idioms are used?
4) What are the concerns of RMTs?

In addition to the above research questions, this study also aimed to provide a general overview of the impact of multiculturalism within the music therapy profession in aged care. Therefore, demographic information about cross-cultural music therapy with aged clients was sought and addressed at the first section of the survey. These demographic questions concerned age, gender, state / territories of employment (question 1-3), year of experiences (question 7), academic degree of entry into the profession (question 6), utilization of Language Other Than English (question 4 and 5), the number of CALD client whom the respondents served (in approximately the last six months from the launch date of the survey) and the cultural groups these clients belonged to (question 8 and 9).

Regarding cultural groups and the number of CALD clients who receive music therapy services, respondents were asked to estimate rather than quoting an exact figure. This was because an exact figure would involve diligent record keeping on the therapist’s part or utilizing databases of respective aged care facilities or hospitals where the respondents work. These extra procedures were not necessary for the purpose of this study. Therefore, the results of these two demographic items were the perceived major CALD groups as well as the perceived number of CALD clients, as estimated by the respondents.
The questionnaire contained four sections. As mentioned above, the first section consisted of nine questions regarding demographic information. The second section consisted of eight questions regarding ‘methods used in cross-cultural music therapy practice.’ These included

- The type of methods used (receptive, active or both),
- Frequency of use of various methods (song writing, instrument playing along with music, vocal improvisation, singing with or without reminiscence, instrumental improvisation, music and movement, folk dance, and listening to music that the therapist plays/sing, or played on CD)
- Whether these methods work well, are difficult to implement or are culturally inappropriate or insensitive.
- Frequency of music of various repertoire styles
- Musical style used in receptive music therapy

Repertoire styles were addressed in question 15, in which respondents were asked to rate a range of repertoire styles from ‘almost always’ to ‘almost never’ used in their music therapy group involving CALD clients. This question required careful wording. As discussed in section 3.2 in chapter 2: literature review, questions regarding repertoire styles can be confusing for the respondents, as songs often span over more than one musical style. Therefore, the researcher created the following categories for the interest of the cross-cultural study. These were ‘songs with cross-cultural appeal,’ ‘culture specific songs,’ ‘popular songs, folk songs and songs from musicals (in English),’ ‘religious songs,’ ‘national anthems,’ ‘songs from European Classical music.’ Popular songs, folk songs and songs from musicals were grouped together. In the researcher’s opinion, these song styles are usually interchangeable in the context of aged care repertoire, especially when it concerns clients who come from CALD backgrounds. Additionally, to further improve clarity of question 15, songs examples were provided under each category. As a result, the following explanation paragraph / text box was displayed in the questionnaire:
In question 15, I am interested to know about the types of songs that you use in music therapy groups involving multiple CALD clients. As songs often span over more than one musical style, please refer to the following examples while you make your selections:

- Songs with cross-cultural appeal (known by more than one cultural group, excluding anthems) e.g. Home sweet home, Roll out the barrel/ Rosamunda, La vie en rose, Tulips from Amsterdam, Muss ich den/ Wooden heart (German), Pote tin kyriaki / Never on Sunday (Greek).
- Popular songs (e.g. You are my sunshine), songs from musicals (e.g. Edelweiss) and folk songs in English (e.g. Home on the range).
- Cultural specific songs (sung in LOTE, known by one specific culture only): e.g. Jasmine Flower (Chinese), Hava Nagila (Yiddish), De ZilverlOOT (Dutch), Sakura (Japanese).
- Religious songs or hymns (from any faith/ culture.)
- National anthems (from any country.)
- Songs from European Classical music: e.g. Schubert Ave Maria, Brahms lullaby.

The second section concluded with one open-ended question, which read,

**Q18 Do you prefer to work with CALD clients individually or as a group? Please give reason.**

The third section consisted of two questions regarding the incorporation of cultural specific idioms into cross-cultural practice. These included culturally specific musical instruments (question 19), varying rhythm, specific mode or scale, cultural specific dance, varying vocal timbre (question 20).

The fourth section consisted of seven questions regarding challenges faced by RMTs when working with CALD clients, the influence of the RMT’s personal background and
training as well as the strategies used in cross-cultural music therapy. Three questions were open-ended. They read,

\[ Q22: \text{`Are there any factors in your personal background or experience that influence your style of cross-cultural music therapy practice (eg. country of origin, family heritage, travel or work experience.) If possible, please elaborate on how it influences your practice.'} \]

A few examples were given to the above question to prompt responses, to stimulate thinking and to encourage elaboration.

\[ Q23: \text{`Apart from using music, what strategies do you use in communicating with CALD clients who are not proficient in English?’} \]

\[ Q25: \text{`Do you find rapport building difficult with CALD clients who are NOT proficient in English?’ ‘Yes, because…/ No because…’} \]

Question 27 was an optional open-ended question asking for any additional comments as necessary. It reads, ‘as you reflect on cross-cultural practices, do you have any comments?’

In summary, the questionnaire contained 21 closed questions that include rating scales and multiple choices, and 6 open-ended questions.

1. Demographic data (question 1-9)
2. Methods used in cross-cultural music therapy practice (question 10 – 18)
3. Incorporating cultural specific idioms (question 19 - 20)
4. Challenge experienced by RMTs (question 21-26)
1.5 Procedure

A printed version of the survey was piloted with seven RMTs at a music therapy postgraduate seminar to ascertain clarity. As a result, several questions were reworded. It was established that the survey would take approximately 10-15 minutes to complete.

The administrator of AMTA was contacted on September 22, 2008 to assist in the recruitment of participants. Invitations to participate were sent out in bulk to a total number of 281 practicing RMTs listed in the AMTA email database. The email invitation, that was equivalent to a cover letter of a postal survey, began with the following introduction:

‘Greetings aged care RMTs!
Please spare 10 to 15 minutes to complete the following online survey (anonymous). The result will contribute to our knowledge of methods utilized in cross-cultural music therapy in aged care. Please find the link below. It will take you to my survey.’

Following the above message was a 300 words plain language statement (see appendix B) explaining research aims, methods, data management, researchers contact details and assurance of confidentiality. At the end of the email was a hyper-link connecting to the online questionnaire hosted by surveymethod.com.

The initial email was distributed on September 25, 2008. Three weeks was given for response, but initially only 22 RMTs completed the survey. Several reasons could have contributed to this low response rate. Firstly, the wording qualifying the respondents was too imprecise - the phrase ‘aged care RMTs’ can be confused with ‘aged care facilities only,’ thus RMTs who worked outside residential setting, i.e. in medical or community settings were excluded. Secondly, there were RMTs who claimed to have not received the initial email.
A reminder email, with an extended introduction further qualifying the respondents, was sent in order to increase the response rate. It read as follow:

Greetings RMTs doing GROUP WORK (more than 3 participants) with aged clients (in aged care, psychiatric care, palliative care, etc)…

The response increased from 22 (25%) to 30 (34%). Out of these 30 completed responses, 26 (29%) were suitable for data analysis. Data collection ended on November 20, 2008, two months after it was launched.

1.6 Method of analysis

Both quantitative and qualitative data collected were stored in the researcher’s personal computer and the web site hosting the survey, both of which were protected by passwords known only to the researchers.

Quantitative data were analysed using techniques of descriptive statistics including rank ordering, medians and frequency counts to be presented in graphs, tables and pie charts; whichever is the clearest. A thematic analysis was conducted based on results obtained from the qualitative data collected from the open-ended questions. The researchers read through these responses/comments many times until common themes emerged, and then codes were allocated. Similar comments were grouped together under the codes, and subsequently these codes answered the questions.
CHAPTER FOUR

RESULTS

This chapter presents the results and findings of the survey mentioned in the method chapter. Eighty-eight RMTs were identified from the AMTA directory as practicing in ‘aged care/ old age care/ dementia/ community aged care/ aged psychiatry.’ Since the AMTA directory does not specify whether these RMTs work with CALD clients or not, it was assumed that all of them did. A 34% (n=30) response rate was achieved for this study, although only 26 responses (29%) were suitable for data-analysis.

Results will be presented in the order of the question of the survey (See Appendix).

1. Demographics – cross-cultural music therapy in aged care
1.1 Therapists age, gender and state/territories of practice. (Question 1-3)
Of these respondents, there were considerably more female (n=20, 76.92%) than male (n=6, 23.08%). The same number of respondents were in the 20-29 age group (n=8, 30.77%) as in the 30-39 (n=8, 30.77%) age group. One respondent only was over 60. (Figure 4.1).

![Figure 4.1: Therapist age](image)

Most respondents practiced in Victoria (n=14, 53.85%), then New South Wales / ACT (n=6, 23.08%), Queensland (n=4, 15.38%), and South Australia (n=2, 7.69%), in order of
the most to the least. None of the respondents practiced in Northern Territory, Western Australia and Tasmania (Figure 4.2).

![Figure 4.2: Therapist by state](image)

### 1.2 Second language(s) spoken by therapists (Question 4 and 5)

More than half of the respondents (n=14, 53.85%) spoke only English. For those who were fluent in a second language (‘sufficient to engage in a conversation’ as qualified in the questionnaire), most spoke German (n=4, 15.38%), French (n=3, 11.54%), then Italian (n=2, 7.69%) (Figure 4.3). Other languages spoken by the respondents were Chinese, Latvian, Serbian, Russian, Croatian, Bosnian, Korean, Urdu, Hindi and Serbian.

![Figure 4.3: LOTE spoken by therapists](image)
Twenty-two (84.62%) respondents knew a smattering of words in another language, which is defined in the survey as using ‘LOTE vocabulary or phrases in their music therapy practice despite not really speaking the language.’ Of these respondents, most spoke Italian (n=19, 73.08%), French (n=8, 30.7%) and German (n=7, 26.9%). Two respondents (7.69%) knew a smattering in Chinese, including Cantonese and Mandarin. ‘Other languages’ were Spanish (n=3), Russian (n=3), Vietnamese (2), Dutch, Japanese, Serbian, Croatian, Bosnian, Polish, Hungarian, Mandarin, Greek, and Indonesian. (Figure 4.4)

![Figure 4.4: Vocabulary or phrases known by therapists](image)

1.3 Academic degree for entry into the profession and clinical experience (Question 6)

Of all respondents, exactly half (n=13, 50%) held a Graduate Diploma in music therapy, 26.92% (n=7) held a Bachelor’s degree and 23.08% (n=6) holds a Master’s degree (coursework) in music therapy. In terms of clinical experience, the average was about 6.55 years, ranging from 26 years the highest to 0.5 year the lowest. The median was 5 years (Figure 4.5).
1.4 Aged CALD clients served by music therapists

The estimated number of aged CALD clients that music therapists work with varied across the board. For example, two respondents (7.69%) each chose the categories about 100%, 20%, 70%, and none of them reported 50%, 80% and 90%, while most respondents (n=9, 34.62%) claimed that about 10% of the clients come from CALD backgrounds (Figure 4.6).
Therapists reported working with 35 different CALD groups (apart from clients of Anglo-Celtic backgrounds) in the last six months. Of these cultural groups, seventeen were provided as multiple-choice answers. Respondents were also asked to specify the cultural groups that they worked with, if it was not included in the multiple-choice answers. As a result, 18 other CALD groups were specified.

Multiple choice answers have the following CALD groups: indigenous Australian, German, Macedonian, Arabic (including Lebanese), Italian, Greek, Maltese, Dutch, Vietnamese, Russian, Sinhalnese, Turkish, French, Croatian, Serbian, Spanish, Chinese (including Cantonese and Mandarin).

The other 18 CALD groups specified were Latvian (n=2), Polish (n=3), Austrian (n=3), Egyptian (n=2), Hungarian (n=3) and Indian (n=2). Six of these groups were mentioned more than twice.
The least encountered groups were those mentioned only once, these are: *Thai, Korean, Estonian, Lithuanian, Filipino, Ukranian, Slovakian, Iceland, South American* (specific countries unknown), *Japanese, Indonesian* and *Ethiopian*.

The table below listed all the aforementioned CALD groups in order of prevalence. The groups most frequently encountered were *Italian* (80.7%), *German* (65.4%), *Greek* (42.3%), *Chinese* (42.3%), *Maltese* (38.5%), *Croatian* (38.5%) and *Dutch* (34.6%). Tied ranks occur at the 3rd, 4th, 8th, 10th, 11th and 12th ranks. As a result, there were only 13th ranks for 35 CALD groups mentioned in the responses.

Table 4.1: CALD groups that RMTs encountered in the last six months.

<table>
<thead>
<tr>
<th>Rank</th>
<th>CALD Group</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Italian</td>
<td>21</td>
<td>80.7</td>
</tr>
<tr>
<td>2</td>
<td>German</td>
<td>17</td>
<td>65.4</td>
</tr>
<tr>
<td>3</td>
<td>Greek</td>
<td>11</td>
<td>42.3</td>
</tr>
<tr>
<td></td>
<td>Chinese (including Cantonese and Mandarin)</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Maltese</td>
<td>10</td>
<td>38.5</td>
</tr>
<tr>
<td></td>
<td>Croatian</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>5</td>
<td>Dutch</td>
<td>9</td>
<td>34.6</td>
</tr>
<tr>
<td>6</td>
<td>Spanish</td>
<td>8</td>
<td>30.8</td>
</tr>
<tr>
<td>7</td>
<td>Sinhalnese (Sri Lanka)</td>
<td>7</td>
<td>26.9</td>
</tr>
<tr>
<td>8</td>
<td>Arabic (including Lebanese)</td>
<td>6</td>
<td>23.1</td>
</tr>
<tr>
<td></td>
<td>Vietnamese</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td></td>
<td>Russian</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>9</td>
<td>Serbian</td>
<td>5</td>
<td>19.2</td>
</tr>
<tr>
<td>10</td>
<td>French</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>11</td>
<td>Polish</td>
<td>3</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>Austrian</td>
<td>&quot;</td>
<td>&quot;</td>
</tr>
<tr>
<td>Hungarian</td>
<td>“”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12*</td>
<td>Turkish, Indian, Latvian, Egyptian</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td>13*</td>
<td>Thai, Korean, Estonian, Lithuanian, Filipino, Ukrainian, Slovakian, Iceland, South American (specific countries unknown), Japanese, Indonesian, Ethiopian.</td>
<td>1</td>
<td>3.8</td>
</tr>
</tbody>
</table>

* These are not combined statistics. Each CALD group under these positions occurred with the frequency and percentage displayed in their respective column. E.g. Turkish (n=2, 7.7%) and Indian (n=2, 7.7%).

2. Methods used in cross-cultural music therapy practice

2.1 Active and receptive music therapy (Question 10)

‘Active music therapy’ was defined as clients’ active involvement in music making, while in ‘receptive music therapy,’ clients listen to music that the therapist play, sings, or played on CD. All, except two therapists (n=24, 92.31%) used both receptive and active music therapy methods in music therapy group involving multiple CALD aged clients. The remaining two respondents claimed to use active and receptive methods respectively.

2.2 Music therapy methods used in CALD group therapy (Question 11 and 12)

Figure 4.7 lists the frequency of use (from “almost always” to “almost never”) of various music therapy methods employed in group therapy involving CALD clients.

Most frequently used methods are those reported by most respondents as either ‘almost always’ or ‘often’ used. These were ‘singing with reminiscence” (n=23 88.46%), ‘listening to music that the therapist plays/ sings or played on CD’ (n=19, 73.08%) and “instrument playing along with music” (n=17, 65.38%).

Moderately used methods are those identified by most respondents as either ‘often’ or ‘occasionally’ used. These were “singing without reminiscence” (n=17, 65.38%), and “music and movement” (n=19, 73.08%).
Rarely used methods are those identified by most respondent as either ‘rarely’ or ‘almost never’ used. These were “song writing” (n=16, 61.54%), and “folk dance” (n=20, 76.92%).

The frequency of use for both “instrumental improvisation” and “vocal improvisation” varied across the rating scale. Similar numbers of respondents voted for all degrees of the rating scale, except for “almost always” (figure 4.7). The general tendency regarding the frequency of use for these methods could not be determined.

<table>
<thead>
<tr>
<th>Method</th>
<th>Almost always</th>
<th>Often</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Almost never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Song writing</td>
<td>0(0%)</td>
<td>2(7.69)</td>
<td>8(30.77%)</td>
<td>4(15.38)</td>
<td>12(46.15%)</td>
<td>26</td>
</tr>
<tr>
<td>Instrument playing along with music</td>
<td>8(30.77%)</td>
<td>9(34.62)</td>
<td>5(19.23%)</td>
<td>1(3.85)</td>
<td>3(11.54%)</td>
<td>26</td>
</tr>
<tr>
<td>Vocal improvisation</td>
<td>1(3.85%)</td>
<td>5(19.23)</td>
<td>6(23.08%)</td>
<td>6(23.08)</td>
<td>8(30.77%)</td>
<td>26</td>
</tr>
<tr>
<td>Singing with reminiscence</td>
<td>12(46.15%)</td>
<td>11(42.31)</td>
<td>1(3.85%)</td>
<td>1(3.85)</td>
<td>1(3.85%)</td>
<td>26</td>
</tr>
<tr>
<td>Singing without reminiscence</td>
<td>4(15.38%)</td>
<td>11(42.31)</td>
<td>6(23.08%)</td>
<td>1(3.85)</td>
<td>4(15.38%)</td>
<td>26</td>
</tr>
<tr>
<td>Instrumental improvisation</td>
<td>3(11.54%)</td>
<td>6(23.08)</td>
<td>7(26.92%)</td>
<td>4(15.38)</td>
<td>6(23.08%)</td>
<td>26</td>
</tr>
<tr>
<td>Music and movement</td>
<td>3(11.54%)</td>
<td>12(46.15)</td>
<td>7(26.92%)</td>
<td>3(11.54)</td>
<td>1(3.85%)</td>
<td>26</td>
</tr>
<tr>
<td>Folk dance (cultural specific dance)</td>
<td>0(0%)</td>
<td>2(7.69)</td>
<td>4(15.38%)</td>
<td>7(26.92)</td>
<td>13(50%)</td>
<td>26</td>
</tr>
<tr>
<td>Listening to music that the therapist plays/sings, or played on CD</td>
<td>10(38.46%)</td>
<td>9(34.62)</td>
<td>6(23.08%)</td>
<td>1(3.85)</td>
<td>0(0%)</td>
<td>26</td>
</tr>
</tbody>
</table>

Figure 4.7 The frequency of use of various music therapy methods

Respondents suggested additional methods as follow:

- **Music & sensory experiences**: ‘with silk scarves, bubbles or a scent’
- **Singing**: ‘… in different languages,’ ‘…with physical exercise, ‘encouraging clients to sing with the therapist,’
- **Requests**: ‘responding to requests from people of different cultural backgrounds,’
- **Musical Quiz**: ‘guess title/ lines of songs,’
- **Reminiscence**: ‘in regards to culturally significant food, or perhaps events such as war or joyful memories,’ and to ‘ask client of their culture or language related to the session themes or songs (English).’
2.3 Which music therapy methods work well, are difficult to implement or are culturally inappropriate or insensitive? (Question 13)

Methods that were considered ‘difficult to implement’ were:

‘song writing (n=19, 82.61%),’ and ‘folk dance (n=16, 72.73%).’

Methods that were considered to ‘work well’ were:

‘instrumental playing along with music’ (n=19, 79.17%),
‘singing with reminiscence’ (n=22, 88%),
‘singing without reminiscence’ (n=19, 79.17%),
‘music and movement’ (n=19, 79.19%) and
‘listening to music that the therapists plays/ sings, or played on CD’ (n=25, 100%).

Interestingly, a significant number of respondents considered ‘vocal improvisation’ and ‘instrumental improvisation’ as ‘works well’ and ‘difficult to implement.’ (Figure 4.8)

However, none of the suggested methods were thought to be particularly ‘culturally inappropriate or insensitive.’ (Figure 4.8).

<table>
<thead>
<tr>
<th>13. In your experience with cross-cultural music therapy groups, which of the following music therapy methods work well, are difficult to implement or are culturally inappropriate or insensitive?</th>
<th>Difficult to implement</th>
<th>Inappropriate or insensitive</th>
<th>Works well</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Song writing:</td>
<td>19(82.61%)</td>
<td>0(0%)</td>
<td>4(17.39%)</td>
<td>23</td>
</tr>
<tr>
<td>Instrument playing along with music:</td>
<td>5(20.83%)</td>
<td>0(0%)</td>
<td>19(79.17%)</td>
<td>24</td>
</tr>
<tr>
<td>Vocal improvisation:</td>
<td>10(43.48%)</td>
<td>3(13.04%)</td>
<td>10(43.48%)</td>
<td>23</td>
</tr>
<tr>
<td>Singing with reminiscence:</td>
<td>3(12%)</td>
<td>0(0%)</td>
<td>22(88%)</td>
<td>25</td>
</tr>
<tr>
<td>Singing without reminiscence:</td>
<td>1(4.55%)</td>
<td>2(9.09%)</td>
<td>19(86.36%)</td>
<td>22</td>
</tr>
<tr>
<td>Instrument improvisation:</td>
<td>8(33.33%)</td>
<td>1(4.17%)</td>
<td>15(62.5%)</td>
<td>24</td>
</tr>
<tr>
<td>Music and movement:</td>
<td>4(16.67%)</td>
<td>1(4.17%)</td>
<td>19(79.17%)</td>
<td>24</td>
</tr>
<tr>
<td>Rock dance (cultural specific dance):</td>
<td>16(72.73%)</td>
<td>3(13.64%)</td>
<td>3(13.64%)</td>
<td>22</td>
</tr>
<tr>
<td>Listening to music that the therapist plays/ sings, or played on CD:</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>25(100%)</td>
<td>25</td>
</tr>
</tbody>
</table>

Figure 4.8 Methods that work well, are difficult to implement or culturally inappropriate/insensitive.
The following themes are the result of the thematic analysis of the sixteen (61.54%) responses collected on question 14. In this question, respondents were asked to provide examples of time when a music therapy method was inappropriate. Seven themes emerged and these were:

1. **When the therapist has poor understanding of music and its context**
   - ‘When a RMT plays in a cultural inappropriate context or style…’
   - ‘A culturally sensitive song. Eg: Chinese song for a Taiwanese patient, brought back many bad memories for this patient.’

2. **When idiographic information and individual preference are overlooked.**
   - ‘I presented “I love to go a-wandering” which an Austrian client associated with his concentration camp experience, as a work song. He said he hated this song, and I apologized for 1) playing the song 2) that he’d had the concentration [camp] experience.’
   - ‘Sometimes an individual may choose not to participate in a particular activity. Sometimes, it has been mentioned that an activity (like improv (sic)) is “childish” or “unseemly” for a woman to participate in.’
   - ‘Asking residents to participate in active music therapy when clearly they were fine at a passive level.
   - ‘When playing songs that were appropriate for one individual in the group but not appropriate for others (e.g. Russian v. Hungarian)’

3. **Level of acculturations**
   - ‘Generally, my clients who had migrated to Australia had been in Australia in excess of 40 years and had assimilated to a large degree.’

4. **When there is language barrier**
   - ‘Song writing can sometimes be difficult if there are language barriers within groups.’

5. **When the client has poor cognitive function**
• ‘The above methods are inappropriate with my clients because of their cognitive functioning level. They are no longer able to reminisce.’
• ‘…the combination of impaired mobility and impaired cognition made dancing very difficult …’
• ‘Song writing does not tend to work well when working with clients who have dementia. They respond better to songs they relate to from their long term memory.

6. When the client has poor physical function and risk of fall
• ‘Active activities may be inappropriate if a client is unwell or tired.’
• ‘When clients have physical disabilities, high risk of falls as my client are mostly frail aged.’
• ‘Movement to music, or dancing is best avoided with my clients. They are elderly, frail and are considered a ‘high fall risk.’
• ‘The combination of impaired mobility and impaired cognition made dancing very difficult and a large fall risk.’

7. Methods that are inappropriate/ difficult to use:
Vocal improvisation and/ or song writing are inappropriate because
• ‘Vocal improvisation requires self-confidence and familiar songs can build confidence and provide reassurance. Vocal improvisation with the elderly, unless the person has been a singer, is likely to cause stress.’
• ‘The clientele were not capable of much vocalizing except for known songs, making improvisation challenging or impossible.’
• ‘Creating new music – song writing or vocal improvisation does not sit well with my clients
• ‘Song writing does not tend to work well when working with clients who have dementia. They respond better to songs they relate to from their long term memory.

Instrumental improvisation is inappropriate because
• ‘Instrumental improvisation in rhythmic support can work well but otherwise requires very strong leadership from the RMT and is unlikely to be beneficial in a long run.’
• ‘Instrument improv (sic), movt (sic), dance, instrument playing – difficult because of environment which I practice in.’

Folk dance and/ or music and movement are inappropriate because
• ‘Movement and dance were generally inappropriate due to lack of space rather than cultural reasons.
• ‘Folk dance – I don’t feel confident enough to attempt something like this in case the way I do it is offensive.’

2.4 Repertoire used in CALD active group therapy (Question 15 and 16)
In active group therapy involving CALD aged clients, most frequently used repertoire styles were ‘songs with cross-cultural appeal’ (n=23, 88.46%), ‘culture specific songs’ (n=17, 65.38%), and ‘popular songs/ folk songs and songs from musical’ (n= 24, 92.31%), as they were claimed to be used ‘almost always,’ and ‘often’ by the majority of respondents. No one chose ‘almost never’ for these three categories (Table 4.9).

Moderately used repertoire styles were religious songs (n=17, 65.38%) and songs from European Classical music (n=18, 69.23%), selected by most respondents as ‘often’ and ‘occasionally’ used (Table 4.9).

National anthems was a rarely used repertoire style. The majority of respondents (n=16, 61.54%) reported that this style was either ‘rarely’ or ‘almost never’ used (Figure 4.9).
Respondents suggested six other types of music styles. These were:

1. ‘Classical instrumental music (piano) e.g. Liszt for Hungarian, Bach for German.’
2. ‘Jazz, country songs, songs of the 60’s’
3. ‘Use a lot Polish trad (sic) songs’
4. ‘More contemporary music from the 1950’s and later.’
5. ‘Free improvisation (with untunes (sic) percussion and diatonic instruments)’
6. ‘Cultural specific songs, sung in English.’

2.5 Repertoire used in CALD receptive group therapy (Question 17 and 18)

Amongst all repertoire style suggested in the survey, none of the respondents chose ‘New Age’ music for their CALD clients to ‘listen to’ in music therapy groups (Figure 4.10). Most therapists (n=21, 87.5%) chose traditional (culturally-specific) songs, followed by Classical (European) music (n=11, 45.83%) and nature sounds (n=4, 16.67%) (Figure 4.10). Other repertoire was suggested such as ‘client’s selections,’ ‘Elvis and Rock ‘n' Roll,’ ‘1940- assorted jazz sub-genres,’ ‘1960 anglo-immigration era,’ ‘songs with multiple appeal.’
2.6 Preference for individual or group therapy with CALD elderly clients (Question 18)

Overall, therapists had no preference for individual therapy or group therapy with CALD elderly clients. A small and the same percentage of respondents (n=5, 20%) preferred to work in groups and individual therapy respectively (Figure 4.11).

A number of additional comments were made to this question regarding work preference. Five themes emerged from the thematic analysis of the responses.
1. **Language barrier does not hinder interactions amongst clients.**
   - ‘They tend to be very comfortable expressing their music in the form of singing and dancing.’
   - ‘They can reminisce with each other, whereas I am unable to understand most of their verbal communication’
   - ‘The language barrier I may have is often forgiven as the clients (usually with dementia) fill in the gaps and engage more with one another…

   One therapist suggested that the language barrier might even help achieving therapeutic goal:
   
   ‘When residents need to explain to me something in English their academic thought processes are triggered.’

2. **Client’s preference determines the use of individual or group approach.**
   - ‘Depends on the individual - some people do not want to be in a group.’
   - ‘Sometimes clients request individual time to explore personal or difficult issues with the therapist. Other times the group dynamics work beautifully to support clients when they are coping with difficult issues, loss and grief, perhaps bereavement, social and cultural isolation.’

3. **Client’s abilities (physical/ cognitive /mental) determine the use of individual or group approach.**
   - ‘Some need individual work due to language difficulties and/or impairment due to aural or comprehension deficits.’
   - ‘It depends whether or not there is dementia in which case I prefer (in general) individual.’
   - ‘It depends on the physical state of the patient. If they are well enough then in a group, if they are weak then individually.’
   - ‘Depends on a whole range of issues including physical well-being of the client.’
4. Individual focus within group work.
   • ‘I tend to work individually within the group, focusing on 1 person at a time and trying to engage them primarily (often with spouse/ carer) and others secondarily re interest and appreciation of individual talents and cultural diversity.’

5. Other external reasons unrelated to ethnicity.
   Presence of family members
   • ‘Depends on a whole range of issues including… presence of family members.’

   Workplace condition and requirements
   • ‘All CALD clients just happen to be in groups in my circumstance with Anglo-Saxons.’
   • ‘To have a preference for treatment modality based on the clients' background is considered unprofessional in my workplace.’
   • ‘This particular contract was for group work though in general I think this is a decision to be made on a case by case basis.’

   Ease of the approach
   • ‘Individual work would be easier with CALD but takes more time and effort to arrange.’
   • ‘It is easier to work [with clients individually] and to concentrate on client’s CALD needs.’
   • ‘It is much easier to individualise the music and conversation to be culturally-specific in a 1:1 situation.’

3. Incorporating cultural specific idioms (question 19 - 20)
   Therapists were asked whether they use any musical instruments that are culturally specific to their clients. Most respondents (n=20, 76.92%) indicated ‘no,’ however, a wide range of other instruments was suggested by the remaining six respondents. These include:
From 5 respondents: World percussion instruments, Irish flute, Spanish guitar idiom, ‘Chinese instrument gu zhen (sic) (Zither) and piano accordion.

From 1 respondent: Spanish castanets, Indian bells & finger cymbals, Indonesian shakers, Irish harp, Japanese flute and Taiko drums, Irish Whistle, the spoons (Australian), Didgeridoo, Zither (Austrian), Mongolian bells, Chinese bamboo chimes, Swiss cowbells and Indian drums.

Culturally specific music idioms were used by 80.77% (n=21) of the respondents in the last six months. Of these respondents, a significant majority (n=17, 80.95%) varied rhythm, 14 (66.67%) varied vocal timbre, 9 respondents (42.86%) utilize ‘specific mode or scale’ and the same number use ‘cultural specific dance.’ (Figure 4.12) Other idioms employed were ‘Opera- Italian (sic)’ and ‘I regularly sing in whatever language is needed.’

Figure 4.12 The use of culturally specific music idioms
4. Challenges experienced by RMTs

Figure 4.13 shows the result of the question, ‘In your opinion, are you able to provide less, more or an equal amount of music therapy service for your CALD clients compared to your English-speaking clients?’ One respondent skipped this question.

![Figure 4.13 Level of provision of music therapy service to CALD clients.](image)

Respondents elaborated on a number of factors in their personal background or experience that influence their style of cross-cultural music therapy practice. Six factors emerged from the thematic analysis of responses:

1. **Study of languages and / or experience from living overseas**
   - ‘Study of language at school helps…’
   - ‘Living in Japan, study of Japanese and Vietnamese language… useful in the understanding of language learning and cultural difference.’
   - ‘Some travel.’
   - ‘I lived in Russia, England, Thailand and Singapore (and travelled around). I lived in London from the age of 20-25 and travelled through Europe.’
   - ‘English is not my first spoken language and I have numerous languages that I speak and understand.’
• ‘I have travelled and lived in many countries and become familiar with different cultures through my work as a musician and performer in different countries. I think that this has provided me with a better understanding of the cultural differences in human relationship and in the music of different countries.’

2. **Therapist’s cultural/personal background**
• ‘Well my personal background has an influence in my style as I am aware of its importance.’
• ‘I was a refugee on arrival in Australia. These experiences have influenced my practice.’
• ‘German background.’
• ‘I am a migrant with family spread around the world. I can readily identify with my clients when we talk about identity in terms of nationality, citizenship and cultural heritage.
• ‘My Italian background greatly influences my Italian language and knowledge.’
• ‘I was brought up overseas from the age of 7-18.’

3. **Experience in foreign music from music education**
• ‘I am a percussion specialist and did the majority of my music degree focusing on latin percussion. This was very useful with the South American client.’
• ‘Classical singing has led to a greater use of opera repertoire in nursing homes.’
• ‘Prior to training in music therapy I played in various ensembles with influences including music from Africa, South America, Western Europe, Celtic, Eastern Europe, Middle East, the former Ottoman Empire, India and the sub-continent and south east Asia as well as western classical music and the various genres to emerge from USA last two centuries including rock, blues and jazz.’

4. **Love of multicultural music and fascination of world cultures**
• ‘I have an avid interest in culturally diverse music, which keeps me motivated to learn songs from the cultures of my CALD clients.’
• ‘Love of Italian music.’
• ‘I am just interested in how music is used by peoples of different cultures, and the differing sounds of various music from around the world.’

5. **Exposure to cultural group in community**

• ‘Previous exposure to cultural group in the community before becoming a music therapist.’

• ‘My work with international refugees and teaching overseas has allowed me to understand customs of a variety of cultures. This assists with establishing a good relationship instantly by greeting them in the appropriate way, relating to them appropriately using correct body language etc. and being able to talk a little about their home land.’

6. **Music therapy training and experience**

• ‘Extensive music therapy experiences has been the most influential.’

• ‘During my student prac (sic) I worked with an RMT who had a German background. She worked in an area with mostly Italian background client.’

4.1 **Strategies for communicating with CALD clients (Question 23)**

Five strategies were suggested by therapists as communication strategies with CALD clients who are not proficient in English.

1. **Non-verbal communication** was a most frequently mentioned strategy (n=14, 60.87%), which include

   ‘gestures,’ ‘hand gestures (guitar, dinner time, etc),’

   ‘cues,’

   ‘eye contact,’

   ‘mimicking the physical movement of CALD clients,’ ‘mime,’

   ‘smiling’

   ‘facial expression,’ or ‘facial features’

   ‘body language’ or ‘body actions,’ (n=5)

   ‘exaggerate non-verbal communication,’

   ‘vocal intonation,’ or ‘vocal inflection,’
2. **Empathy.** Although the term ‘empathy’ had not been directly mentioned in the responses (except one), general empathy was suggested/ implied. For example:

‘Repeating back a non-English phrase spoken by the CALD client as a method of validation,’

‘Gesture and gentleness. Sharing tea breaks.’

‘I try to encourage them talk about their cultural memories and listen to them very hard. It build strong rapport with them.’

‘General **empathy** with the plight of immigrants.’

3. **Interpreters.** The third frequently mentioned strategy was the use of **interpreters.** It was mentioned four times. The term interpreters include ‘relatives,’ and ‘family members who has good English’.

4. **Using greetings and farewells in LOTE** were mentioned three times:

‘I still speak to them in English, but use greetings that they are familiar with.’

‘Usage of their language in greetings and farewells.’

‘A smattering of language.’

5. **Use of props:**

‘Using photos to stimulate reminiscence (though I can’t always understand),’

‘Visual cues such as illustrated song cards (the title of the song and a picture) that allows them to choose songs non-verbally by pointing at their choice.’

‘Pictures/ written word in conjunction with speech language cards with English and other language.’

4.2 **Skills in assessing the mood and affect of CALD clients (Question 24)**

Most therapists (n=21, 84%) rated their skills in ‘assessing the mood and affect of CALD clients’ as ‘equally well.’ Only four (16%) therapists rated their skills were ‘worse,’ and no one indicated ‘better.’
4.3 Rapport building with CALD clients (Question 25)

Many more respondents (n=16, 69.57%) found rapport building NOT difficult, compared with those who found it difficult (n=9, 39.13%). Half of the respondents who stated that ‘rapport building is not difficult,’ pointed out the many ways in which music can aid communication and rapport building:

- ‘Often music create immediacy.’
- ‘Music assists in therapeutic process.’
- ‘Music helps to connect to their emotive state.’
- ‘They each seem to enjoy joining the group the group and listening/ playing music even if they don’t understand the conversation.’
- ‘Music is a great expression and connects RMT with resident.’
- ‘Music is so varied you can always find lines of communication.’
- ‘Music is a universal language.’
- ‘I use music and gesture, at times they teach me songs in their native language.’

Respondents pointed out that speaking a common language is irrelevant to rapport building,

- ‘I do not rely on language alone,’
- ‘Many clients I have worked with cannot communication verbally anyway.’
- ‘Some of my clients have never learnt English but smile and laugh and watch other clients during the group and communicate through body language and gestures.’

Also they use the same approach with any other client, who has dementia, implying that CALD clients would not be treated differently,

- ‘I approach them as if I would any other client.’
- ‘Impaired verbal language is often an issue in my practice whether the client is from CALD category or not.’

Other comments were:

- ‘Our common humanity is at the heart of all our therapeutic interactions.’
• ‘Usually there is a little English and I can make educated guesses about how the client feels.

### 4.4 Training of cross-cultural music therapy

Most therapists (n=23, 92%) rated their ‘knowledge about different culture, their values and beliefs’ higher than their university training (Figure 4.14). Training in both multicultural music and in preparation for cross-cultural work were both rated as either “average” or “below average” (Figure 4.14). A range of comments regarding adequacy of university training were given by the respondents at the end of the survey (refer to 4. Anecdotal information).

<table>
<thead>
<tr>
<th>26. In regard to cross-cultural music therapy practice, please rate the following items.</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Average</th>
<th>Below Average</th>
<th>Poor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your knowledge about different cultures, their values and beliefs:</td>
<td>1(4%)</td>
<td>13(52%)</td>
<td>10(40%)</td>
<td>1(4%)</td>
<td>0(0%)</td>
<td>25</td>
</tr>
<tr>
<td>The adequacy of university training in using ‘multicultural music’</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>12(48%)</td>
<td>9(36%)</td>
<td>4(16%)</td>
<td>25</td>
</tr>
<tr>
<td>The adequacy of university training in preparing you in working with CALD clients:</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>12(48%)</td>
<td>9(36%)</td>
<td>4(16%)</td>
<td>25</td>
</tr>
</tbody>
</table>

Figure 4.14 Therapists’ rating on their knowledge and training

### 5. Anecdotal information

Respondents were given opportunities to provide extra comments as they reflected on cross-cultural practices at the end of the survey. A range of topics were mentioned:

#### 1. Adequacy of university training

• ‘I think that more familiarity with multicultural music and knowledge of different cultural values and beliefs would contribute enormously to music therapy with CALD clients.’

• ‘I feel I really need to do a course in Multicultural music.’
• ‘Speaking from an experienced nurse and music therapy, training in cross cultural practice has NOT been a priority both in nursing and music therapy, and it's only been in the last few years that the need for such education has become increasingly highlighted in the medical and allied health industry.’

2. Music and the act of Musicking break barriers
• ‘The act of musicking can help bring people together who are seemingly on different wavelengths.’
• ‘Most of my cross-cultural experiences were in my prac (sic) sessions. Most clients were non-verbal or minimal -verbal, so body language was the best language to use. Music is a great barrier breaker in itself, so it did most of the work.’
• ‘Most people respond to music, in whatever language, even if they don't fully understand all the words. I often use music in other languages for English speaking people as well, as they normally have some appreciation of other cultures, especially European.’

3. CALD clients enrich music therapy programs.
• ‘They [CALD clients] enrich MT programs and groups, and bring a greater awareness to group members not only of the differences between group members, but also the common humanity we ultimately share.’

4. Lack of resource
• ‘The paucity of resources makes this a challenging area.’

5. The role of English music in cross-cultural music therapy is not to be overlooked.
• ‘Some CALD clients are trying to fit into a predominantly Anglo-Celtic residence, and are thus more enthusiastic about participating in English music than music from their own cultural background. When I have sung a European-language (e.g. Italian or French) song with clients of that background, they seem delighted & grateful for the acknowledgement.’
Recommendations:

6. Need for better staff education
   • ‘Need for creating more awareness amongst aged care staff to get a better understanding of the RMTs role with CALD clients.’
   • ‘It would be good if more staff spoke the language of residents in order to facilitate allied health workers.’

7. Peer supervision for music therapists
   • ‘RMTs could assist each other by sharing culturally specific ideas/ music/ knowledge.’

General comment
   • Historical background is particularly relevant with elderly clients from different countries as many have suffered through war times and had no choice to stay in their country, and have to be grateful to Australia despite the trauma of moving to a strange land.’
   • It is difficult to answer this survey as there are many other factors apart from ethnicity which affect response in clients. e.g. level of dementia, other sensory and cognitive deficits, sociability, knowledge of the client's music preferences, level of potential integration.
   • It is interesting issue. Thank you for studying in this topic.

The results will be discussed in detail in the next chapter.
CHAPTER FIVE

DISCUSSION

“Culture is the accumulation of customs and technologies enabling and regulating human coexistence” (Stige, 2002, p38)

This study examined cross-cultural music therapy practice in Australian aged care settings. The research questions for this study were:

In cross cultural music therapy in aged care in Australia:

1. Which music therapy methods are used a) the most and b) the least, by RMTs?
2. Which music therapy methods are perceived by RMTs as a) effective, b) difficult to implement, or c) culturally insensitive/inappropriate?
3. What musical styles are used by RMTs?
4. What culturally specific music idioms are used by RMTs, if at all?
5. What are the concerns or challenges experienced by RMTs in conducting cross-cultural practice?

The author will first discuss demographic information, followed by a discussion of the result of the above research questions and subsequent methodological issues. This chapter will conclude with implications and recommendations for cross-cultural music practice in aged care.
**Demographic information: The changing culture in the profession.**

Most of the RMTs surveyed were practising in Victoria (n=14, 53.85%), followed by New South Wales and the ACT (n=6, 23.08%). None of the therapists were practising in the Northern Territory, Western Australia or Tasmania. A sizeable proportion of therapists were in the younger age group. There were as many 20-29 year-olds (n=8, 30.77%) as there were 30-39 year-olds (n=8, 30.77%). They trained at different music therapy courses (one respondent was trained in Germany), and had diverse professional experience prior entry to music therapy, including nursing, welfare worker, language teaching overseas and community musician. The survey also suggested that the RMTs possessed diverse theoretical orientations and styles of music therapy practice (palliative music therapy, creative music therapy, music activity therapy, etc).

It would be interesting for future studies to compare methods used by younger and older music therapists, or to correlate the results of ages and various methods used, to examine if experience (either professional or personal) influences choice and utilisation of techniques, for example: repertoire acquisition, variety of methods used, working style and degrees of empathy.

With an increase in music therapy training opportunities in recent years – four courses provided by the University of Melbourne, the University of NSW, the University of Western Sydney (in association with Nordoff Robbins Music Therapy Australia Ltd.) and the University of Technology (Sydney) (AMTA web site, 2007). Australian music therapists have a unique mixture of theoretical orientations /styles. This brings creativity and innovation in music therapy methods employed across Australia. Exchange of ideas across States can improve the resourcefulness of individual therapists and refine their clinical techniques, as well as increasing one’s exposure to diverse cultures. (Chase, 2003; Dileo & Starr, 2005)

**Linguistic skills**

Australian music therapists working in aged care reported a total of thirteen LOTEs as their second languages. Mainstream European languages (i.e. Italian, German and
French) were most prevalent (34.6%); Serbian, Hindi, Russian, Croatian, Bosnian, Korean, Chinese, Urdu and Polish were also spoken. A possible explanation for this phenomenon could relate to the language options available in Australian schools before the 1990s, which favoured Latin, French and German. Interestingly, of all respondents who spoke a language other than Italian, German and French (n=7, 26.85%), only one was over 39 years old.

It could be speculated that younger RMTs are more equipped to communicate in Asian languages with their clients because of the more recent introduction of Asian languages in schools as well as the high exposure to diverse cultures in today’s society. Migration or CALD family heritage could also be factors: responses from the last question of the survey showed that at least two respondents were migrants and refugees to Australia and another two claimed to have ‘German’ and ‘Italian’ backgrounds.

A majority of RMTs (73.08%) knew a smattering of Italian. This is likely due to the fact that Italians are a prominent group in aged care and will continue to be so for the next 15 years. (Gibson, Braun, Benham and Mason, 2001). German, similarly, was the third most widely-known of the ‘vocabulary/phrase known by therapists’ (26.9%), which corresponds to the position of Germany in the top ten countries of CALD origin projected for over 65s in 2011(Gibson et al., 2001). On the other hand, while Greek and Dutch are in second and fourth place, only one respondent knew Greek and one in Dutch (in vocabulary and phrase). Given the high proportion of Greek and Dutch clients projected for the future, Australian RMTs should have greater knowledge of repertoire and language of these cultures. Furthermore, with the rapid growth of Chinese and Vietnamese elderly (projected to reach the top ten in 2026 (Gibson, 2001), it is time to also improve our knowledge of these cultures.

Currently in residential aged care services, CALD people represent over one quarter (27%) of permanent residents (Australian Institute of Health and Welfare, 2007). It is therefore unsurprising that a number of respondents claimed that ‘about 30%’ of their clients are of CALD backgrounds. However it is not known what proportion of these
CALD clients are from community, medical or residential settings. A future survey could ask respondents to specify their area of work. Correlation of the number of CALD clients and areas of aged care settings in which music therapy is provided would be an interesting addition to existing data.

This is the first Australian study to collect data on cross-cultural music therapy methods used in aged care.

**Q1: Which music therapy methods are used a) the most and b) the least, by RMTs?**

The survey found that a combination of both receptive and active music therapy was most preferred by 92.31% of RMTs (n=24) when working with aged CALD clients in group therapy. Vink (2000)’s study found similar result: the majority (78.6%) of Dutch aged care music therapists used active and receptive music therapy in group therapy with aged clients, although it was not restricted to CALD clients.

**Receptive methods**

Receptive methods refer to listening to music that the therapist plays/ sings or played on CD, but the clients were actively involved in either reminiscing, relaxing (through induction) or experiencing different emotions. Most respondents (88.46%, n=19) frequently used this particular method (almost always’ or ‘often). Suitable repertoire to use for this method will be discussed later in this chapter. The reason for the popularity of listening to music might due to its ease of use. It might also provide a more authentic musical experience than the therapist’s attempt to reproduce the song in a foreign language. Further, the original vocalist might be preferred by the client (e.g., Vera Lynn, Frank Sinatra), and a RMT might intentionally choose the original recording and artist rather than play the song live.

Instead of verbal conversation, active music making can follow to address any feelings or issues that might be evoked. This method was adopted by Orth (2005), Orth & Verburgt (1998) for their multicultural music therapy groups situated in a refugee centre (in the Netherlands), where it was impossible for the therapist to learn songs from all the
cultures presented in such diverse group. In the group described by Orth and Verburgt (1998), clients listened to each other’s music recording of their choice from their cultures at the beginning of the session, before flowing into music improvisation based on a style (e.g., reggae, Arabic, blues) elicited from music sharing and decided on by the group.

**Improvisation**

On the subject of music improvisation, the survey result did not clearly show whether it was a popular method or not. This was due to unclear questioning: question 11 and 12 asked respondents to rate, amongst other music therapy methods, the frequency of use for ‘vocal improvisation’ and ‘instrumental improvisation.’ However, improvisation is a very broad term. In future studies it would be important to identify the different styles of improvisation such as creative music therapy (Nordoff Robbins method), and simple music dialogue based on modelling of expected response, etc., in order to avoid an ambiguous result.

The equally distributed result for both ‘instrumental’ and ‘vocal improvisation’ could suggest that RMTs had varied perception about improvisation. Although improvisation was either popular or unpopular amongst RMTs in the present survey (with only 1 respondent (3.85%) choosing ‘almost always’ for vocal improvisation and 3 respondents (11.54%) choosing ‘almost always’ for instrumental improvisation), it is a useful non-language dependent method for cross-cultural work. Improvisation techniques are featured in several multicultural case studies/journal articles (Amir, 1998, Moreno, 1988, Orth and Verburgt, 1998, Orth, 2005), however the following examples were not aged care specific. Moreno (1988) described the use of African drumming as an activity that transcends language and cultural barrier. Orth (2005) described the use of a vocal holding technique in unlocking emotions through improvised singing while the therapist provides a basic two chord accompaniment to support the client’s voice. Amir (1998) used improvisation (vocal or instrumental or both) to further explore the emotions evoked after the singing of Israeli folksongs (chosen by clients in the group).
**Question 1a): The most frequently used.**
Apart from ‘listening to music that the therapist play/sing or played on CD’ (discussed above), the following music therapy methods were also reported as the most frequently used (‘almost always’ or ‘often’): “singing with reminiscence” (n=23 88.46%) and “instrument playing along with music” (n=17, 65.38%). Both were considered as effective methods, which will be further discussed below (refer to Question 2a).

**Question 1b): The least frequently used.**
Contrary to improvisations, it is very clear that most RMTs rarely or almost never used ‘folk dance (n=20, 76.92%)’ and ‘song writing (n=16, 61.54%).’ Not surprisingly, these methods were also considered ‘difficult to implement’ by RMTs. These two methods will be further discussed below (refer to Question 2b).

**Question 2: Which MT methods are perceived by RMTs as a) effective, b) difficult to implement, or c) culturally insensitive/inappropriate?**

The participants in music therapy studies in aged care have been predominantly Anglo-Saxon. A meta-analysis of these studies showed that instrument playing and dance/movement were most preferred by elderly who have dementia, and even though singing remains popular, responses decline over time (Brotons, 2000). Also noted was that techniques such as modelling expected response, could ensure and maintain participation in music activities for older adults with dementia (Brotons, 2000). In the present study, RMTs appeared to have chosen the same methods, namely ‘singing,’ ‘music and movement,’ and ‘instrument playing along’ frequently with their CALD aged clients. This section will discuss the appropriateness of applying these methods to CALD clients.

**Singing with and without reminiscence**
Overall, singing was the most popular method in this survey. Indeed, it has been integral to music therapy for older adults over many years (Bright, 1991; Clair, 2000). In multicultural case studies, singing had been a form of active music making (Amir, 1998)
or be used powerfully to engage with clients in palliative care (Forrest, 2000). However, the researcher questions the effectiveness and appropriateness of using ‘singing with reminiscence’ as a method for groups of CALD clients who are not proficient in English. Presently, more therapists used ‘singing with reminiscence (88.46% ‘Almost always’/ ‘often’)’ than ‘without reminiscence (65.38% ‘often’/ ‘occasionally’).’ These responses could mean that a number of CALD clients are proficient in English, or that therapists reminisce in a way that is not language dependent. Either possibility does not safeguard the risk of evoking powerful emotions, which the clients/therapists might not be able to explore or resolve adequately.

Hence Dileo (2000) recommended that therapists focus on ‘activity-orientated experiences,’ rather than verbal therapy in multicultural group work, especially for those clients who have ‘low levels of acculturation (p.166).’ In the opinion of the author, reminiscence, or any form of cultural and verbal based techniques should only be used after careful ethical consideration, particularly when declining cognitive function and language barriers are prevalent problem amongst aged CALD clients.

‘Movement to music’ and ‘Instrumental playing along with music’
Most RMTs (79.17%, n=19) perceived ‘music and movement’ and ‘instrumental playing along with music’ as effective methods in engaging aged CALD clients. In a linguistically diverse group, non-verbal interactions can compensate for the lack of common language. Instrumental playing along and movement to music are both useful and easy (for both therapist and the clients) to achieve that. It is well known in research and in practice that people with dementia participate longer in instrument playing than in singing (Brotons, 2000), with the use of familiar music and the act of making music together, clients will be motivated.

As for movement to music, although several comments pointed to the fact that ‘physical disabilities,’ ‘lack of space’ and ‘the risk of fall’ sometimes inhibit the use of this method, movement to music is still considered by most RMTs (79.17%, n=19) as effective and is rated as a ‘moderately used method’ (73.08%, n=19 ‘often’/
‘occasionally’ in this survey. Examples of movement to music are balloon throwing or the use of parachute: A giant colourful balloon or a parachute is very stimulating. It encourages hand-eye coordination, social and physical interaction. It is a natural reflex to hit a balloon, or to hold on to the fabric (of the parachute) as it moves, so there are no language required in these activities. The accompaniment of up-tempo and rhythmic music helps to motivate and liven mood. Another example provided by a respondent was ‘music and sensory experiences with silk scarves, bubbles or a scent.’ Obviously, the choice of music will affect the level of participation. Repertoire choice will be further discussed in later section (refer to question 3).

**Question 2 b) methods that are ‘difficult to implement’**

**Song writing**
In this survey, RMTs had clearly indicated that song writing was ‘difficult to implement’ (82.61%, n=19), thus was also rarely used (61.54%, n=16, ‘rarely’ / ‘almost never’). One respondent commented,

‘song writing does not tend to work well when working with clients who have dementia. They respond better to songs they relate to from their long term memory.’

The prevalence of dementia is high amongst aged clients in care facilities. With speech and memory impairment commonplace, song writing is a difficult method for this population, even without language barriers and cultural differences. Although there is no literature or case studies that support the use of song writing with aged CALD clients, it is an important and useful technique in facilitating self-expression and as a validation of feelings. It might be possible to simplify song writing for this population: for instance, lyrics substitution in client’s language, or English, rearranging an English song into a cultural specific style (i.e., playing ‘Daisy’ in Phrygian mode to create a Spanish/Arabic/Middle Eastern sound) or vice versa, which calls for creativity on the therapist’s part.
Folk dance

Folk dance, or cultural specific dance, was perceived by most RMTs (72.73%, n=16) as difficult to implement. However, there were as many RMTs who thought folk dance was ‘culturally inappropriate (13.64%, n=3)’ as those who thought that it ‘works well (13.64%, n=3),’ which showed that there were some contrasting views on the use of folk dance in music therapy group. Three explanations were given by RMTs:
1) Clients have impaired mobility and were considered ‘high fall risk (n=4).’
2) Workplace’s environment/ lack of space (n=2).
3) Lack of confidence in attempting folk dance (n=1).

The last comment regarding confidence implied a deficiency in the RMT’s skill in this area, which could be addressed by teaching and introducing folk dance as part of multicultural music therapy training in Bachelor/ Masters programs, and also for current RMTs as part of their professional development. It would be highly valuable to provide opportunities for those RMTs who are skilled in folk dance to share their knowledge and practice with their peers and future students.

Dance, along with music, is a fundamental non-verbal means of expression in many cultures around the world. For example, in southern Italy, the tarantella dance and its music were associated with both romantic courtship and the frenzied remedy for the toxic of the ‘tarantula’ spider bite (Britannica, 2010). The dancers of the tarantella played the tambourines to fast and whirling music (6/8 time) characterized by **accelerando** toward the end. Other examples of cultural specific dance and music featured in *Voices: The World Forum for Music Therapy*: Spanish music therapist Sabbatella (2004) claimed that the richness of both traditional Spanish music and dance were incorporated into modern practices allowing a wide range of music, rhythms and moods (Sabbatella, 2004). In Turkey, Bakshi dance, which originated from the traditional shamans’s healing ritual, is used in music therapy practices in the areas of autism, geriatric, oncology, immunology, neurology, cardiology, depression and anxiety (Guvenc, 2006). Nigerian music therapists Aluede and Lyeh (2008, “Definition of music therapy,” para 2) also claimed that, ‘in most cases in Nigeria, music and dance are closely knit. This is so because dance is rarely ever
performed without music and music in very many instances calls for dance. (Aluede & Lyeh, 2008). Dance and music in some cultures is therefore, inseparable. It should also be noted that dance and music are intertwined within its cultural traditions and meaning, which needs to be understood by the therapist in order to provide an authentic experience for the client.

Contrary to cultural specific methods discussed above, several responses seem to imply that working in cross-cultural music therapy is not so different than working with non-CALD clients:

‘Many clients I have worked with cannot communicate verbally anyway.’
‘I approach them as if I would any other client.’
‘Impaired verbal language is often an issue in my practice whether the client is from the CALD category or not.’

It is a fair and positive attitude to treat all clients equally regardless of their ethnicity, yet therapists should be careful not to assume a one-size-fit-all approach in their practices. To do this is dishonouring the diversity and the richness of cross-cultural relationships. Rather, a competent therapist should be creative and resourceful in his/her practices (Kenny & Stige, 2002), and have their methods refined over time.

In concluding the discussion question 2, Australian aged care RMTs used a wide range of methods in their cross-cultural work. Frequently used methods were listening to music that therapists play or sing, singing (with and without reminiscence), movement to music and instrument playing along. These methods, apart from singing, are non-language dependent methods, thus allowing CALD clients to express themselves and interact with each other non-verbally. Singing with reminiscence, although a frequently used method with older adults, should be used after careful ethical consideration, particularly when the CALD clients are not proficient in English. RMTs should not ignore the danger of evoking powerful emotions that might be unnoticed or unable to be explored or resolved with the clients due to cultural and linguistic barriers. The frequency of use for both vocal and instrumental improvisation could not be accurately determined in this survey due to
unclear questioning. It would be important for future studies to identify different styles of improvisation in the questionnaire. However, on reviewing multicultural case studies (Amir, 1998; Orth & Verburgt, 1998), it is recommended that improvisation be utilised more often with CALD population due to its expressive and reflective quality, and to complement receptive music therapy methods such as listening to recorded music.

Song writing and folk dance were rarely used with aged CALD clients. It was generally recognised that song writing might not be appropriate for the dementia population, and compounded with language barrier, this method is difficult to implement. On the other hand, folk dance could be utilised more in a multicultural context. Dance and music are inseparable in many cultures around the world and are deeply rooted within their traditions. It would be advantageous to incorporate folk dance in cross-cultural practice to enhance relevance as well as enjoyment.

**Q3: What musical styles (repertoire styles) are used by RMTs?**

The most frequently used repertoire styles were ‘songs with cross-cultural appeal,’ followed by ‘popular songs’ in English, and ‘cultural specific songs.’ So far, there is only one study regarding repertoire for the aged and CALD population (Baker & Grocke, 2009). While Baker and Grocke’s studies collected and examined music selections, the present survey looked at the frequency of use for each particular music style. Part of the finding of this study was consistent with that of Baker and Grocke’s (2009) study, in which a number of song selection were pan-cultural, that is, songs with cross-cultural appeal. On reviewing the foreign music selection from Baker and Grocke’s (2009) study, at least 28 out of the 109 (25.7%) suggestions were known by more than one culture:
Songs with cross-cultural appeal

Box 5.1 Selection of songs with cross-cultural appeal based on Baker & Grocke (2009)

<table>
<thead>
<tr>
<th>Song</th>
<th>Original Language(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Que Sera Sera</td>
<td>English, Italian, Spanish, French</td>
</tr>
<tr>
<td>Lilli Marlene, Happy Wanderer, Edelweiss</td>
<td>English, German, Dutch</td>
</tr>
<tr>
<td>Stille Nacht, O Tannenbaum, Muss Ich Den, Wooden Heart,</td>
<td>German, English</td>
</tr>
<tr>
<td>Farewell song, Auf Wiedersehen</td>
<td></td>
</tr>
<tr>
<td>O Sole Mio, Over The Waves, Loveliest Night of the Year,</td>
<td>Italian, English</td>
</tr>
<tr>
<td>Santa Lucia, Reginella, Campagnola, Woodpecker song,</td>
<td></td>
</tr>
<tr>
<td>Senza Catene, Unchained melody</td>
<td></td>
</tr>
<tr>
<td>La Vie En Rose, Allouette</td>
<td>French, English</td>
</tr>
<tr>
<td>Pote Tin Kyriaki, Never on a Sunday</td>
<td>Greek, English</td>
</tr>
<tr>
<td>Spanish Eyes</td>
<td>Spanish, English</td>
</tr>
<tr>
<td>Tulips from Amsterdam, Grootvader klok, Grandfather clock</td>
<td>Dutch, English</td>
</tr>
<tr>
<td>La Paloma, La Spagnola, Brahm's Lullaby, Blue Danube</td>
<td>Italian, Spanish, Classical composer</td>
</tr>
<tr>
<td>Waltz, Marseillaise</td>
<td>French anthem</td>
</tr>
</tbody>
</table>

Source: Baker & Grocke (2009)

The above song selections appeal to diverse cultures, they are chosen frequently for RMTs who conduct multicultural groups. Group members can participate in communal singing even though they might be singing the same song in different languages. For a song to achieve pan-cultural status, it is often very popular in its country of origin before its reproduction and reinterpretation in other cultures, settings or arrangement. An example of this is Muss Ich Den, which was originally a German folk song (English version ‘Farewell song’ - time unknown). In the 1960s, it was reinterpreted into a popular song called ‘Wooden Heart’ performed by Elvis Presley and was featuring in his film ‘G.I. Blues.’ The song even incorporated some of the German words. Presley’s ‘Wooden Heart’ has made this German folk song truly pan-cultural, at least across the dominant cultures of Britain and America. Therefore, the same song, when played in a multicultural group, can conjure up different images, feelings and associations for the clients, depending on the way it was understood and experienced by the listener.
**Popular songs**

Popular songs, in the current study, include the often-interchangeable categories of folk songs (e.g. Home on the range) and songs from musicals (e.g. ‘Edelweiss’), and were rated as the most frequently used repertoire style (n=24, 92.31%). Along with this figure, respondents also reported that they used ‘Jazz, country songs, songs of the 60s’ and ‘more contemporary music from the 1950’s and later’ with the aged CALD population. As discussed in the literature review chapter, songs that were popular in the dominant cultures of Britain and America during late 20s to 50s can be suitable for the CALD population in Australia. Most of the aged CALD clients in Australia were post-war migrants from European countries (i.e. the old migrant streams – Italy, Poland, Germany, Greece and the Netherlands). People from these communities may have encountered or learnt English songs from a range of sources: e.g.: schools, mass media in their home countries or in Australia. In fact, Baker and Grocke (2009) concluded that a substantial repertoire of songs post 1950 is needed to serve the needs of the general older Australians at present. In any case, due to the changing cultural environments, the individual’s level of acculturation, it is likely that popular English songs may appeal to CALD clients and should not be overlooked.

**Cultural specific songs**

Cultural specific songs were amongst the most frequently used in active music therapy. Similarly, findings from Baker and Grocke’s (2009) survey showed that Australian music therapists had a relatively large repertoire of foreign languages (20% of all music selection were in LOTE), while a similar study in the US (Vanweelden & Cevasco, 2007) had 2% only. However, Baker and Grocke’s (2009) study also found that repertoire from some important cultural groups were limited. These groups were Chinese, Russian, Vietnamese, Yugoslavian and Indian. There was no repertoire suggested for Aboriginal, Eastern European nations, African or Middle Eastern cultures. Obviously, as one respondent commented, ‘the paucity of resources makes this a challenging area.’ As almost half (n=13, 46.15%) of the RMTs in the current study were fluent in a second language, and a large LOTE repertoire was know amongst RMTs (Baker & Grocke,
it would be advantageous for these therapists to be provided with a space (e.g. Internet web site) to contribute and to learn each other’s repertoire. Several case studies showed that culturally specific music can transcend language barriers (Amir, 1998; Forrest, 2000; Orth & Verburgt, 1998), and affirms one’s cultural identity. When possible, clients could be encouraged to talk at length about their memories of the cultural specific song, which could be interesting for other group members. It is however, important to have prior knowledge of the cultural context and the emotional content of the music to ensure a positive therapy outcome (Bright, 1993; Brown, 2001).

**Religious songs and songs from European Classical music**

Religious songs and songs from European Classical music share common roots, for Classical music written in the Baroque and Classical period is associated with churches and Christianity (e.g., Bach’s Jesu Man’s Desiring, Schubert’s Ave Maria). Most RMTs reported both religious songs (n=17, 65.38%) and songs from European Classical music (n=18, 69.23%) were used only occasionally/often. Religious songs, according to Baker and Grocke’s (2009) study, were perceived as songs from the Christian faith. It was uncertain to what extent that other religions use singing in their rituals, so individual research by the therapist is warranted prior to the use of religious song. With the growing cultural diversity in the aged care sector, the singing of Christian songs (or hymns) might no longer be appropriate in a multicultural group situation.

Well-known Classical music like *The Blue Danube Waltz, Brahms Lullaby, Saint Saens The Swan*, have reached true pan-cultural status through mass media and Classical music is known around the globe. However, it should not be assumed that Classical music is suitable to everyone. Therapists should ask themselves whether their selection of Classical music, and their belief in the aesthetic beauty of Classical music is culturally driven, or informed by their own personal preferences and bias.
New Age music and Nature Sounds

In Question 17, RMTs were asked what music styles they would choose for CALD clients to listen to, no therapist chose ‘New Age’ music while 4 (15.38%) respondents chose ‘Nature sounds.’ In a Dutch survey (Vink, 2000), many more respondents chose ‘New Age’ music (46.4%) and ‘Nature sounds’ (53.6%) to be used in receptive music therapy with aged client (but not restricted in the CALD population). New Age music and Nature sounds are unfamiliar repertoire to the clients. Although studies (Brotons, 2000; Brotons, Moore, & Staum, 1992) showed that familiar songs work best for older adults in dementia care, it is difficult, and even impossible to be restricted to only familiar songs in a multicultural group. For receptive music therapy, the sounds of Nature and New Age music might be a safe choice that is relatively context free and emotional ties free option for CALD client, however, research on the effect of New Age and Nature sounds on the aged population is recommended.

Three respondents gave examples of times when the choice of music was inappropriate for the group or the individual:

- ‘when playing songs that were appropriate for one individual in the group but not appropriate for others (e.g. Russian v. Hungarian)’
- ‘I presented “I love to go a-wandering’ which an Austrian client associated with his concentration camp experience, as a work song. He said he hated this song, and I apologized for 1) playing the song 2) that he’d had the concentration [camp] experience.’
- ‘A culturally sensitive song. E.g., Chinese song for a Taiwanese patient brought back many bad memories for this patient.’

It is important then, not to rush into a music therapy intervention before consultation with the client and their family, as well as to understand the context of various music repertoire, as an essential part of cultural sensitive practice.
Q4: What culturally specific music idioms are used by RMTs, if at all?

Cultural specific music idioms used by RMTs include:

‘Varied rhythm’ (n=17, 80.95%)
‘Varied vocal timbre’ (n=14, 66.67%)
‘Using specific mode or scale’ (n=9, 42.86%)
‘Cultural specific dance’ (n=9, 42.86%)

Other culturally specific idioms employed were instruments. Although only a small percentage of RMTs (23.1%, n=6) used culturally specific instruments with their CALD clients, one of the respondents reported fourteen cultural specific instruments used. In Elwafi’s article on music therapy in Qatar (2005), she mentioned the use of Oud (Arabic guitar) in her music therapy group. Sometimes, to be culturally sensitive, she had to avoid using instruments altogether, because some interpretations of Islam do not allow music that uses stringed or wind instruments.

The high selection of music idioms showed that RMTs were interested and equipped in playing diverse styles of music. Three respondents commented that their love of multicultural music and fascination with world cultures influenced their music therapy practices. Other respondents indicated that they relied on their experiences gained from music education:

• ‘Classical singing has led to a greater use of opera repertoire in nursing home.’
• ‘I am a percussion specialist and did the majority of my music degree focusing on Latin percussion. This was very useful with the South American client.’

One respondent had listed a wide range of music styles that he/ she was experienced in:

‘Prior to training in music therapy I played in various ensembles with influences including music from Africa, South America, Western Europe, Celtic, Eastern Europe, Middle East, the former Ottoman Empire, India and the sub-continent and south east Asia as well as western classical music and the various genres to emerge from USA last two centuries including rock, blues and jazz.’
Modern composers since the turn of the 20th century (e.g., Stravinsky, Bartok, Prokofiev, Grainger) experimented with ways of incorporating folk idioms into their composition. With the diversion away from the diatonic scale and the widespread use of modes (e.g.: mixolydian) in Jazz and popular music, people of all ages these days are accustomed to more colourful tonality and more complicated rhythms. It is beneficial for music therapists to incorporate more cultural specific idioms in their music. Moreno (1988) stressed that,

‘Music therapists should be familiar with a wide variety of ethnic musical idioms to enhance the possibility of establishing effective musical and interpersonal communication with clients from diverse ethnic backgrounds.’ (Moreno, 1988, p.19)

This study did not fully investigate the incorporation of cultural specific idioms. For future research, it would be interesting to examine how exactly RMTs utilise these idioms. Further training in the area of cultural specific idioms is recommended in equipping students for cross-cultural work.

Q5: What are the concerns or challenges experienced by RMTs in conducting cross-cultural practice?

The results suggested that RMTs were generally confident in conducting cross-cultural practices, and 92% of RMTs rated their knowledge about different cultures, their values and beliefs as ‘very good’ and ‘average.’ In contrary to findings from Stolk’s study (2002) on Victorian mental health professionals, 84% of RMTs (in this survey) rated their skills in assessing mood and effect of their CALD clients as ‘equally well,’ compared to more than half respondents from Stolk’s study acknowledged their skills as poor. Most RMTs (n=17, 65.38%) also indicated that they were able to provide ‘equal amount’ and ‘more’ music therapy service for their CALD clients.
RMTs are skilled in utilising music as a means of communication, whereas other mental health practitioners may have to rely on mainly verbal communication. The following responses seem to support this.

- 'often music create immediacy.'
- 'music assists in therapeutic process.'
- 'music helps to connect to their emotive state.'
- 'they each seem to enjoy joining the group and listening/ playing music even if they don’t understand the conversation.'
- 'music is a great expression and connects RMT with resident.'
- 'music is so varied you can always find lines of communication.'
- 'music is a universal language.'

Hence, language barriers were not considered a problem by some RMTs, particularly when group work was concerned, as shown in the responses below:

- ‘They tend to be very comfortable expressing their music in the form of singing and dancing.’
- ‘They can reminisce with each other, whereas I am unable to understand most of their verbal communication.’
- ‘The language barrier I may have is often forgiven as the client (usually with dementia) fill in the gaps and engage more with one another…’

One therapist even suggested that the language barrier might help achieving therapeutic goal:

‘When residents need to explain to me something in English their academic thought processes are triggered.’

The communication aspects of music are very useful in compensating for the language barrier and in helping RMTs to making a connection with CALD clients, but that does
not substitute the need for cultural empathy. A sense of complacency was felt from the responses, with only one mention of the term empathy: ‘General empathy with the plight of immigrants.’ It is known that even general empathy is not enough for working with CALD clients. Brown (2002) and Valentino (2006) argue that cross-cultural music therapists need to take a step further than general empathy, toward cultural empathy, which is described as ‘a balance of ethnic self-awareness, multicultural knowledge, cognitive and affective empathy (Valentino 2006, p110),’ with the aim to reduce misunderstanding and misinterpretation of the client’s world-view.

Furthermore, therapists must pay attention to how empathy is expressed in clients’ culture. For instance, when working with clients who come from the Collectivist culture, where group interdependence is valued, the strength and support given by family members could be the most beneficial form of intervention. In this case, therapists might include communicating empathy to the client’s family and significant others. Collaborating with the client’s family will ensure the therapy is in line with the client’s culture values (Brown, 2002).

Personal cross-cultural skills had not been discussed or mentioned in the survey, yet cultural self-awareness is of utmost importance. RMTs must recognise the influence of their own ethnicity on their values and belief system. Cultural counter-transference, which is viewed as ‘a matrix of intersecting cognitive and affect-laden beliefs and values existed within the therapists’ varying levels of consciousness (Foster, 1998, p235),’ can easily occur, for example, when the therapist unconsciously relates to the client as he/she has related to others from the client’s culture in the past (Foster, 1998; Valentino, 2006).

With cognitive impairment and physical decline commonplace amongst aged clients, they could lose confidence and become confused about their identity. Specific knowledge about different cultures (and their values and music practices) is valuable for therapists and instrumental in affirming our client’s heritage, although it is not usually easy to acquire, especially if working with clients from many countries. AMTA could look into supporting and encouraging special interest groups in the area of cross-cultural practice in
aged care, in allowing therapists to share and exchange specific cultural knowledge. Even more important is to adopt an attitude of openness. Through actively exploring difference, similarity, expectation and bias with clients, ethnocentrism can be prevented.

Training

Despite the confidence shown in conducting cross-cultural work, all RMTs regarded their university training as ‘average’ to ‘poor.’ Therapists (n=3) indicated their concerns about lack of knowledge of multicultural music and knowledge of different cultural values and beliefs. RMTs were also challenged by the lack of resources in multicultural music and education. Findings of this survey pointed to the following areas of training: folk dance, incorporation of cultural specific idioms and cultural empathy. Furthermore, recommendations from the articles reviewed for this study indicated that more comprehensive training for students is required in preparing them to provide cultural sensitive practice (Brown, 2001; Dileo, 2000; Toppozada, 1995). The curriculum should be infused with cultural issues and an emphasis on world musics, awareness of own identity, knowledge on cultural belief and values, rather than offering separate or ‘stand alone’ classes on multiculturalism.

A skilled cross-cultural music therapist must observe the guiding principles for generic music therapy practice, such as positive regard for clients, the ‘iso’ principle and the notion that it is the therapist who finds ways of adapting music to the individuals (or groups) not vice-versa. A skilled cross-cultural therapist

1. Recognises that music and musical activities are context-dependent (Stige, 2002).
2. Is musically flexible, that he/ she is familiar with music of many world cultures (Moreno, 1988) and is able to utilise a range of music idioms.
3. Has knowledge of different cultural values and belief (Dileo, 2000; Estrella, 2001; Valentino, 2006).
5. Actively and openly explores differences, similarity, expectation and biases with clients (Dileo, 2000).


7. Is flexible but directive and structured in his/ her approach, rather than being ambiguous. Verbal based approach may not be appropriate when a language barrier exists (Dileo, 2000).

8. Is creative in adapting and inventing music therapy methods that engage CALD clients.

9. Actively seeks and expands music repertoire that is meaningful and familiar to the clients (Baker & Grocke, 2009).

10. Participates in regular professional cultural exchange. This can be achieved from regular reading of international case studies, personal accounts and other music therapy journal articles such as those from *Voice: the World Music Therapy Forum*. Also, this can also be achieved in person, through conferences, seminar or creating workshops opportunity with other therapists experienced in multicultural music. Dokter (1998) speaks of arts therapists going aboard to facilitate workshops or training *in situ*, as well as “foreign” students training in arts therapy outside their country of origin.

This study is limited as the number of RMTs who participated was only 30 people. Statistics and themes that emerged from a small sample should be viewed with caution. The response rate for this study, however, is consistent with that of Baker & Grocke (2009), who targeted also aged care RMTs. It should be noted that, when compared to Baker & Grocke ‘s (2009) study, the present study had two extra inclusion criteria: 1) worked with CALD clients in the last six months, 2) involved CALD clients in group work. It is possible that, out of 88 practising aged care RMTs identified, many therapists did not satisfy the inclusion criteria, making recruitment difficult for this study.
Conclusion

Aged care clients in Australia represent a diverse range of ethnic, cultural and religious backgrounds, yet studies pertaining to multicultural music therapy in Australia are few in number. This study addressed that discrepancy, surveying thirty Australian RMTs on the subject of cross-cultural music therapy methods. The RMTs surveyed reported that cross-cultural music therapy in aged care was influenced by various factors, including personal experience, professional training backgrounds and client’s abilities, level of acculturation and preference. This study also found that most respondents were confident in providing music therapy to CALD clients and that CALD clients enjoyed an equal amount of service. Additionally, the respondents were generally comfortable with utilising culturally specific musical idioms, including ethnic instruments, dances and various musical aspects (i.e. rhythm, scales, modes, vocal timbre.) However, a number expressed reservations about the level of preparedness for cross-cultural work provided by university training, preferring to emphasise the importance of personal (rather than professional) experience and interests.

This study concludes that a systematic professional approach to fostering cross-cultural awareness and methods is desirable. Music therapists will benefit individually from diversifying their methods and actively acquiring musical resources with an appropriate understanding of cultural context. More generally, the Australian music therapy profession and its association should strive to offer more multicultural training and support for practising therapists, as well as emphasising cross-cultural methods and self-insights for students.

A serious and comprehensive approach to cross-cultural training will necessarily reflect the complexity of the individual cultural background of each CALD client, resting as it does on both nomothetic and idiographic components. The ever-growing complexity of human experience and demographics demands no less.
REFERENCES


APPENDIX A

Questionnaire
APPENDIX B

Plain Language Statement
EXECUTIVE SUMMARY IN PLAIN ENGLISH

TITLE: Methods used in cross-cultural music therapy in aged care in Australia.

Researchers:

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My research will examine methods used by Australian Registered Music Therapists (RMTs) in ‘cross-cultural music therapy’: that is, group music therapy involving participants from various cultural backgrounds.

Background, importance and relevance of the project:

Aged care clients in Australia in 2008 represent a diverse range of ethnic, cultural and religious backgrounds. Australian RMTs are being increasingly called upon to work with this changing population. Over the last decade, a large body of research supports the effectiveness of music therapy as a psychosocial intervention for the elderly; on the other hand, research addressing multicultural practice in music therapy is far less comprehensive. Many music therapists have written about their personal experiences and ethical considerations in cross-cultural practice; yet most of these studies concern individual clients. In actual practice, the group approach is the most commonly used in aged care. My project will address the shortage of research in these areas.

Key questions

In cross cultural music therapy in aged care in Australia:

- Which music therapy methods work well?
- Which methods are difficult to implement or culturally insensitive/inappropriate?
- How are cultural specific idioms utilised?
- What are the concerns of RMTs in conducting cross-cultural practice?

Research design

Data will be collected through a web-based questionnaire, with assistance from a professional web company ‘www.surveymethods.com.’ This web site is designed to ensure participant anonymity and is also password protected - it is only accessible to the abovementioned researchers. Participants will be recruited through the Australian Music Therapy Associations (AMTA). Inclusion criteria for the participants are as follows:

- Professional practicing member of AMTA
- Currently employed in aged care as a RMT
- Have conducted group music therapy involving clients from various cultural backgrounds.
Author/s:
Ip-Winfield, Vannie

Title:
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