How are multicultural considerations playing a role in music therapy practice? A Nordic music therapist's experiences from working in a paediatric hospital setting in Peru

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Abstract

In the field of music therapy, global collaborative research and clinical practice in multicultural settings are evolving. Therefore, there is an important need for integrating a multicultural perspective in music therapy. This study presents a heuristic analysis exploring the role of culture in music therapy, from the perspective of a Nordic music therapist working with paediatric patients in Peru during the autumn of 2017. The connection between cultural differences (Northern Europe and Latin America) and music therapy was explored from a personal and theoretical perspective. From a heuristic inquiry, nine themes were identified which represent the qualities of the music therapist's personal experiences of the role of culture in music therapy practice: 1) Various expectations, 2) Music – the primary language, 3) Finding my role, 4) Expressions & reactions, 5) Time, 6) Interactions, 7) Music & emotions, 8) To connect, and 9) Sharing experiences. The findings of this heuristic analysis reflect upon the importance of self-reflection, cultural sensitivity and the music therapist's responsibility to respect, support and keep an openness to the personal-cultural-musical background of the patient. An awareness of the music therapist's and the patient's cultural backgrounds is needed, as music and culture can be considered as both personal and as phenomena shared with others. Therefore, cultural considerations in music therapy practice can be necessary both in settings where cultural differences might be more apparent and in meetings with subtler multicultural aspects. Nevertheless, it is essential to strive for a balance between cultural considerations and the spontaneous connectivity in the music, in music therapy.

Keywords: *Paediatrics, heuristic analysis, multicultural music therapy, here-and-now, intersectionality*

Introduction

Music has an ability to cross barriers of cultures and create connections between people regardless of their background (Morris, 2010). Music can help cultural exchange and cultural education (Baines, 2016) and can be seen as a universal language, but music is also linked to culture (Morris, 2010). This raises the questions: is the therapeutic perspective on music universal as well or culturally connected? What is important for the music therapist to take into consideration and be aware of when working across borders of countries, cultures and languages? These questions arose for the first author of this publication in her experience of working in a cross-cultural context in Peru. Yet these questions can be relevant not only in international and cross-cultural music therapy practice and research. Our societies are becoming more and more multicultural as a result of immigrants, multiracial and minority groups and the increasing age gap between generations. The term *multicultural* indicates contrasting elements relating or interacting with each other (Kim & Elefant, 2016). The term multicultural connects to the concept of *intersectionality,* i.e. when these contrasting elements, such as gender, language, class, race, ethnicity, sexual orientation, age, and dis/ability, overlap and contribute to and increase systemic inequalities and discrimination (Tomlinson, 2018). The question of how to respectfully and sensitively interact with patients to enable a safe and beneficial space for the therapeutic process arose during the project of the first author in Peru. As each individual brings their own cultural background into the interaction in music therapy, a cultural sensitivity is essential. The aspects of *cultural sensitivity* consist of knowledge, consideration, understanding, respect and tailoring (Foronda, 2008). Cultural sensitivity also relies on the understanding that one's background, values and biases must initially be considered so one is able to recognise how these may affect their perceptions of others. Furthermore, with a cultural sensitivity perspective one must understand the importance of other people's beliefs and experiences. With global collaborative research and clinical practice in multicultural settings evolving, there is an important need for integrating a multicultural (knowledge, awareness and respect of other cultures) and intersectional (awareness of social relations, social structures and the overlap of various social identities) perspective in music therapy. With this article, the roles and influences of culture in music therapy practice were explored from a personal and theoretical perspective. A heuristic analysis was conducted of the personal experiences of the first author of this publication of working in the public hospital for oncology patients *Instituto Nacional de Enfermedades Neoplasicas* (INEN) and in the public children's hospital *Instituto Nacional de Salud del Niño* (INSN) in the city of Lima, Peru, during the autumn of 2017. This project in Peru followed the first author's music therapy training on the master's programme at Aalborg University in Denmark.

Meeting of traditions

Music therapy traditions

The tradition of music therapy in Denmark started in the 1960s with the use of music in special education. It evolved from a pedagogical perspective influenced by the Nordoff-Robbins approach from the USA and the psychoanalytic and psychodynamic perspectives from Germany and England (Bonde, Jacobsen, Pedersen & Wigram, 2019). Today the Danish tradition of music therapy is based on the psychodynamic approach (Pedersen, 2014). The first Danish Association for Music Therapy (*Dansk Forbund for Musikterapi*, DFMT) was founded in 1969 (Bonde et al., 2019). In 1982 the first music therapy programme in Denmark started at Aalborg University. Over the years the programme has developed and created a partnership with Aalborg University Hospital, where the *Music Therapy Clinic* was established in 1994. Furthermore, the international research programme started in 1993 and the Center for Documentation and Research (*CEDOMUS*) in 2012, sparking an important development for music therapy from a scientific and professional perspective (Bonde et al., 2019).

In South America the music therapy tradition got underway in the 1950s in Argentina and Brazil (Barcellos, 2001) as a group of music educators began applying music in special programmes for children with disabilities (ASAM, 2018). In 1974 the Peruvian Music Therapy Society (*La Sociedad Peruana de Musicoterapia*) was founded by professionals in medicine, psychiatry, psychology and music education (Barcellos, 2001; Zagal, 2004). In 1998 the Music Therapy Society of Peru (*La Sociedad Musicoterapeutica del Perú*) was formed, and since then there has been a growing movement in the country with the Music Therapy Society of Peru, the Peruvian Association for Music Therapy (*La Asociación Peruana de Musicoterapia*) and the Center for Art Therapies' Development (*El Centro para el desarrollo de las Terapias de Arte*) working on developing clinical practice in music therapy and creating music therapy training programmes in Peru (Barcellos, 2001). The theoretical framework was based on the ideas of the Argentinian psychoanalyst Dr Benenzon and has developed with influences from various approaches, such as psychoanalytical, behavioural and cognitive therapies (Wagner, 2007). There are still no formal music therapy training programmes or specialisations in Peru (Zagal, 2004).

Healthcare system

Peru is located in western South America, on the Pacific coast. It is the fourth most populous country in South America with more than 32 million inhabitants. Spanish is the official language in Peru, spoken by more than 80% of the population, but there are also

about 150 indigenous languages, of which Quechua and Aymara have official status as well (WPR, 2018). According to statistics on the socioeconomic situation in Peru, around 40% of the population belongs to the medium socioeconomic level, while more than 50% live in poverty, and of these, 20% in extreme poverty (INEI, 2007). There are about 72 ethnic groups in Peru, with roots primarily from Amerindian and Spanish traditions as well as from various Asian, African and other European countries (Nureña, 2009). There are social, political and economic inequalities between cultural groups, creating tensions and challenges in their interactions. Access to healthcare can be a challenge in some areas of the country due to geographical barriers. Strengthening the ongoing health sector reform toward universal health coverage is needed, as well as adapting health services to cultural diversity and improving the health information system (Nureña, 2009). In the last decade there has been a significant improvement in access to health services and in the health of the population of Peru (Alcalde-Rabanal, Lazo González & Nigenda, 2011), especially in child health and nutrition (Huicho, Segura, Huayanay-Espinoza, de Guzman, Restrepo-Méndez, Tam, Barros & Victora, 2016). The health care system in Peru has two sectors, one public and one private. Treatment in the public sector is free, unlike private sector, and there are noticeable differences between the two sectors (Huicho et al., 2016). Denmark, located in Northern Europe, has a population of 5.7 million people (Healthcare Denmark, 2018). With the basic principle of the Danish social welfare system – often referred to as *the Scandinavian Welfare System* – all citizens have an equal right to social security. All health and social services are financed by general taxes, e.g. education is provided free of charge at all levels. All residents in Denmark have access to the public healthcare system, and most services are provided free of charge (Healthcare Denmark, 2018).

Music therapy in paediatric hospital settings

Music therapy as a practice is still quite unknown and uncommon in Peru (Zagal, 2004). In Denmark the tradition for music therapy is further developed, though within the paediatric hospital setting music therapy is new and not yet established compared to many other European countries, the USA and Australia (Sanfi & Bonde, 2019). Paediatrics is the field of medicine working with children and their diseases (Sundhedsstyrelsen, 2018). A child's pattern of health differs from those of an adult, and therefore a child's symptoms, treatment, prognoses and recovery process are also different (Sanfi & Bonde, 2019; Sundhedsstyrelsen, 2018). Working as a music therapist in a paediatric hospital setting differs from other fields of music therapy, as this setting involves a broad range of ages and levels of development, addressing a wide diversity of diseases and needs of the patients (Sanfi & Bonde, 2019). The duration of the child's time at the hospital is uncertain, therefore the focus in the music therapy sessions is usually short-term, on the moment, rather than on creating a long-term

music therapy course. Music therapy sessions can be provided for both hospitalised patients and ambulatory patients, i.e. out-patients visiting the hospital to receive treatment (Sanfi & Bonde, 2019).

The structure of music therapy in paediatric hospital settings is often a short(-term) session which requires flexibility on the part of the music therapist and an ability to create a safe and trusting relationship with the patient in a very short time (Sanfi & Bonde, 2019). Music has an immediate appeal that quickly catches the child's attention, and by using her voice, body language and mimic, the music therapist can engage the child in an interaction. It is through this active interaction that music therapy can change the child's experience of being at the hospital (Aasgaard, 2002). The child needs to receive support and help to cope with diagnosis, treatment and hospitalisation as well as side effects. The family also needs help to cope with the situation and strategies to support its child in the process (Dun, 2013). With a holistic approach to the child's treatment, music therapy can facilitate the child before, during and after medical procedures (Avers, Mathur & Kamat, 2007). The goal of music therapy is to support the child in managing medical procedures, decreasing experiences of anxiety and pain, and working against negative experiences of repeatedly painful procedures that can become traumatic. Another benefit is facilitating the child's co-operation during treatments (Sanfi & Bonde, 2019; Whitehead-Pleaux, Zebrowski, Baryza & Sheridan, 2007). Live music has the advantage of creating an additional activity, offering a distraction during medical procedures or during waiting times (Longhi, Pickett & Hargreaves, 2015). Studies show that live music performed by a music therapist not only helps the child, but the parents and the medical staff to relax as well. When the child and the surroundings around the medial procedure are calmer, the staff is facilitated in performing the procedures. This provides efficiency of care as well as job satisfaction by the staff (Sundar, Ramesh, Dixit, Venkatesh, Das & Gunasekaran, 2016; Whitehead-Pleaux et al., 2007). During medical procedures, the music therapy intervention serves as an interdisciplinary collaboration aligning with the work of the medical team and the medical procedures. It is an individually focused session, following and listening to the child's needs and responses during the procedures (Sanfi & Bonde, 2019).

Connecting to recent studies in this area of music therapy, one study explored the impact of music therapy on paediatric patients based on parental perception of their child's distress during intravenous placement (Ortiz, O'Connor, Carey, Vella, Paul, Rode & Weinberg, 2019). The study found music therapy intervention to enhance adaptive coping strategies and reduce distress in patients (Ortiz et al., 2019). Another music therapy study describes the qualities in interaction with children and their parents in music therapy during and after paediatric haematopoietic stem cell transplantation (Uggla, Mårtenson Blom, Bonde,

Gustafsson & Wrangsjö, 2019). Three main themes emerged from the interviews with the children, the parents and the music therapist: 1) Experiences of competency and recognition of self, 2) Interactive affect regulation as potential for change, and 3) Importance of the therapeutic relationship. The authors concluded that music therapy developed into a significant and helpful experience for the participants and became an important factor in coping with and managing the treatment period at the hospital (Uggla et al., 2019). In a third recent study the researchers analysed the use of live lullaby singing for two premature infants during venepuncture in comparison to only standard care, and the infants' physiological and affective responses emerging before, during and after this procedure (Ullsten, Eriksson, Klässbo & Volgsten, 2017). The authors used video microanalysis and Behavioural Indicators of Infant Pain (BIIP) to assess the different outcomes. The findings suggest that live singing with premature infants is a communicative interaction which may optimise the homeostatic mechanisms of the infant during painful procedures. The study highlighted that it is important in a painful context that the vocal performance is predictable and provide regular and comforting intensity, shape and sequential structures from the start of the live singing intervention (Ullsten et al., 2017).

Theoretical perspective

Music & culture

Music is a complex phenomenon shaped by culture and, at the same time, one that influences culture (Baines, 2016). Music is an important element in social contexts, and its role is contextualised whereby the experience of music is connected to the perceiver's attention and personal cultural context (Chase, 2003). Music can have a fundamental and essential role in a person's life and identity, with the potential to remind him/her of joyful memories, to provide sensation of safety, and to help strengthen the sense of identity (Cominardi, 2014). When working with paediatric patients, encouraging them to explore another person's perspective can be a resource , as this can help them to understand how people in cultures different from their own culture construct knowledge and interpretations of the world, including music (Howard, 2018). As communication is based on learning a system of signs, customs and tendencies unique to every culture and understood by us after repeated experiences, musical understanding is similarly developed (Yehuda, 2002). Reception of music is based on understanding the structure of music (Baines, 2016). When we understand the structures, the music becomes more communicative and opens up for emotional attachment (Ansdell & Pavlicevic, 2005). Music is a culturally derived phenomenon, and

the challenge is finding a balance between cultural considerations and the spontaneous connectivity of music in music therapy (Morris, 2010). There is a risk in perceiving music as a universal language, recognised and accessible to all, as it may create the false notion that multicultural considerations are not necessarily an issue in music therapy (Brown, 2002).

Music therapy – a multicultural engagement

Adapting to a culture, i.e. *acculturation*, is a process of learning the language, the social norms, lifestyles and "hidden rules". Stige (2002) describes culture as customs connecting to and regulating a group of people and traditions transferred from generation to generation. Culture is also a personal matter, with the music therapist and the patient bringing their own culture into music therapy (Kim & Whitehead-Pleaux, 2015). In the dynamic therapeutic process the music therapist is not an external observer (Mössler, Gold, Aßmus, Schumacher, Calvet, Reimer & Schmid, 2019). According to Stige (2015), music therapy is a cultural engagement, meaning that each person has a cultural identity, and when participating in cultural experiences it promotes socialisation that can improve the person's quality of life. Music therapists need to understand the role of music within the patient's culture and familiar environment. Music can offer a contraindication in music therapy if the music therapist is not aware of how specific songs, sounds or genres can affect the patient (Schwantes, 2009). Consulting with cultural liaisons or professionals who are familiar with the present culture is crucial. As music therapists move across borders, taking music therapy into multicultural practices, cultural differences may impact the therapy session and the relationship, and cultural considerations are important, therefore (Gadberry, 2014). Pavlicevic (1997) describes therapy as a mutual meeting where the music therapist and the patient together create their own musical culture. This connects to Stige's (2002) statement that it is not always possible to adjust completely to the patient's culture, but the interest and respect communicated by the music therapist are more important than the degree of success in adjusting to those specific cultural codes. Aigen (2001) emphasises that cultural references may facilitate the therapeutic process, but there should not be the assumption that a musical idiom will suit a patient only because the music therapist believes he/she has knowledge of the patient's musical identity or is able to play in the patient's cultural style, or that having a similar cultural background will automatically make the music therapy sessions beneficial or easier.

Cultural sensitivity in music therapy

In music therapy it is critical for the music therapist to respect, support and keep an openness to the personal-cultural-musical background of the patient together with an awareness of

cultural sensitivity (Grimmer & Schwantes, 2018). Having a musical cultural understanding is essential, and assumptions should be put aside and not imposed on the patient (Morris, 2010; Wood & Ansdell, 2018). *Cultural sensitivity* is a term used in many contexts when discussing the topic of culture, but with various descriptions of its meaning (Ruddock & Turner, 2007). Through a concept analysis, Foronda (2008, p. 210) defines cultural sensitivity as "employing one's knowledge, consideration, understanding, respect, and tailoring after realizing awareness of self and others and encountering a diverse group or individual". As music therapists, an openness to explore one's own cultural identity, as well as that of the patient, is essential (Donley, 2018). Additionally, it is important to explore personal thoughts on cultural differences and the music therapist's opinion of the patient's cultural background (Gonzalez, 2011). Both perspectives of cultural consideration – the music therapist's self-exploration and the understanding of the patient's culture – are essential, and differences and similarities that exist between the music therapist and the patient need to be taken into consideration as this may affect the therapeutic process (Hadley & Norris, 2016). As cultural assumptions, cultural values, misinterpretation and culturally unsuitable reactions can occur in the therapeutic process, an awareness of the patient's cultural world is critical (Bilu & Witztum, 1994). Music is a process based on elusive cultural symbols that contain meanings beyond verbal definitions and is a fundamental element of the cultural experience (Gouk, 2017).

Method

A heuristic analysis design was chosen to explore the role of culture in music therapy and why cultural considerations can be necessary in the field of music therapy. In heuristic methodology one seeks to obtain qualitative depictions that are at the heart and depth of a person's experience – depictions of situations, events, conversations, relationships, thoughts, values, feelings and beliefs (Moustakas, 1990). This research design has proved to be an inquiry particularly suited to exploring personal, internal and subjective experiences (Borgal, 2015). This approach gives personal descriptions of subjective experiences with the phenomenon being studied (McGraw, 2016). With this analysis, personal experiences of working as a music therapist across borders of language, culture and countries were studied.

According to Moustakas (1990), heuristic research is organised in three main stages: 1) Formulating the question, 2) Exploring and answering the question, and 3) Creating the research manuscript. A heuristic inquiry is a process that begins with a question that has been a personal puzzlement in the search to understand one's self and the world in which

one lives. Interactions with people have always fascinated the first author of this publication, who is the main object of this study. According to her, there is something captivating about meeting people, sharing a moment together and through that, learning more about that other person. Through meeting others, she finds that she learns more about herself as well. Interacting in music is a particularly amazing experience as here exist other ways of communicating – of expressing oneself, listening to and sharing with each other – and other rules and traditions, creating a possibility for interactions where limits or barriers in other situations might not be present. In music therapy, interactions in various ways can develop. As music is often described as a universal language, she wanted to explore whether the therapeutic perspective on music is also universal or whether it is culturally connected. With an aspiration to understand this experience more fully, she searched for an internship in a country with a culture and language different from hers. From her experiences, the research questions for this heuristic study developed:

> *Based on a heuristic inquiry, how is culture playing a role in music therapy practice within the interaction between a Nordic music therapist and paediatric patients in a hospital setting in Lima (Peru), according to the perspective of the music therapist in an autobiographical analysis?*

There are different ways of answering a question in heuristic research. In this study we used the autobiography design (where the first author, as a music therapist, is the only participant in this study). This design follows trends in social science research focusing on personal narratives (Etherington, 2004). Such narratives can focus on parts or the entirety of one's life, on particular kinds of experiences, or on others at a particular time in one's life (Denzin, 1989). We believe that this is a relevant heuristic design, as it allows a deep comprehension of the first-person experience with the phenomenon (Bruscia, Abbott, Cadesky, Condron, Hunt, Miller & Thomae, 2005). After defining the type of heuristic research, it is necessary to define how the data will be collected. We have chosen the reports and notes written by the music therapist as the main resource. In addition, we consider information from transcriptions of music therapy sessions and questionnaires conducted and filled out by the music therapist during the development of her clinical practice. These questionnaires were part of another research process conducted by the music therapist and integrated in the same music therapy project in Peru. This second research analysed through a thematic analysis the parents', volunteers' and medical team's perception of the music therapy interventions at the hospitals (Helander, 2018). Following the third main stage suggested by Moustakas (1990) when developing a heuristic study, we wrote the research manuscript. This document has been created according to the different steps suggested by McGraw (2016), who wrote guidelines on how to describe the research processes of a heuristic investigation in music

therapy. The steps proposed by McGraw (2016), adapted from Moustakas (1990), for the research processes in a heuristic approach are:

1. **Initial engagement**
   Identifying the focus of the inquiry.

2. **Immersion**
   Exploring personal and professional experiences related to the research topic, as well as reading about related topics.

3. **Incubation**
   Taking a step back from going deeper into the topic in order to allow experiences and knowledge to integrate, clarify and develop into a new, broader understanding of the topic.

4. **Illumination**
   Experiencing a gaining of new awareness, insight or epiphanies as the understanding of the core nature of the topic unfolds.

5. **Explication**
   Developing a broader understanding of the topic by comparing and contrasting aspects of the topic that have appeared during the process. New views and alternative explanations are identified as a comprehensive picture of the topic falls into place.

6. **Creative synthesis**
   Integrating experiences, insights and understandings to form a coherent description of the meaning of the topic.

Personal perspective

The first author of this publication, being the music therapist who conducted the music therapy sessions at the hospitals in Peru, is a Swedish-speaking Finn originally from Finland, with a BA and a MA in music therapy from Aalborg University, Denmark. In this section of the article, when presenting a personal experience of how culture is playing a role in music therapy based on the music therapist's own experiences of working in a cross-cultural

setting in Peru, the authors found it relevant to describe the personal perspective in the format of the first person.

Initial engagement

I began the process by considering my personal experiences of the connection between culture and music therapy. Before going to Peru I reflected on how to prepare myself for a meeting with a new culture and for working in a new language (Spanish). How would they react to my coming to their hospital as a white, European woman, not being able to speak Spanish fluently? Would they be receptive to music therapy? How would I be able to explain or present myself and my purpose at the hospital? During my time in Peru I regularly kept notes recording personal descriptions of my experiences, thoughts from discussions with my supervisor in Peru and Skype conversations with my university in Denmark. After returning to my studies in Denmark I reflected on my experiences of cultural influences in my work in Peru and my experiences of the role of culture in music therapy practice. Consequently, I became interested in going deeper into exploring the importance of cultural considerations in music therapy.

Immersion

With the focus on cultural influences, I started exploring my personal and professional experiences based on notes I had written before, during and after my time in Peru, and I began structuring the various aspects of the topic through the following mind map (Figure 1).

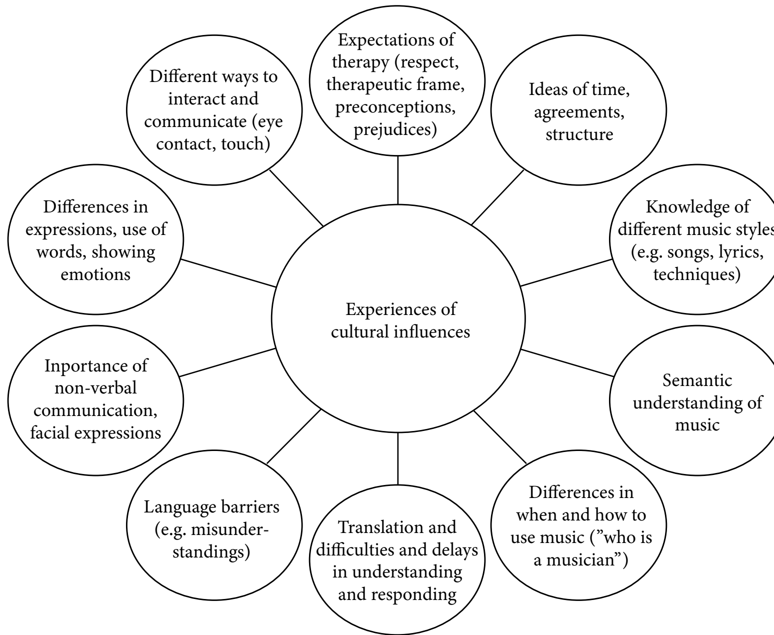

Figure 1. Mind map of my experiences of cultural influences in music therapy

To contextualise the immersion process of my experiences and to provide examples of what happened in the music therapy sessions, the following section contains eight portraits that describe my interactions with patients in music therapy. These quotations are taken from the questionnaires and transcriptions of music therapy sessions that I filled out over the period of the three last weeks of my music therapy project in Peru. These questionnaires were part of another research project integrated in the same music therapy project in Peru, which through questionnaire-based interviews and a thematic analysis analysed the parents', volunteers' and medical team's experiences of music therapy interventions in this hospital setting (Helander, 2018).

Finding my role

Exploring the experience from a professional perspective, I reflected on coming into a new culture, meeting new people, and presenting myself and my cultural background. Based on my cultural background, taking an approach of slowly finding one's place within the structure of the hospital is a respectful way to arrive in a new situation. Due to the language barrier, I was not able to verbally communicate very much in the beginning, which

meant having a quieter and more observant presence. It was not until further into my stay that I discovered how important socialisation and small talk were in this culture and in creating a good connection with my co-workers. Interacting, communicating and being social were also expressed in a different way than in the Nordic countries, e.g. in Finland an interaction typically uses fewer words and gestures, whereas in Peru more words, more hand gestures and greater volume are used to express oneself and to react to each other's expressions. Personally, I found it difficult not to be able to communicate and respond as freely as I would have liked and not to be able to create interactions through verbal communication. However, having a more observant presence created a new experience for me and presented a different side of me. With the challenge of limited skills of communication, I experienced the strength in entering a new setting through mainly observing and taking part gradually. This approach provided me with a different observation of others, of the hospital setting and of myself in this context.

Various expectations

I experienced an important lesson in being professional and learning how to present a distinct role with integrity and confidence, especially as my role (and music therapy) at the hospital was unfamiliar to the other staff members. Once it became clearer to my co-workers that I was a music therapist at the hospital, the communication and teamwork became easier. There remained the challenge of various expectations for my role by the staff and by me. Setting aside the language barriers and not being able to explain music therapy in a deeper way, the whole new experience of working as a music therapist in this particular clinical setting presented its own challenges. In other words, I needed to allow myself time to find out *what* my job entailed and *how* to describe it. The understanding of therapy, its implications and benefits as well as expectations of therapy can be rather different from culture to culture. Therefore, when coming into a new culture I discovered that showing how music therapy could be integrated in this setting was more relevant than trying to explain it. It did not matter whether they thought I was a hospital clown, volunteer, "the music lady", or something else. The important thing was to focus on interacting with the patients and that those moments shared in music therapy could be meaningful and helpful for the patients. The patient, and the interaction with the patient, was my primary focus and purpose of being at the hospital, and once that became clearer to me it was possible to become clearer to my colleagues as well. The hospital staff would make suggestions and requests for how I could help patients. I found it inspiring that they experienced music therapy as relevant and helpful, e.g. during a medical procedure. At the same time I found it important to trust my own knowledge of music therapy and focus on developing my professional decisions on what and how to work as a music therapist in this setting.

Portrait 1

> "When entering the room I focused on finding my ground and being observant of the room today and not on my expectations of the room. It was a new experience to not directly look for (or being asked by) a patient who needed me but instead starting to play 'background music' for a while. I was not stressed by not having a direct interaction with a patient but I needed to focus to stay grounded as I was 'just standing there playing music' and instead working with and following the changes in the environment and the patients in this way."

Music – the primary language

Even as my role at the hospital began to evolve, I recognised that being able to verbally present myself and my work was not really an option. In addition to the language barriers it was difficult presenting myself in this continuously changing environment of people coming and going. Over time I realised that the music itself presented me, which made the role of music in my work increase. In my meetings with patients, their families and hospital staff, the music itself was the primary language and way of communicating. Therefore, I had to rely on the music, and through this I got to experience the broader possibilities of music as a means of communication as compared with if I had been able to speak Spanish fluently. This enhanced both my personal connection to music as well as my ways of using music to connect to others.

Portrait 2

> ”I felt that the music changed the environment, it was distracting in a good way from the stressful and boring silence. The baby had a calmer body language, she did not move as much as before we started. She kept eye contact and though she did cry now and then, she laughed as well, and her crying was not hysterical or aggressive, nor lasted for as long as when I first started working with her."

> ”Through the interaction, many kids started to talk more, they got more energy (woke up) and laughed. Lots of eye contact. Some got tired, relaxed and fell asleep. Many expressed joy, that the music activity was fun and enjoyable both for the kids playing and for the ones listening to it, even if they do not have the energy or if I was not able to work directly with them, they could be a part of the activity as well."

Expressions & reactions

When working in a field that requires a connection to one's intuition and inner personal perspective, expressing oneself in a different language is challenging for many reasons. Even if the words might be familiar to me and I might find "a good therapeutic response", my reaction might feel inauthentic. I found that there is an emotional connection to words and expressions, a personal cultural connection to how we react and respond, and a personal cultural expectation to my own and others' reactions. The language barrier could also be helpful sometimes, as it created a distance and helped me to focus on what the patient was sharing without emotionally reacting to how those words might otherwise affect me. This enabled me to maintain an added professional stance instead of becoming too emotionally attached or involved in the therapeutic situation. On the other hand, not working in my native language required a translation process to happen before responding. Even if this process was not always perceived as a conscious step, it was present and made a delay in the response to the patient. Because of the language barriers, I was forced to give myself more time to understand what the patient was expressing and how to react. This "extra" time given to both the patient and me was many times shown to be meaningful, and had the conversation been in my native language, I might afterwards have felt that I had responded "too fast," with less depth of understanding.

Portrait 3

> ”Most of the kids wanted to play today, both during and between treatments. I also played for some kids while they listened. Development in increased eye contact, relaxed body language, laughing, interacting (with me, their parents or the kid in the next bed). The children mostly wanted to play together, I followed their signs of tempo, rhythm, volume and added vocals, sometimes words as well (the kid's name, talking or asking them in the song). The music helped them to relax, as well as their parents. Some parents wanted to talk a lot with me, making it challenging to keep the interaction and communication with the children, but I tried to involve all of them in the activity, as many parents wanted to take part in some way."

Time

In the Nordic part of Europe and, perhaps, especially among Finns, time is perceived as being quite fixed and non-negotiable. As I sometimes prefer to have a more flexible view on time, I looked forward to experiencing the "South American style" and had expectations of time being perceived differently in Peru. I experienced that when talking about time; there

was a strange combination of both relaxed and stressful attitudes which were often quite confusing. I was not able to expect things to happen in the same way as when something was discussed and planned in the Nordic countries. The word for now (*ahora* or *ahorita*) was used for describing when, for example, a meeting would be held, but it would often mean "at some time it will happen". Given this flexible understanding of time in relation to the intensive pace at the hospital, the only solution I could find was focusing on the present. In this here-and-now focus, with an uncertainty about time, I also needed to give time to the interaction. This meant allowing more time for patients as well as giving myself time to find a connection to myself with all the changes happening around me. I noticed that I was acclimatising to the culture of Peru in the way they communicated, in expressing myself and with the flexible attitude towards time. But in some ways I remained connected to my Nordic culture by bringing a calmer, less talkative and more patient side into my role as a music therapist. Admittedly, it was sometimes a challenge to find a balance between those two cultures, but also an opportunity to try different ways of communicating and adjusting to the present moment.

Portrait 4

> "The girl caught my attention, but it was difficult finding an interaction with her at first. It took some time but with time we found an interaction. It was intense but I felt it to be very important to stay with her. I enjoyed the interaction and it was difficult to stop. The girl wanted to continue. We had a great interaction and I am happy that we got a longer time together. The patients I worked with today all needed time, it was important to give time and stay with them to build an interaction."

Interactions

When looking at the perspective on music, I was interested in exploring how cultural differences would be noticed in music therapy. Would it be a problem, challenge or barrier in my interaction with patients if I was not familiar with a Latin repertoire, not able to sing in Spanish or play instruments in a Latin musical style? Even though these questions kept coming up now and then during my time in Peru, I found that in the meeting with a patient, it was more about creating an interaction than demonstrating my musical background or the patient presenting his/hers. It was about a meeting between two people and an interaction between the personal cultures of these two people. My most important task was to be there in that moment together with the patient, for in that moment we created music together that became our way of communication and our culture. There were cultural influences

in the musical expressions, but even though I learned and practised Latin rhythms to use in music therapy, I also retained my own music style. I found it important to be authentic in my meetings with the patients. This meant, in my connection to the patient, that I also maintained a connection to myself and my own culture. The music I expressed was created from the music of the patient with my personal interpretation and influences. Especially when I was using receptive music therapy methods with a patient, I found the music I provided being similar to the improvised music I had used in music therapy sessions in Denmark. Creating music to express emotions and support was the main focus, rather than creating music within a Latin music style.

Portrait 5

> "The girl started interacting more, she laughed and communicated both through laughter and by playing music. We found an interaction, the girl laughed and interacted with me. When we began, she was kicking a lot and throwing things, but when she realised that she could have some control with me/in the music, she became freer. In our music, she could decide how she would play and she noticed that I followed her. I followed her signs and she did notice mine as well, but she preferred to lead. It created a fun atmosphere and activity which also inspired and captured the attention of other kids. More kids wanted to play and wanted an activity. The music was a fun diversion where the kids could take a lead, show the others."

Music & emotions

Music is deeply connected to emotions and a way to get in touch with, express and share emotions. This was my experience of using music in another culture, where barriers of fully knowing another person's language and background mattered less. Music created a way to interact and share not only that moment, but the emotions that arose in that moment. Although there were not many common elements in my and the patient's diverse backgrounds, we could find a connection in music. Since the experience of being at the hospital could be quite challenging for the patient, the connection could become a source of strength. With an intensive pace, various opposing needs and emotions, many changes and noises surfacing at the same time, using words alone to deal with the situation was inadequate. When approaching patients, I presented the instruments I had with me and let the patient explore the instruments. I then tried to listen and follow the signs and motions the patient expressed non-verbally, verbally and musically. I knew little of the patient's background, but in our interaction the patient could share expressions, feelings and thoughts. Even

without putting into words the things being shared, the interaction could be supportive and helpful for the patient.

Portrait 6

> ”The baby’s mother started to cry while I was playing and singing. She said to me and to the mother by the bed beside her, that the music was nice and helpful. That she and her baby liked it. The mother’s body language became more relaxed, less stressful and she started also playing with her kid and in the end holding her child in her arms and singing to her. This was the first time that I got such a strong connection to a parent. Through the kid, I also interacted with the mother. Not only with the focus on the kid but also connecting with the needs of the mother. It was a strong and powerful experience, that the mother felt empowered and found a way to interact with her kid and both started playing with her daughter and then singing for her.”

To connect

Once I began to find my role in this work, I sometimes “forgot” that I was from a different cultural background. This was especially noticeable in new meetings, as a tall, blond girl with a guitar was a surprising and exotic experience for many. This had both advantages and challenges for the interaction. Some people were curious and wanted to ask me about my background, while others became shy or did not know how to interact with me. Children, however, often have a natural openness and interest in exploring new things. I discovered that walking around with a guitar (as well as some shakers and small percussion instruments in my pockets) helped to create an immediate connection to the children – both the sound of music and the sight of the instruments caught their attention. I found that the child often looked at me, especially when I was singing, and I found the eye contact to be strengthening the interaction. In Peru there are easier and more immediate interactions, and the pace can also be faster and more enthusiastic compared to interactions in the Nordic countries. During medical treatments, however, I noticed that interactions between the medical team and the patient were infrequent. When patients were alone, without any family members around them, no one would interact with them. If there was a family member present, only they would often become involved in the medical procedure and interact with the staff. I therefore tried to “be allowed to” stay by the patient’s side to keep eye contact with and

support the patient. If the situation made it possible, I tried to start creating a connection with the patient before the medical procedure took place and then remained until the procedure was over and continued to interact with the patient once the medical team left. Sometimes I was not able to stay next to the patient, but I tried to maintain eye contact if possible or keep a musical interaction going, e.g. keep singing from behind the bed.

Portrait 7

> "The boy interacted and kept eye contact with me during the whole treatment and his breathing and body language became more relaxed. I felt that the time flew. I wanted to work with more kids, but I had started taking more time for each patient, for each day. Therefore, I was also not able to reach out to as many kids. But the interaction and the change in his body language gave me the impression to stay with him and that it was a good distraction for him. After the doctors left, I stayed with him until he fell asleep. He did not share a word during our interaction, but kept eye contact with me the whole time."

Sharing experiences

Exploring the topic from a personal point of view, I came to think about the need to share my work experiences at the end of the day. My studies and previous work experiences in music therapy had been in Danish, and my identity as a music therapist was, in a way, connected to the Danish language. I realised the importance of having supervision in a language where I would be able to describe my experiences freely. Even while expressing myself in English or Danish there was a translation process happening in my mind. In Spanish that process was even more extensive, as I knew only a few expressions and words. After each day the team of volunteers from the NGO I was collaborating with at the hospital met for a debrief and to hear each other's experiences of what happened each day. These meetings and moments reminded me of the importance of working together in and as a team. Even as I was doing my work on my own at the hospital, having a consistent moment for sharing, using sometimes more, sometimes fewer words was really important and necessary to find motivation, inspiration and ways to proceed with our work. Especially, when working abroad, the support of a team becomes even more critical and valuable.

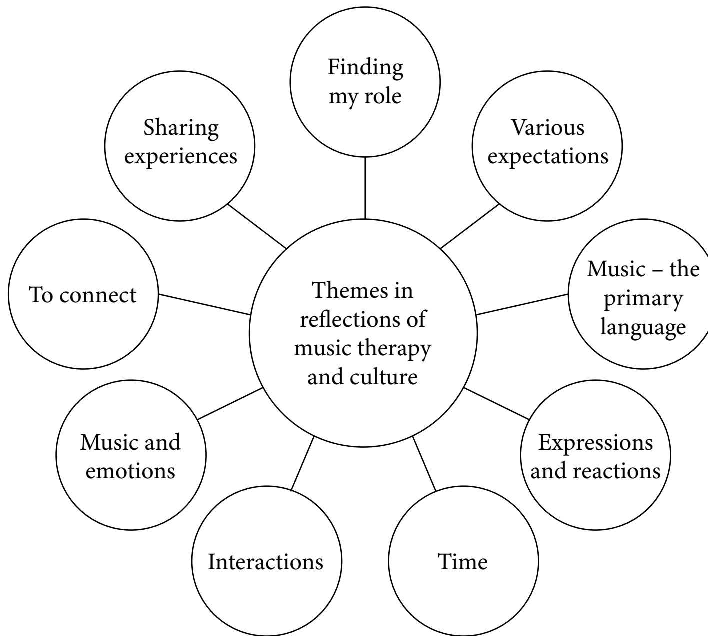

Figure 2. Themes in personal reflections of music therapy practice in a new culture

Portrait 8

> "There were big changes all the time, the tempo was intense. There were a lot of sounds and things going on today. At some moments there were many kids seeking and needing attention and support from me and I needed to make a choice who to stay with, who to work with. The room was quite stressful today, with many changes from a lot of crying to a lot of laughter. Even when the room is quieter, there is always a feeling underneath of stress and pain in the room. Some of the nurses, as well as the volunteers, have started to ask me to come along when they are going to a patient. To be a part of the team during the patient's treatment is an amazing feeling of collaboration and of trying to do the best we can for the patient."

Incubation & illumination

After some time had passed I re-read my reflections and wrote down a title for each section to portray the different themes I had identified in my descriptions of my experiences. These nine themes (Figure 2) highlight emergent themes describing my experiences with cultural aspects in music therapy. Then I connected these themes with quotations from the questionnaires and transcriptions of music therapy sessions that I filled out during my time in Peru in order to broaden the descriptions of the context where the music therapy interventions were taking place.

Explication

As Morris (2010) suggests, having a common cultural background might make communication easier, and therefore in meetings with other cultures, cultural considerations are needed. But cultural understanding is not enough, both in the case of sharing the same culture or having a different culture to the patient. An openness to the patient's culture is important together with setting assumptions aside and not imposing them on the patient (Morris, 2010). As I see therapy to be a personal exploration, I find it important that the music therapist is respectful and open to the cultural background of the patient. This connects to Stige's (2002) description of culture being both a personal matter and a phenomenon connected to and regulated by a group of people. As I experienced in music therapy, there is not only a meeting between two cultures but between two identities – each having a personal and social cultural background influencing the interaction and the creation of the culture in their meeting. I experienced the importance of being observant and listening to the here-and-now as the interaction is created based on that moment. This view is connected to the description of Pavlicevic (1997) who explains therapy as being a mutual meeting where the patient and the therapist create their own musical culture.

As Baines (2016) speaks of the importance of self-reflection on the therapist's own sense of culture, I reflected more on my cultural background and its meaning in my work as a music therapist. As a Swedish-speaking Finn, I grew up in a country with two very different cultures existing next to each other. Swedish-speaking Finns are a small minority of Finland (5%), and even while sharing the same language as the people of Sweden, those cultures are also quite different. During my adult life I have lived in several countries. This has given me the opportunity to experience different cultures, and it has also had an influence on the development of my personal culture. At times I feel a connection to my Swedish/Finnish roots, in other situations like I am a stranger to the Finnish cultures – both when being in Finland and abroad. My experiences with and education in music therapy,

as well as developing my identity as a music therapist, have involved many languages and cultures. In my experience, there is a special connection to one's native language, as singing or expressing personal thoughts in one's mother tongue offers a special, personal and emotional connection to these expressions. In meetings between different cultures and languages, we get a chance to experience different ways of expression and communication which can be helpful in both understanding others and oneself.

Creative synthesis

The aim of this heuristic analysis was to describe my reflections on my personal experiences, adding a perspective from relevant literature to explore the complex phenomenon of culture and its relation to music therapy and why cultural considerations may be needed in this field. In music therapy there is an opportunity for the patient to get in touch with his/her truly personal core, and it is the music therapist's responsibility to support, respect and listen to the patient in his/her self-discovery. In every meeting between people there is a meeting between personal cultures interacting. This may be obvious in meetings across borders of cultures and countries where strong differences are present, but it is just as important to recognise that there are cultural considerations needed in meetings within similar cultures. In multicultural meetings some cultural signs might be easier to notice, whereas others are more difficult to read and understand. However, what I experienced is that being open to those signs enables interactions across any borders. We might not understand all aspects of the other person's culture, or be able to respond in the same way as the other person does or expects, but this does not mean an interaction cannot be created. In music we can share and express elements that are created from our culture and that we have built in our interaction in music. Finally, in meetings across cultures there will always be misunderstandings. These can be of various degrees – some more challenging than others – but misunderstandings cannot be avoided. Based on my experiences, I found it important to proceed with respect and openness, to dare to try and not be impeded by fear in meetings across cultures. In my experience it is when one tries that one can learn, and in all interactions being respectful, sensitive and open to trying is the key.

Discussion

With the heuristic inquiry, nine themes were identified as various roles of culture in clinical music therapy practice. From the reflections of the music therapist in an autobiographical analysis the themes of various expectations, music becoming the primary language, finding

one's role, variations in expressions, reactions, perception of time and interactions, connecting, expressing and sharing emotions (especially through music), and sharing experiences verbally and non-verbally in a foreign language were discovered as personal experiences of cultural influences in music therapy. Cultural factors can have a more present and more direct influence in some of these themes (Various expectations, Finding my role, Sharing experiences, Expressions & reactions, and Time) in comparison with the other themes (Music – the primary language, Interactions, Music & emotions, and To connect) where elements of culture might not become cultural barriers but may have less of an influence or perhaps become a helpful and useful element in creating an intermusical relationship (Jones, Baker & Day, 2004). The first "group" of themes can be considered to have roles that are more dependent on cultural elements such as language and communication, social hierarchies, social relations, relations of power and beliefs and the perception of aesthetics (Fiske, Dupree, Nicolas & Swencionis, 2016). The second "group" of themes show that the musical interactions develop mainly from forms of non-verbal communication centred in the engagement, shared attention and affective synchrony that are usually developed from the first month of life where there is no clear cognitive identification with cultural differences (Hart, 2008). From this broad perspective on the themes we will now discuss them more in detail and explore their understanding by connecting them with other publications – within and outside of the field of music therapy.

The theme *Various expectations* presents the particular element of music therapy practice involving each participant's unique perception of the music therapy process and of possible ways to interact. A concept related to this theme is *The Field of Aesthetics* established by Carolyn Kenny (2006) within her model described as *The Field Play*. According to Kenny, the aesthetics is the first field presented in an interaction between the music therapist and the patient. The field of aesthetics refers to aesthetic perceptions related to music, especially on the view on beauty. Each person has their own aesthetic musical understanding based on their previous cultural-social experiences, whereby they have acquired their conceptions of what is beautiful to play and listen to (Kenny, 2006). Among the seven phenomenological fields present in the Field of Play model, this is the only one where there are clear boundaries separating the patient's field from the music therapist's field. Considering the results of this research, the expectations arose mainly through the dialogue of the different aesthetic fields of the participants. Neither was sure if the other would accept their aesthetic expressions or perceptions of the music, especially as they did not share the same verbal language to give and receive feedback on their musical expressions. When coming into a new setting the music therapist experienced the need to find her way of working and interacting within that specific culture – the Peruvian culture, the hospital culture, the child's culture and the music therapy culture. Within a multicultural music therapy practice the music therapist

discovered the importance of keeping an awareness of the balance between adjusting to the cultures she met and sticking to her own ways. This connects to the following theme of finding one's role within a setting with various expectations.

In the themes *Finding my role* and *Time* the music therapist expressed the need to understand the context one is in. She searched for her role and place in that specific hospital environment, taking into account the cultural aspects involved in the therapeutic setting (including how time was perceived by the patients on the basis of their subjective perception linked to cultural aspects). These themes can be understood through the concepts of cultural competence and cultural humility (Fisher-Borne, Cain & Martin, 2015). Cultural competence involves understanding and appropriately responding to the unique combination of cultural variables and the full range of dimensions of diversity that the professional (the music therapist) and client, patient, or family brings to the interactions (Fisher-Borne et al., 2015). For cultural competence to be reasonable, the music therapist needs to consider these competences from a perspective of humility. In this sense, cultural humility is defined as having traits of respect, empathy and critical self-reflection on both an intrapersonal and an interpersonal level (Foronda, Baptiste, Reinholdt & Ousman, 2016). In this study the music therapist did not only seek to identify the cultural differences existing in this context in order for her to find her role in the clinical practice but strove to understand these differences and to find ways to respond (cultural competences) with a humble attitude in the interactions with the cultural variations.

Regarding *Time*, the music therapist respected cultural differences and focused on finding a perception of time that could be shared between her and the patient: the here-and-now focus. Psychotherapist Irvin Yalom is one among many therapists who emphasises the here-and-now focus in therapy. According to Yalom (2005), a shorter intervention is required in a hospital setting, the focus being on the dynamics that occur in the session rather than going into the child's past history. The music therapist experienced the strength in being sensitive to the moment, for example by giving more time to the interactions in this high-paced and constantly changing hospital environment. She needed time to translate both verbal and non-verbal signs and expressions in order to know how to respond. Therefore, she gave more time and more silence to the interactions than if she would have been able to respond in her native language. The time within the silence was found to be a powerful tool in music therapy. Within such an intensive hospital setting it was helpful and meaningful to provide a moment where the child could choose the pace of his/her interaction, and this gave the child more control in this setting as well. Interactions in Peru were often quite hectic and at a faster pace compared to interactions in the Nordic countries. The music therapist found value in the more "Nordic" approach of communicating by lowering

the pace, using less verbal communication and being together with the patient in silent and non-verbal interactions. This approach connects to *slow music therapy* – a concept that highlights the importance of being in the here-and-now, appreciating the moments and resting in them to enrich the experience and the interaction (Johansson, 2017). *Slow music therapy* is not about stopping the time or being in a timeless state but rather about being together in the present moment and being sensitive to how the moment develops (Johansson, 2017). Whether the music therapist had only one interaction with a patient or met that same child several times, it was important to be present and meet the child where he/she was in that moment. Even in regularly scheduled therapy sessions, where the music therapist will probably meet the patient over a longer period, it is important to be in the present moment and in that particular session. The process is continuing but cannot be planned out and followed in a step-by-step detailed plan. Johansson (2017) emphasises resting in the moment, capturing the here-and-now and creating a space to develop and deepen the experience. In this study the music therapist experienced the value of giving time to the here-and-now to deepen and develop the interaction with the patient.

The themes *Music – the primary language* and *Music & emotions* represent the possibility of musical communication regardless of the languages spoken by the participants in the clinical setting. This theme is directly related to the concept of *communicative musicality*, created by Malloch and Trevarthen (2018), which explores the intrinsic musical nature of human interaction and is used to explain the root of musical interactions in music therapy (Holck, 2019). Communicative musicality is defined as the innate ability to move, remember and plan sympathetically with others, creating an endless variety of melodic narratives by instrumental music or singing. This can be seen in the communication between a mother and her infant where noticeable patterns of timing, vocal timbre and melodic gesture exist. Without intending to do so, the mother-infant communication follows typical rules of musical performance, with distinct timing and melodic narratives (Malloch & Trevarthen, 2018). In other words, although the understanding of how we perceive music can be culturally learned, the musical interaction originates from a form of basic communication that develop in infants. This is not to suggest that the music therapist copies a mother-infant relationship but that the music therapist can musically increase and strengthen basic forms of interaction, thus encouraging communicative interaction and connection. The findings from this research showed that communicative musicality allows forms of interaction, enables ways of sharing affections and creates non-verbal ways of communication that are significant for both the music therapist and the patients, cultural differences aside.

In the theme *Expressions & reactions* the music therapist presented ways in which both the patients and herself responded in different ways in their interactions. In some situations there

were verbal reactions and in others only forms of non-verbal communication. This theme has an interesting resonance with the concepts of narrative metaphors (Barcellos, 2012) and analogy in music therapy (Smeijsters, 2012). According to Barcellos (2012), it is possible to understand music as metaphorical narratives from a contemporary musicological perspective, where the patient acts as a performer, as a narrator, and the therapist acts as the receiver of musical traces and seeks to give meaning to these musical expressions. The analogy in music therapy has the function of portraying internal states, expressed through music. In this way, what the patient expresses through music is a reflection of how he/she feels internally. There is an equivalence between the musical expressions and the internal experiences of how the patient feels, thinks or acts (Smeijsters, 2012). From the different expressions and reactions found in this research, some of them were centred on metaphorical elements and others on analogical elements. In situations where the interactions involved verbal expression it was important to reflect on what the respective words were connected to in the patient's history. When there is a verbal involvement there is a direct relation to a narrative understanding of what the patient shares and the way the music therapist understands this expression. In the case of this research, the receiver did not have all the resources to understand what was being presented, so there was a need to create analogical situations where expressions and reactions could reflect non-verbally the internal states in the here-and-now.

The music therapist found the cultural differences and language barriers not always to be a challenge but also a way to create an interaction and a resource for sharing with each other their personal backgrounds. This gave the patient some control, a contact with their identity – their life and identity besides being a patient at the hospital – and a resource in being able to show and teach someone else, both verbally and non-verbally. The music therapist's experiences connect to the statement that communication is not only about learning the spoken language but also about the non-verbal signs and expressions and the musical language of the culture (Gadberry, 2014). In interactions there are many things being said in various ways of which some are more observable to a person of that culture, while other signs are only noticeable to a foreigner (Gadberry, 2014). Both music and culture are complex phenomena, providing a sense of the person's identity and background (Baines, 2016; Cominardi, 2014). Yehuda (2002) describes a connection between these two phenomena by saying communication is based on learning a system of signs, customs and tendencies which is unique to every culture and understood after repeated experiences. In the same way our musical understanding is developed.

The themes *To connect* and *Interactions* presented how the music therapist found ways to initiate and develop interactions with patients through music. These themes share aspects with the description of *The Processual Stages*, presented by John Carpente (2016) on how

to develop an intermusical relationship between the patient and the music therapist. These stages were inspired by the Nordoff-Robbins model and the interaction model by the free play DIRFloortime. According to Carpente, the first step in this process is to follow the patient's lead in the musical interaction. Although the music therapist can initiate a musical interaction, she needs to be aware of the different ways in which the patient shows an interest in music and how he/she is regulated by the musical interactions. The second step is a two-way propositional communication where the patient and the music therapist create different circles of communication in their interaction. The last step is the affective synchrony where the music therapist and the patient share various elements of affection within the musical interaction. These stages of Carpente are evident in the two themes, as these stages were developed to connect and create interactions independent of the cultural differences in repertoire and the difficulties in verbal communication between the participants.

As previously stated, the music therapist has a responsibility to respect, support and keep an openness to the personal-cultural-musical background of the patient (Grimmer & Schwantes, 2018). In this research the music therapist expressed her experiences of cultural influences and differences being present in meetings between multiple cultures. But first and foremost it is a meeting between two people, and although considerations are needed, it is important to use the here-and-now focus as a source for the interaction and to put assumptions aside. The music therapist found that in the mutual meeting in music therapy, regardless of whether or not you are working in your own culture, the music therapist and the patient bring two personal cultural backgrounds into the interaction where a third shared culture evolves. In the heuristic analysis, music was found to be a guide in the session. Music could provide a structure, keep the child's attention, build anticipation and create playful interactions. Music therapy gave the child an opportunity to be heard in an unfamiliar and intense hospital atmosphere where members of the medical team often did not have much time and might not interact or consult with the patient during the often painful procedures. In music therapy the child can receive an interaction with the music therapist, who only seeks to engage in a creative play where the child has the option of control and interaction (Wildman, 2010). Through an emotionally compelling experience of making music together, the patient can have a meaningful and enjoyable moment in the hospital (Wildman, 2010). The interaction, engagement and enjoyment of music in music therapy help the patient to better cope with the time spent in the hospital and contribute to the patient's treatment from a holistic perspective (Longhi et al., 2015; Sanfi & Bonde, 2019; Whitehead-Pleaux et al., 2007).

The theme *Sharing experiences* presented the opportunities and difficulties for the music therapist to communicate her experiences of the music therapy sessions. There was a

challenge in not being able to express her feelings in her mother tongue, in the place of practice and in supervisions. This theme connects to the field exploring the experiences of multilingual people. According to Stavans (2001), changing languages is like imposing another role on oneself, like being temporarily someone else. Koven (2001) asked French-Portuguese bilingual informants to tell the same story in Portuguese and in French, and they were subsequently interviewed about the experience itself. The author found that bilinguals performed quite differently depending on the language being used, suggesting that different languages allow us to "perform a variety of cultural selves" through a range of communicative tendencies and strategies and conversational forms and styles. In another study conducted by Pavlenko (2007), two-thirds of the 1,039 multilingual participants in the study provided evidence through the Bilingualism and Emotion Questionnaire (BEQ) that multi-linguals might feel more authentic in their first language. Therefore, the challenges experienced by the music therapist in this study were beyond the ability of communicating in a language other than her mother tongue, but mainly due to the fact that expressing and describing one's experiences in a different language require a translation process. One's original perception of a situation might change in the process of translating the experience into words, especially into a foreign language. Therefore, one's description of the experience might become quite different from how a person experienced and originally intended to express herself.

Considering previous publications on heuristic investigations, this study can be considered a novel heuristic study in music therapy, as it is the first to present in a first-person analysis how a Nordic music therapist reflects on the role of culture in a clinical music therapy practice performed in a paediatric hospital setting in a Latin American country. In some previous heuristic studies the analyses were also conducted from a cultural perspective. The study of Han (2015) explored music therapy students' experiences of the respect for cultural identities in relation to music therapy practice with patients from diverse cultural backgrounds. One of the differences of the heuristic inquiry conducted by Han (2015) in comparison with the present study is that the paediatric patients and their families in our study came from similar backgrounds. The study of Bell (2016) also verified how cultural aspects influence the music therapist's perception of herself. Comparing Bell's study with our study, Bell explored a music therapist's reflection on her Métis heritage and how it might influence her personally, instead of verifying how this heritage relates to other cultural backgrounds. In comparison with other heuristic studies, the present research used the same six methodological steps created by Moustkas (1990) and adapted by McGraw (2016) for the music therapy context. In comparison with the other heuristic studies in music therapy, one limitation of this investigation was the absence of a creative product, like a song or a poem at the end of the heuristic analysis, which would offer a more artistic

aspect to the heuristic process. The reason for not using a song or poem as a summary of the creative synthesis was due to the need to creatively summarise the whole heuristic process. Another limitation of the study was the absence of one incubation procedure suggested by Moustskas (1990), i.e. the engagement in activities that were not related to the study during the incubation period. It is important to clarify that this is only one of the two possibilities of the incubation step suggested by Moustskas (1990). Another possibility that was used in this research refers to the recognition of the value of the researcher retreating from intense and focused attention on the topic being explored.

Future perspectives in this field of research point to the need for more heuristic studies based on autobiographical analysis in music therapy. The number is still small, and further studies exploring cultural influences in music therapy practice and research would be important. In addition, it would be significant to see the experiences of other European music therapists in paediatric hospital settings in Latin American countries. From several examples of interactions between different cultures, it would be possible to learn more about subjectivities and the different phenomena present in music therapy from a multicultural perspective.

Conclusion

Multicultural music therapy is evolving due to international collaborations and more multicultural societies. Through a heuristic analysis, the role of culture in music therapy was explored from a theoretical and personal perspective. The heuristic analysis presented the need for multicultural considerations, with an awareness of the patient's culture as well as the therapist's. A person's cultural-musical background is a phenomenon of both personal and interpersonal aspects, and it is important to respect, support and keep an openness to the personal-cultural-musical background of the patient together with an awareness of cultural sensitivity. Presumptions must be put aside in meeting with a patient, both when sharing a cultural background and in meetings across borders of countries, cultures and languages. In the dynamic therapeutic interaction the music therapist is not an observer but is like the patient, bringing his/her own culture into music therapy. The therapy becomes a mutual meeting where the music therapist and the patient together create their musical culture based on the *here-and-now* moment and their backgrounds. Cultural differences can become a way to create a unique interaction and serve as a resource for interactions in music therapy. It is important to remember the music in music therapy, the power of music as communication, and to strive for a balance between considerations and the spontaneous connectivity in music therapy.

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