

Health Practitioners' Understanding and Use of Relaxation Techniques (RTs), Mindfulness Meditation (MM) and Relaxation Music (RM) in the UK and South Korea: a Qualitative Case Study Approach

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A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Doctor of Philosophy

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November 2017

Abstract

Background:

The information exchange between healthcare practitioners in South Korea and the UK has so far been limited and cross-cultural comparisons of Relaxation techniques (RTs) and Mindfulness meditation (MM) and Relaxation music (RM) within the healthcare context of Korea and the UK have previously been unexplored. This has been the inspiration for this qualitative case study focussing on understanding and use of RTs, MM and RM within the respective healthcare contexts.

Methods:

Data were collected through qualitative semi-structured interviews with six Korean and six UK healthcare practitioners in three professional areas: medical practice, meditation, and music therapy. Approval from the Ethics Committee was granted (Application number: HLS/13/05/68). The interviews were transcribed and a thematic analysis was undertaken. The topics explored include: a) the value and use of RTs, MM and RM; b) approaches and methods; c) practitioners' concerns; d) responses of interventions; e) cultural similarities and differences; and f) the integration of RTs, MM and RM within healthcare. Underlying cultural factors have been considered, including education systems and approaches, practitioner-client relationships and religious influences alongside the background of cultural change and changing perspectives within healthcare in the UK and Korea.

Findings:

A great variety of approaches to RTs, MM and RM were discussed among the sample group. Across a wide client spectrum common therapeutic purposes included stress reduction, emotional support and regulation, rehabilitation, personal transformation and spiritual development. The participants were both discerning and creative in terms of mind-body interventions they use. Practitioners' training, personal experience and insights gained through practice inform their professional work and they were keen to share knowledge among colleagues.

Nevertheless, practitioners' level of competency and abilities with respect to the use of RTs, MM and RM were a common concern; training opportunities exist to varying degrees in both countries, however, and growth in the use of mind-body-spirit interventions is a significant trend. Nation-specific and cultural factors can affect the use of interventions, settings and client group. Similarities (focus on individual and subjective factors, client acceptance and practical concerns) and differences (related to historical background, educational culture, prevailing religious outlooks and the respective health services) were found between Korea and the UK.

Conclusion:

The value of cross-cultural and multidisciplinary research and integrated health is increasingly recognised and the use of RTs, MM and RM as mind-body-spirit interventions considered to be useful integrated treatment within healthcare context. This study shows the difference in range of RTs, MM and RM resources and the approaches in integrating practice and these may lead to cross-fertilisation within therapeutic practice.

The value of knowledge sharing and integrated medicine is increasingly recognised across the globe and this study opens up a number of themes that might be taken up again and built on by future researchers. More generally, the study contributes to cross-cultural qualitative research between Korea and UK and integrating theory and practice with respect to RTs, MM and RM.

Key words: Relaxation techniques (RTs), Mindfulness meditation (MM), Relaxation music (RM), Meditation, Music therapy, Healthcare, Healthcare practitioners, South Korea, UK

Table of Contents

Abstract	i
Table of Contents	iii
Statement of Original Authorship	ix
Acknowledgements	x
Preface	xii

Chapter 1: Introduction1

1.1 Relaxation Techniques (RTs), Mindfulness Meditation (MM) and Relaxation Music (RM) in Healthcare	1
1.2 Cross-Cultural Communication regarding Music Therapy and Meditational Practices	3
1.3 Research Aims and Research Questions	6
1.4 Structure of the Thesis.....	9

Chapter 2: Literature Review11

2.1 Introduction	11
2.2 Literature Review Process.....	13
2.3 RTs, MM and RM as Mind-Body Interventions.....	15
2.4 Detailed Contents of the Literature Review.....	17
2.5 RTs, MM and RM for Health and Well-being	18
2.6 Music in Health	26
2.6.1 Music in Medicine.....	27
2.6.2 Music Therapy in Health.....	30
2.7 Collaborative and Multidisciplinary Approaches	38
2.7.1 Music Therapy: Collaborating.....	39
2.7.2 Combining RTs and RM in Music Therapy.....	40

2.8 Characteristics of RM	42
2.9 Types of RM	46
2.10 RTs and Meditational Practices in Health	52
2.11 Stress Management and Mind-Body Interventions	56
2.12 Mindfulness-Based Practice in Health	60
2.13 Creativity and Spirituality	64
Chapter 3: Methodology	72
3.1 Introduction to Research Design	72
3.2 Reflection on Case Study Qualitative Methodology.....	73
3.2.1 Case Studies.....	73
3.2.2 Qualitative Research.....	77
3.2.3 Philosophical Assumptions.....	78
3.3 Research Procedures	79
3.3.1 Fieldwork and Interview	79
3.3.2 Sampling and Size of Groups	79
3.3.3 Information about the 12 Interviewees	81
3.4 Data Collection and Data Analysis	81
3.4.1 Interview Data Collection.....	81
3.4.2 Data Analysis	82
3.5 Ethical Considerations and Application.....	84
3.6 Engagement with the Research Process through Reflection	85
3.7 Reflections on Quality Criteria	85
3.8 Reflection of Cross-Cultural Interviewing.....	90

Chapter 4: Finding Chapters: Music and Health	94
4.1 Introduction to Finding Chapters.....	94
4.2 Music and Music Therapy Approaches	94
4.2.1 Use of Music	95
4.2.2 Criteria for Choice of Music	102
4.2.3 Music Genre	107
4.2.4 Musical and Sound Instruments	109
4.2.5 Receptive and Active Approaches	112
4.3 Music, Health and Well-being	114
4.3.1 Personal Motivations in Using Music in Health	114
4.3.2 Use of Music in Health Contexts	121
4.4 Qualities and Abilities of the Practitioners	128
4.4.1 Personal Qualities and Abilities of the Practitioners	128
4.4.2 Level of Competency and Abilities of the Practitioners	134
4.4.3 Qualifications and Interventions Training	138
Chapter 5: Finding Chapters: RTs and MM and Health.....	144
5.1 RTs and MM Approaches	144
5.1.1 Purposes of RTs and MM.....	145
5.1.2 Practitioners' Personal Motivations in Using RTs and MM...	148
5.1.3 Types of RTs and MM	150
5.1.4 Adaptations of RTs and MM	153
5.2 RTs and MM as Healthcare Interventions	160
5.2.1 Understanding of RTs and MM for Health and Well-being....	161

5.3 Use of RTs and Meditation in Health Contexts.....	163
5.3.1 Breathing Techniques.....	163
5.3.2 Progressive Relaxation Technique (PRT)	169
5.3.3 Body Scan	172
5.3.4 Imagery and Visualisation	174
5.3.5 Autogenic Therapy (AT)	176
5.3.6 Walking Meditation	177
5.3.7 Loving-Kindness and Compassionate Meditation	180
5.3.8 Mandalas	182
5.3.9 Mindfulness Meditation (MM)	184
Chapter 6: Finding Chapters: RTs, MM and RM Applications and Responses	188
6.1 RTs, MM and RM, Creativity and Spirituality	188
6.2 RTs, MM and RM as Stress Management	192
6.2.1 Use of RTs, MM and RM for Stress Management with Patients and Clients	193
6.2.2 Healthcare Practitioners' and Trainees' Use of RTs, MM and RM for Stress Management	194
6.2.3 Demand for Stress Management	196
6.2.4 Active and Receptive Methods for Stress Management	197
6.3 Practitioners' Understanding of Relaxation and Relaxation Responses (RRs)	198
6.4 Stress Responses and Relaxation Responses (RRs)	202
6.5 Responses to RTs, MM and RM	203
Chapter 7: Finding Chapters: Cultural Context	210
7.1 Cultural Factors/Understanding and Use of Interventions	210
7.1.1 Cultural Factors and RM	210

7.1.2 Cultural Factors and Sound Instruments	213
7.1.3 Cultural Background and Responses to Interventions	215
7.1.4 Religious Influence	218
7.2 Similarities and Differences	221
7.2.1 Similarities and Differences between the UK and Korea	221
7.2.2 Similarities and Differences between the Three Groups of Participants across the Countries	225
7.2.3 Differing Familiarity with the Use of Interventions and Differences in Attitudes towards Family Care.....	228
Chapter 8: Discussion and Recommendations	236
8.1 Cultural Differences and Similarities between the UK and Korea.....	238
8.1.1 Learning and Teaching Differences between the UK and Korea.....	238
8.2 Differences in Approach and Adaptations of RTs, MM between UK and Korea	243
8.2.1 Practical versus Theoretical Approaches.....	244
8.2.2 Similarities in Approaches.....	247
8.2.3 Cultural Differences regarding Attitudes towards the Integration of Meditational Practices in Music Therapy and Healthcare Services.....	248
8.2.4 Differences in Atmosphere during Meditational Practice.....	249
8.2.5 Can Anything be learnt by Practitioners in the UK and Korea from One Another's Approaches?	251
8.3 Collaboration Work	254
8.4 Client-Centredness and Individual Sensitivity	260
8.5 Active and Receptive RTs, MM and RM	265
8.6 Music for Mindfulness in a Present-Moment-Focused Way	269
8.7 Creativity and Spirituality	278
8.7.1 Similarities and Differences in terms of Spiritual Practices between the Two Countries	278

8.7.2 Taking Care of Mind and Spirit	279
8.7.3 Creativity and Spirituality in Education	282
8.8 Interviewees' Recommendations	284
8.8.1 Value of Experiential Knowledge of RTs, MM and RM	285
8.8.2 Guidance for Practice	291
8.8.3 Financial Support	293
Chapter 9: Conclusions	297
9.1 Conclusions	297
9.2 Limitations of the Study	297
9.2.1 Expected Limitations	297
9.2.2 Unexpected Limitations	298
9.3 Contributions of the Study	300
9.4 Future Research Possibilities and Final Reflection.....	304
9.4.1 Future Research Possibilities.....	304
9.4.2 Final Reflection.....	306
References	308
Glossary	340
Appendices	

Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature: _____

Date: _____

Acknowledgements

Undertaking a PhD has been a life-changing experience and I would like to acknowledge all the people who have played a vital part in it. First and foremost, I would like to express my sincere thanks and appreciation to my two supervisors, Prof, Dr Leslie Bunt and Dr Stuart McClean of the Faculty of Health and Social Sciences, University of the West of England. They have both given me patient help, encouragement, guidance and advice at every step of the way and this has been an invaluable and enduring benefit in my career. The Music Therapy Department in UWE has been a great source of inspiration and personal help and support too and I would like to thank Dr Denise Grocke and Dr Mary Mitchell for their suggested amendments and advice in completing the final stage of the dissertation.

My gratitude also goes to my previous supervisors, Prof, Dr Mun-Gi Park from Dongguk University, who introduced me to the idea of combining meditation techniques with music, and Prof, Dr Kyung-Suk Kim from Hansei University, who introduced me to music therapy. My association with Prof, Dr Park and Dr Kim has lasted over ten years and all this time they have been a constant source of advice and support. They turned my thoughts to music therapy and have been a major influence in my career development. Also to my meditation department colleagues (monks and nuns), music therapy colleagues and my personal friends - they have kept me feeling positive.

Although I am not permitted to name them individually the twelve interviewees who made this research possible each deserve a special note of thanks. Each of them not only cooperated fully in the interviews providing the information that I needed, they also took an interest in my project and provided supplementary information through emails, showing me around their places of work, etc.

I must also give special thanks to all the people who have given me language support since coming to the UK. Apart from my supervisors, there are many who have given me valuable assistance in proofreading and in other ways too.

I grew up in a temple under the influence of Buddhism and my life has been blessed by the Buddha. For about twenty years my spiritual growth has been particularly affected by the teachings of my Zen master Thich Nhat Hanh. My beliefs have been a constant and very special motivation throughout my study and I am grateful to all those who have supported me through my spiritual journey.

Finally, my very special thanks must go to all those in my family, who have all had to make sacrifices for the sake of my study abroad. My daughter Julia (Hwan Hye Ju) lives here with me, but has patiently accepted that her mother has her own work to do. My daughter gives me a powerful sense of joy in my life. My mother (Jung Sun Sae) and brothers (Il-jung Hwang and In-wook Hwang) have also been a wonderful support and source of peace in my life. My mother has helped to cure my homesickness with constant supplies of Korean food and she has made my life happy and kept me grounded and in good health. Especially, my father (Young Ung Hwang) is the rock in my life, he stood solidly behind me and he is a priceless gem. He kept me strong. My deepest thanks, however, goes to my husband of twenty years, Tai Keun Ju, for his endless love and active support and help. Without his constant help I would not have been able to finish the PhD study in the UK. Thanks and Love.

Preface

I will write a personal note as to why I have chosen the topic of ‘Relaxation Techniques (RTs), Mindfulness Meditation (MM) and Relaxation Music (RM)’ in this research. There are many ways to cultivate happiness and health. My belief (reinforced by personal experience) is that music and relaxation techniques, meditation, either as an individual or collective experience, can benefit health and well-being and these are valuable healing resources for mind-body health (心身健康; 심신건강) that can enhance spiritual well-being and growth. Moreover, I believe that music therapy and meditation therapy have potentially integrative aspects and these include non-attachment, non-duality and non-judgemental awareness.

I trained in music composition before starting the Korean equivalent of sixth form, but I changed my major to Korean Philosophy (including meditation). I went on to study meditation at undergraduate, master’s degree and PhD candidate at Dongguk University. During my research course in meditation at Dongguk University, I strove to find ways of incorporating meditation with other disciplines and how to use meditation in practical applications in a variety of healthcare and social community settings. Because of its long history of Buddhism, meditation is well established in practice as well as academia in Korea. My aim was the development of Korean traditional spiritual practice for general healthcare purposes through the incorporation of meditation.

I later came to music therapy as a post-graduate. By chance, I had attended a personal music therapy session and I encountered the strong healing power of music and I decided to study more about music in health. Music therapy courses had recently started in Korea and I decided to embark on a music therapy masters course in Sungshin University. During the music therapy course I was introduced to Guided Imagery and Music (GIM) training course and had the opportunity to complete Level 1 GIM training given by Frances Smith Goldberg.

After finishing my GIM Level I training, I attended Goldberg's Music Imagery (MI) Methods for Group Therapy course. These learning experiences focussed my attention on the benefits of receptive techniques, including meditation, combined with music.

Later my family moved to the Middle East and I could not continue my studies in Korea. I practised as a music therapist in Dubai and Sharjah and my attention turned to the use of music, meditation and relaxation techniques outside of Korea. Eventually I contacted The University of the West of England (UWE) music therapy department with a view to coming to study for a PhD in the UK.

Chapter 1: Introduction

1.1 Relaxation Techniques (RTs), Mindfulness Meditation (MM) and Relaxation Music (RM) in Healthcare

RTs, MM and RM are widely used therapeutically in various healthcare settings whether as a main purpose of clinical treatment or as a supportive treatment. RTs, MM and RM have been investigated in fields such as: music in health, music in art, music therapy, music education, psychotherapy, complementary and alternative therapies, advanced nursing, mental health, hospice and palliative medicine, behavioural medicine, cancer nursing, behaviour therapy and experimental psychiatry, international stress management, and traumatic stress management (Klainin-Yobas et al., 2015; Kwekkeboom et al., 2006; 2010; Dobkin, 2008).

Music for relaxation, often in combination with meditation, has become an important feature of the potential range of complementary therapies in clinical situations within the context of integrated healthcare and psychotherapy treatment (Witte and Dundes, 2001). ‘Music involving receptive methods’ and the ‘link between meditation and music’ have been explored (Jo, 2014; Lin et al., 2008; Grocke and Wigram, 2006; Wolsko et al., 2004; Chang et al., 2003).

In addition, clinical trials of the effectiveness of techniques relating to RTs, MM and RM have been critically reviewed (Cochrane, 2016) and diverse health benefits reported, such as reduced psychological distress, reductions in stress symptoms and negative emotions, maintaining positive feelings, emotion regulation, increased sense of *spirituality* (See Glossary) and self-actualisation (Edwards, 2016; Smith, 2008; Davidson et al., 2003; Jacobs, 2001).

This use of RTs, MM and RM in healthcare has been driven by:

- therapeutic concern to resolve difficulties in mental and emotional care (chronic unhappiness, anxiety and trauma, chronic pain and depression)
- a movement to harmonise Eastern and Western therapies, using a combination of meditational techniques and music and complementary and alternative medicine (CAM)
- emerging interest in spiritual wellness related to health
- recognition of the potential benefits of RTs, MM and RM as effective interventions
- practitioners' need to expand their therapeutic approach for various clients group and treatment settings
- a desire to integrate cooperative work involving music or meditational practice in order to maximise health benefit outcomes
- recognition of the potential value of holistic treatment and mind-body-spirit interventions in CAM
- the need for self-help techniques to reduce health problems such as chronic stress

Particularly, with increasing recognition of the advantages of working within a multidisciplinary team and interdisciplinary study for health, practitioners are stimulated by possibilities of a mix of new therapeutic tools, collaborative working, sharing their ideas and creating a secure knowledge base for evidence-based practice (Carr and Wigram, 2009).

For those reasons, resources for health and well-being such as RTs, MM and RM and their incorporation into other disciplines and specialisms have grown in popularity, as instanced by the number of texts, self-help books and online publications. We may therefore expect an expansion and diversification of healthcare resources within therapeutic environments and practices too.

1.2 Cross-Cultural Communication regarding Music Therapy and Meditational Practices

Music can support and facilitate a client's physical, mental, social and spiritual well-being. Therefore music therapy and, more generally, music in health is increasingly used in countries across the globe such as South Korea and the UK (Edwards, 2016; Wheeler, 2015; McClean et al., 2012; Kim et al., 2009; Choi et al., 2008).

In terms of music therapy, the actual history of music therapy in the UK and South Korea (in this dissertation, I will refer to Korea, simply as a shorthand, rather than South Korea) is quite different. In Korea, music therapy is a fast growing university subject. Each year hundreds of students enrol on music therapy degree courses at university and application rates may be up to several times the number of places taken (8:1 for example at Ewha Woman's University, where 200 students can attend the introductory music therapy classes), (Chong, 2005; Kim, 2016). Music therapy in Korea is a young discipline compared to some other countries, and still developing as an evidence-based practice (EBP) in the healthcare service.

In the UK, the history and development of the music therapy profession can be divided up into several stages. 1958-1976 can be called the foundation years of UK music therapy. In 1958, Juliette Alvin formed the Society for Music Therapy and Remedial Music and in 1967 it was renamed the British Society for Music Therapy (BSMT). The following year the first course at the Guildhall School of Music and Drama, London, was started by Alvin. In 1976, the Association of Professional Music Therapists (APMT) marked the real start of professionalisation. During the 1980 and 1990s, music therapy was further developed with the setting up of new masters-level music therapy courses.

In 1997, state registration was established together with a music therapy profession register by the Health Care Professions Council (renamed as the Health and Care Professions Council in 2012) which gives legal protection to registered music therapists. In 2011, a new professional organisation, the British Association for Music Therapy (BAMT) was formed. This brought together the old APMT and BSMT (Bunt and Stige, 2014; Barrington, 2005). These developments are part of a wider phenomenon of the professionalisation of complementary health that helped improve state and voluntary regulation.

Compared to the longer history of UK music therapy, the first formal postgraduate music therapy courses in Korea started in 1996. In order to develop a music therapy profession the Korean Music Therapy Association (KMTA, 사단법인 음악치료학회) was established in 1996, which is now an organisation member of the World Federation of Music Therapy (WFMT). Despite this short history, Korean music therapy has grown fast and is well-organised. Korea music therapy has fused Korean cultural elements together with Western theory and practice (See Chapter 8). In 2011, for the first time in an Asian country the 13th World Congress of Music Therapy was held at Sookmyung Women's University in Seoul, Korea. Around 1350 music therapists (485 from outside Korea) from 46 different countries gathered (Kim, 2014; Dimitriadis, 2011).

American music therapy and music in health have been the dominant influence on developments in Korea because the founding professors were mostly graduates from America (where they had carried out their clinical practice too) and most qualified practitioners were trained in the USA and they pass on their learning and expertise.

By contrast, there is little knowledge within Korea of UK music therapy and music in health, nor general understanding of the UK cultural and healthcare context. In international healthcare conferences in Korea, the UK seldom figures in terms of subject-matter or attendees. This is one of the reasons why I have chosen to study in the UK, which has its own tradition and expertise as well as practices, qualifications, and where informative comparisons can be made.

In relation to music and health and RTs, MM too, there is little in the way of cross-cultural research and practice between the UK and Korea, despite the fact that cross-cultural dialogue and international congresses involving the West and Korea are frequent happenings. Individually, however, Western meditation practitioners often interconnect with Korea in order to learn meditation theory and learn insights regarding practice from monks and nuns. One example is Kabat-Zinn, the founder of MBSR (Mindfulness Based Stress Reduction) who popularised systematic programmes of mindfulness meditation in the world as well as the UK with Mark Williams (Williams, 2008; Baer, 2003). Kabat-Zinn learnt mindfulness meditation and Zen practice from the Korean famous Zen meditation master Seung Sahn in 1974 (Wilson, 2013; Conn, 2011).

Mindfulness meditation is a representative example of the syncretic meeting of East and West. It has become popular in the West in part at least because, as will be discussed, it can markedly reduce stress levels and impact on quality of life and health, chronic pain, and anxiety (See Chapter 2.12). The technique of MM, which originally comes from Zen (Seon, 선) meditation is the foremost meditation practice in Korea where it belongs to a very well established tradition. One of the interests in my research is the extent to which meditation including MM practice follows similar principles and

approaches in the two countries and, if so, the cross-cultural comparisons that can be made.

1.3 Research Aims and Research Questions

Korea and the UK represent different cultural models of healthcare and this is reflected in the use of music and meditation in their healthcare services. The adaptation and use of RTs, MM and RM has taken different forms and cultural differences and similarities will be seen between the UK and Korea. Music therapy is Western in its origins in the way it is used in Korea, where it broadly follows Western practice. Therefore approaches and understanding are shared in many ways between UK and Korea. But nevertheless cultural differences exist due to the respective cultures in which new ideas are received and developed. On the other hand, meditational practices are Eastern in their origins. In Korea meditation has followed its own line of development, which might be seen as spiritual nutrition for Korean people (See Chapter 8.2.3). Similarly, we might expect both similarities and differences in understanding and practice between the UK and Korea. Through uncovering the ideas that underline UK and Korea practice, it should be possible to take steps towards the development of cross-cultural understanding and related theory.

Cross-cultural research is one domain which will help to develop better ways of assessing the practical value of RTs, MM and RM in healthcare settings (See Chapter 8). Our rationales may be very different and without cross-cultural exploration, our understandings may be limited in this respect.

In the East and West, diverse approaches have been developed and sometimes have become well-established in their own way, based on the respective practitioners' own beliefs and traditional backgrounds. They may have different tendencies, religious influences, educational traditions and those different cultural backgrounds may influence the healthcare service and use of interventions in the UK and Korea.

Despite the growing interest in music therapy and meditational practice in healthcare contexts there is little cross-cultural dialogue or interconnection between Korea and the UK and there is still a clear need to broaden the research foundation. Also there is a lack of cross-cultural understanding between the UK and Korea of their respective healthcare services and this may give rise to confusion. To my knowledge, there is as yet no study and research relating to the cross-cultural understanding of RTs, MM and RM into healthcare practice. This is the focus of my study and in Chapter 9 the contributions of this study and possible future studies will be further explored.

Both in Korea and UK, the use of RTs, MM and RM within healthcare work have been and are being explored and many practitioners recognise RTs, MM and RM as potential resources for integrated health, CAM, self-regulation strategy as well as for resources for cultivating *creativity* (See Glossary) and spirituality. Consideration of creativity and spirituality were not specific research questions in this dissertation, but these subjects clearly emerged among the themes from the interviews and during data analysis.

The practitioners in this study apply RTs, MM and RM in the promotion of creativity and spirituality and they consider RTs, MM and RM useful resources for cultivating creativity and spirituality in education, counselling, music therapy, preventive medicine, art therapy, and meditation practice. The general concepts of creativity and

spirituality as well as key aspects of practitioners' own understanding of creativity and spirituality in using RTs, MM and RM will be investigated in Chapters 2.13, 6.1 and 8.7.

Exploring the range of practices and practitioners' understanding of using RTs, MM and RM within health contexts and drawing cultural comparisons between the UK and Korea is seen as a worthwhile exercise. Research into cross-cultural understanding of RTs, MM and RM will both enable a knowledge gap to be addressed and ultimately increase the scope of possibilities for those seeking to learn new therapeutic approaches and treatments.

Initiating a cross-cultural dialogue with professional practitioners allows us to determine how practitioners use interventions and how they understand the use of RTs, MM and RM. Are there differences in the understanding and value ascribed to the use of RTs, MM and RM in specific countries and situations and what, practically speaking, are the results of this? Thus, a comparison of the Korean and UK practitioners' understanding and use of interventions will be an important feature of this study.

My main primary research aim and sub-questions are below:

Primary research aim

The primary aim is to explore the cultural differences in understanding and use of RTs, MM and RM within health contexts, drawing critical comparisons between the UK and Korea.

Research sub-questions

I will pose the following research sub-questions, which emerge from the main aim:

- What RTs, MM and RM practices are being adopted in healthcare contexts in the UK and Korea?
- How do practitioners make sense of and understand their use in differing cultural and healthcare contexts?

1.4 Structure of the Thesis

In Chapter 2 the theoretical background and evidence base for the use of RTs, MM and RM will be examined.

In Chapter 3 I will describe the case study methodology used in my study - how interview data was gathered and analysed.

In Chapter 4 practitioners' use of music in different healthcare settings will be looked into; their approaches, how they view RM in health contexts and what they take to be the qualities and abilities of the practitioner will be discussed.

In Chapter 5 I will describe how the interviewees have adopted RTs and MM in healthcare settings for people's health and well-being and how the interviewees understand their use of RTs and MM.

In Chapter 6 I will explore how participants apply RTs, MM and RM for purposes of exploring spirituality, creativity and for stress management. I will also consider client responses and practitioners' understanding of stress and relaxation responses.

In Chapter 7 the differences in participants' outlooks and attitudes due to cultural factors and cultural similarities or differences between the UK and Korea will be explored.

In Chapter 8 I will discuss various topics related to cross-cultural perspectives, practical issues and recommendations arising from the interviews. I will include observations from my own professional experience. Finally I will provide some recommendations based on my study.

Lastly, in Chapter 9 the contributions and limitations of my study, and potential future work will be proposed.

Chapter 2: Literature Review

2.1 Introduction

In the current healthcare environment there is a growing interest in the relationship between RTs, MM and RM and healthcare as well as the link between spirituality and music (Tsirir, 2016; Le Roux and Sauer, 2016; Wlodarczyk, 2007; Aldridge, 2003; Lipe, 2002). RTs, MM and RM are being used as an integrated treatment approach by health professionals to bring the body, mind, emotions and spirit into harmonious alignment as well as help manage stress and promote well-being. Particularly within mindfulness-based studies, mental healthcare, music therapy, mindfulness meditation practice, complementary therapies and integrative oncology, RTs, MM and RM have undergone a number of important stages of development (which will be outlined in Chapter 2.3).

Such interventions are being researched in the West and the East and many studies focus on RTs, MM and RM for systematic treatment and practical applications in a variety of community and clinical settings. Depending on the specialist area and their applications, a variety of terms are currently used to describe RTs, MM and RM and related concepts. A discussion of the terminology used in the literature and in my study is found later in the Chapter 2.3.

RM in combination with meditation has also become a significant addition to the potential range of *complementary therapies* (See Glossary) in clinical situations within the context of integrated healthcare and psychotherapy treatment (Soo et al., 2016; Witte and Dundes, 2001).

Incorporating meditation and other receptive techniques into clinical practices as ‘integrated health’ has grown in popularity (Greenlee et al., 2014; Sarris et al., 2012; Simpkins and Simpkins, 2010). To some extent, the use of RTs, MM and RM has been stimulated by therapeutic mind-body concern and these interventions are considered to be useful in psycho-physiological therapeutic processes (Hill and Frederick, 2016; Hardison and Roll, 2016; MacKenzie and Kocovski, 2016).

In Korea, the mix of RTs and music is creating a new form of therapeutic treatment, resulting in an expansion of healthcare and nursing activities (Kang et al., 2009; Kim, 2005). In Western music therapy, this trend towards spirituality and receptive elements has also attracted a growing movement in academia as well as being acknowledged within healthcare practice contexts (Laansma and Haffmans, 2016; Longa et al., 2001; Ernst and Whitea, 2000). Meditation has now become “one of the most enduring, widespread and researched of all psychotherapeutic methods” (Walsh and Shapiro, 2006, p.227). In music therapy, RTs are sometimes associated with the induction stages of *GIM* (Guided Imagery and Music), (See Glossary) or *MI* (Music Imagery). *GIM* is often used and is popular as a music-assisted therapy in Korea and now increasingly recognised and developing as such in the UK. It frequently combines RTs with listening to music. Besides *GIM*, a wide range of methods involving receptive techniques have been used as therapeutic tools showing that a range of receptive approaches can work at different levels (Grocke, 2016; Summer, 2011; Bunt, 2008; Goldberg, 1995).

2.2 Literature Review Process

In conducting the literature review a range of electronic databases have been used to discover how RTs, MM and RM have been introduced and used in various healthcare clinical settings in the East and West. The data collection focuses on articles, journals, original research, evidence for meditation and music in healthcare contexts. Care was taken to ensure data collection methods for the UK and Korea were comparable. The main databases were:

- (for Korea) RISS, KoreaMed and KAMJE (Korean Association of Medical Journal), KAN (Journal of Korean academy of nursing), KJAN (Korean Journal of Adult Nursing), KSHPC (Korean society for hospice and palliative care), KISS (Korean studies Information Service System) and KERIS (Korea Education and Research Information Service).
- (for the UK) Cochrane Library, PubMed, Medline, PsychInfo, CINAHL, Wiley Online Library, PsychInfo, NHS National Library for Health, NICE, NHS Evidence in Health and Social Care and BMJ Clinical Evidence.

These specific databases were used as they enabled me to look at the evidence base for RTs, MM and RM. These databases contain journals which have a reputation for applying strict criteria regarding the quality and validity of the research they publish. Many journals and databases recognise clinical problems or uncertainties as regards their own published research, such as the ‘NHS National Library for Health’ which has developed the ‘UK Database of Uncertainties about the Effects of Treatments’. Also the NHS (National Health Service) and NICE (National Institute for Health and Care Excellence) provide journals, databases, national guidance and advice for in order for improving health and social care. These have all been valuable to me in my efforts to take a critical look at the literature review and a number of such concerns have been reflected in my own study too.

A broad range of databases was therefore used and a part of the literature review was undertaken before fieldwork in UK and Korea so as to generate topic questions. Databases work in different ways in the UK and Korea and each database have their specific terminology relating to key terms and *subject headings* (See Glossary). Therefore, it was necessary to adapt the search strategy for each of the databases used. In order to identify resources for my study, the following key search terms were used (English and Korean):

Relaxation Techniques (이완요법), Mindfulness Meditation (마음챙김명상), Relaxation Music (이완음악), Music Therapy (음악치료), Music (음악), Meditation Music (명상음악), GIM (심상음악치료), Meditation (명상), Health (건강), Healthcare (헬스케어), Well-being (웰빙), UK (영국), South Korea (한국).

I also used many alternative words and phrases, common synonyms and different terminology related to key search terms (See Chapter 2.3). I searched the data firstly ‘sorted by relevance’ then ‘sorted by dates’. Some databases allowed for ‘broader term’, ‘narrower term’ and ‘related terms’ and I used the latter two terms which give more specific data, but using ‘broader term’ helped me to explore a wider range of work by other researchers. Such search strategies helped me to undertake an in-depth literature review as well as preparing interview data and process. The literature review was subsequently extended during analysis and writing up: interviewees drew my attention to other sources and it was necessary to explore topics and questions (some new) that arose. The number of academic articles and journals resources used in this literature review search was 442. The referenced dictionary sources, books (both academic and non-academic) and other grey literature explored are not included in this number.

2.3 RTs, MM and RM as Mind-Body Interventions

In this section, I will explain what different kinds of terminology are used in the literature and in this study. I will explain how RTs, MM and RM are characterised in the context of mind-body therapies, complementary therapies and complementary medicine, integrative health and how RTs, MM and RM are used as mind-body interventions.

Throughout the literature, different terms are used by different researchers to represent RTs, MM and RM:

- RTs are variously described as relaxation techniques, mind-body therapy, relaxation interventions, mind-body interventions, relaxation skills, or relaxation programmes.
- MM can be referred to as mindfulness meditation, mindfulness-based stress reduction (MBSR), mindfulness courses, mindfulness meditation programmes, mindfulness practice, mindfulness-based practice, mindfulness-based interventions, mindfulness-based approach, mindfulness-based meditation intervention or meditation (when MM is simply described). Some practitioners regard MM as a form of Zen meditation, some use it in the full version of 8-week MBSR programme, while other use shorter versions.
- RM can be described as relaxation music, soft music, music assisted relaxation, receptive music, sedative music, music for relaxation, music relaxation, music while relaxing, music which suitable for relaxation programmes, *meditation music* (See Glossary) or music (when RM is simply described).

The term *intervention* (See Glossary) is widely used and may be taken to include many medical and therapeutic techniques. RTs, MM are often characterised as mind-body therapy and the term *intervention* is more generally used in the context of mind-body therapies both in research and practice.

Jacobs (2001) claims there are more than 2000 studies published in the past 25 years about mind-body medicine and argues that *mind-body interventions* (See Glossary) are clinically effective in health and stress-related illness. Mind-body medicine is regarded as part of complementary medicine but the distinguishing factor lies in whether the mind plays a key role in the connection with body and health or not. His contention is that “any presumed separation of mind and body is false” (p.83) and mind, thought and emotions have an important influence on health. In mind-body medicine studies, the nature of the connection of mind and body to promote health has been a constant theme.

The category of CAM including mind-body interventions is commonly used in healthcare (Wahbeh et al., 2008). Korea tends to follow the American system and the American NCCAM (the National Center for Complementary and Alternative Medicine) classifies CAM into five categories: alternative medical systems, mind-body interventions, biologically based therapies, manipulative and body-based methods, and energy therapies (Ventola, 2010). NCCAM supports studies pointing to EBP and their claim is that integrative medicine combining mainstream medical therapies with CAM therapies has scientifically been shown to be both effective and safe.

As in the US, in the UK CAM has been widely explored in NHS priority areas and maternity services (NHS, 2016; Mitchell and McClean, 2014). There is a developed system for scientific validation and regulation. The House of Lords Select Committee report on CAM includes key areas and categories (Table 1), scientific validations of CAM as EBP, regulations regarding CAM, recommend training courses, professional training and education, and recommendations for researchers (House of Lords, 2000).

<i>Group 1</i> Professionally Organised Alternative Therapies	Acupuncture, Chiropractic, Herbal medicine, Homeopathy, Osteopathy
<i>Group 2</i> Complementary Therapies	Alexander Technique, Aromatherapy, Bach and other flower remedies, Body work therapies, including massage, Counselling stress therapy, Hypnotherapy, Meditation, Reflexology, Shiatsu, Healing, Maharishi Ayurvedic Medicine, Nutritional medicine, Yoga
<i>Group 3</i> Alternative Disciplines	3a: Long-established and traditional systems of healthcare: Anthroposophical medicine, Ayurvedic Medicine, Chinese Herbal Medicine, Eastern Medicine, Naturopathy, Traditional Chinese medicine 3b: Other alternative disciplines: Crystal therapy, Dowsing, Iridology, Kinesiology Radionics

< Table 1 >

The term ‘integrative health’ is more frequently used in the UK where ‘mind-body interventions’ might be used in Korea and the US, and which is the term most frequently used in this study.

RTs, meditation, music intervention, guided imagery, meditative prayer, mental healing, cognitive and behavioural techniques are all classified as mind-body intervention practices (Samuelson et al., 2010; Kwekkeboom and Gretarsdottir, 2006; Wai Fan, 2005; Tomlinson and Kline, 2004). In my study, RTs and MM and RM will generally be referred to, for simplicity’s sake, including both active and receptive forms. Various types of RTs, MM and RM will be mentioned which in the above literature, are described as mind-body interventions, relaxation interventions, music interventions or meditation interventions whether in experimental studies or practice.

2.4 Detailed Contents of the Literature Review

In the remainder of this chapter, the literature relating to RTs, MM and RM will be explored focusing on how these interventions have been used in healthcare services as EBP and the therapeutic value of RTs, MM and RM within the healthcare service. I

have identified nine main characteristics in studies of RTs, MM and RM in healthcare contexts:

- RTs, MM and RM for health and well-being (Chapter 2.5)
- Music in health (Chapter 2.6)
- Collaborative and multidisciplinary approaches (Chapter 2.7)
- Characteristics and types of RM (Chapter 2.8 and 2.9)
- RTs and meditational practices in health (Chapter 2.10)
- Stress management and mind-body interventions (Chapter 2.11)
- Mindfulness-based practice in health (Chapter 2.12)
- Creativity and spirituality (Chapter 2.13)

2.5 RTs, MM and RM for Health and Well-being

The use of RTs, MM and RM within health services both East and West is clearly growing in popularity. In the NHS National Library for Health there are more than 250 articles looking at the use of music in order to enhance a client's own self-healing capacities and reduce stress and pain in hospitalised patients (Ng et al., 2016; Warth et al., 2014). In Korea, since the 1980s many studies have demonstrated RTs and meditation to be valuable therapeutic mediators for health, education and social community settings.

Jang (1986) describes how relaxation responses can be achieved through meditation. He claims meditation is a 'the way to inner calm', 'clarity of body and mind' and when consciousness sharply focuses on one particular subject, the body and mind become stable and insight arises along with it.

Meditation can cultivate tranquillity (고요함) and an insightful mind (통찰). Those states of mind can enable us to live life 'being present'. Examples of the meditation object can be varied (e.g., breathing meditation) and through the practice of

meditation, the mind becomes focused, purified, grounded (or still) and insightful. Also meditation which is 'calm behaviour' can enhance the ability to solve the problems of life and in this process mind and body will also relax. According to Lee (1997), the sound of music, especially listening to melodic string music is a kind of meditation to stimulate our hearing. He uses RM and meditation especially for the purpose of conflict resolution of young people who have emotional difficulties within school or family life.

Music can be helpful to revive minds to a bright and healthy state after receiving a lot of stress in school. School life is very different in Korea from the UK and problems relating to high school stress are very significant in Korea (See Chapter 8.1.1). Many studies show that using RM with young people can help manage the pressures of learning and school life (Kim, 2011; Hong and Yeo, 2010).

In the West, many studies provide evidence that RTs, MM and RM are effective components of healthcare practice. Klainin-Yobas et al. (2015) describe RTs as relaxation interventions and provide a systematic review of the empirical evidence regarding the effects of RTs and RM on anxiety and depression among older adults. Their recommendation is that healthcare practitioners use relaxation interventions (progressive muscle relaxation, music intervention and relaxation training) as standard care for older adults in community and hospital settings because of the positive effects such as greater reductions in depression and anxiety among older adults.

Hubbard and Falco (2015) describe RTs use as a mind-body therapy and list many goals for RTs, such as improving clarity of thinking, calm breathing and reducing tension. They provide guidance for medical practitioners in the use of RTs (meditation, guided imagery, progressive muscle relaxation, yoga and hypnosis and autogenic

training) and show how practitioners can incorporate RTs into their treatment plans. They claim the greater *medical community* (See Glossary) now accepts RTs but many practitioners find it difficult to incorporate RTs into treatment plans.

A wide variety of RTs, MM and RM are used within complementary medicine and some of these complementary therapies, such as relaxation, hypnosis, progressive muscle technique, meditation and stress management, are today found within conventional medicine. However, these complementary medicine techniques are not yet well developed within conventional medical curricula (Vickers et al., 2001). For this reason, it is still the case that many practitioners lack the training and expertise to incorporate RTs, MM and music into health maintenance programmes. In order to deliver mind-body interventions effectively in healthcare and medical community, education and guidance concerning the use of RTs, MM and music is still needed.

For hospitalised patients, the role of RTs, MM and RM can vary depending on the patient's condition. RTs have been found to be effective in post-operative pain management for instance (Carroll and Seers, 1998). Not only pain management, but also during hospitalisation, people can learn the way of restoring the body to return to natural state of balance by experiencing a relaxed state (fresh or new experience of comfort) through the relaxation session.

Many studies report the trends in CAM (including meditation and music) use in the US (Falci et al., 2016; Ghildayal et al., 2016; Barnes et al., 2004). For example, Eisenberg et al. (1998) found that RTs were among the top 16 alternative therapies, most frequently applied treatments for different medical conditions (fatigue, neck and back pain) in American health services. In general, even though there is growing recognition of the benefits of CAM, the scientific basis, EBP and rationale for CAM

is young and marked by uncertainty (Maha and Shaw, 2007; Adams and Jewell, 2007). Within CAM the evidence-based support for the use of RTs, meditation and music is relatively weak. On the other hand, within music therapy the use of music, the evidence-base has continuously developed and the same is true for mindfulness meditation, as will be argued in Chapters 2.6 and 2.12.

There is an emerging evidence base to suggest that, under certain conditions at least, RTs, MM and RM can be of benefit to clients such as those dealing with anger management, stress management, *interpersonal insensitivity* (See Glossary), depression, anxiety, and hostility as well as cancer and hospice patients. For example, patients in hospice settings and cardiology patients often experience profound breathing problems and breathing techniques associated with RTs in combination with RM can regularise breathing (Adams, 2016; Kavak et al., 2016; Hanser, 2014; Upadhyay Dhungel et al., 2008). However, caution is recommended with the use of breathing techniques for certain client group such as asthmatics, particularly techniques involving deep breathing and holding breath, and with hyperventilators, who “typically cannot relax the diaphragm fully” (Fried, 1990, pp.161-162). Teaching deep diaphragmatic breathing for above clients is one of the most challenging tasks according to Fried.

Fried (1990) maintains breathing techniques have mental as well as physical benefits. For example, an anxious client has “relatively rapid and shallow chest breathing (15 breaths/min or more) and may hyperventilate [...] One effective way to ensure proper ventilation is to deep diaphragmatic breathing” (Fried, 1990, pp.161-162). Integrating music (e.g., *Silk Road* by Kitaro, the *Anti-Frantic Alternative Series* by Steven Halpern) in breathing training is useful and music can be used in the clinical practice of anti-anxiety strategies.

In music therapy, sufficient evidence exists to support the effectiveness of Music-Assisted Relaxation (MAR) including listening to music, deep diaphragmatic breathing, progressive relaxation technique (PRT) and imagery (Wolfe et al., 2002; Bonny, 2001; Robb, 2000; Thaut and Davis, 1993; Pfaff et al., 1989), (See Chapter 2.7.2). Also RTs and music use have been shown to be effective for reducing the pain management (Gardstrom and Sorel, 2015; Ghetti, 2012; Good, 1996). The field of music in medicine will be explored in various contexts (See Chapter 2.6). When combining RTs and music, the characteristics of music and types of music should be considered in order to maximise health benefits and this will be further discussed in Chapters 2.8 and 2.9.

The potentially beneficial effects of MM and music for clients with attention span disorders, such as ADHD (Attention Deficit Hyperactivity Disorder) and ASD (Autism spectrum disorders) have also been reported (McFerran, 2009; Zylowska et al., 2008; Rickson, 2006). Music interventions can contribute to a reduction of impulsive, restless behaviours and a range of ADHD symptoms. The use of music for ADHD and ASD has been researched in music therapy and many music resources offer possibilities for these client groups (Helle-Valle et al., 2017; Rickson, 2006; Jackson, 2003; Clarkson, 1998).

Zylowska et al. (2008) trialled an 8-week mindfulness training programme for 24 adults and 8 adolescents with ADHD. The 8-week programme consisted of once-a-week evening sessions lasting 2.5 hours and daily at-home practice. Each weekly session began with a short opening meditation. Then followed a discussion of the at-home practice, an introduction to and practice of mindfulness, a group discussion, talking about the coming week's at-home practice and finally a closing sitting meditation.

For the at-home practice, participants received three CDs containing guided sitting meditations. The study found that the mindfulness programme led to significant pre- to post-test improvements in ADHD self-reported symptoms and improved performance on selected tests of associated neurocognitive impairments. As the authors hypothesized, mindfulness training may improve attention and as a self-regulation tool, MM can facilitate emotional regulation to a certain degree in ADHD.

The effectiveness of MM has been demonstrated for ADHD and ASD (Evans et al., 2017; Van der Oord et al., 2012) and MM can be a useful tool for improving concentration levels and supporting everyday routine activities for these groups. However, there are still difficulties regarding mindfulness practice (especially in an in-depth way) for ADHD and ADS. MM can be practiced in a simple or intensive form. MM, if practised in depth, can be a type of insight or concentration meditation and a self-awareness process exploring the inner self. If clients do not have this level of cognitive understanding, the degree of intensive practice of MM needs to be considered.

Nevertheless, Zylowska et al. (2008, p.2) argues that the rationale for using a mindfulness-based approach in ADHD is “built on several levels of potential impact, including behavioral symptoms of inattention and impulsivity, associated neurocognitive deficits of attention and inhibition, and secondary impairments of stress, anxiety, and depression.” Mindfulness practices adapted into an attention exercise programme can be regarded as a special and rewarding challenge for ADHD sufferers (Wexler, 2007; Klingberg et al., 2005). And those on the spectrum who may be regarded as not too severely affected may possibly have the internal resources to follow specific mindfulness programmes.

Therefore, in use of MM and meditation, further research is required about how deep to go, how long to practise and how to guide clients with ADHD and mental illness. Other factors to consider (since their effects are not clearly established) include group size, socioeconomic status, IQ and educational levels, gender, age group and degree of ADHD and ASD (Costa et al., 2014; Maxim et al., 2012; Yerys et al., 2009).

Returning to the topic of RTs, MM and RM for health and well-being, the link between sleep quality and health has been explored by many healthcare practitioners and RTs and RM are actually often used in clinical settings as for treating sleeping problems. Lai and Good (2005) report an investigation of the effects of soft music on sleep quality in older community-dwelling men and women. Sleep for elderly people is a common problem often discussed in practice. Not only for elderly people but also clients such as cancer and postoperative patients, RTs and RM can often provide benefits by inducing semi-conscious sleep through relaxation (Carlson and Garland, 2005; Zimmerman et al., 1996). Such patients frequently report sleeping difficulties because of pain and fear. Just 5-10 minutes sleep during a relaxation session may provide pain relief for a short time. The patients may even find the way to go back to sleep again when pain interrupts their sleep. It may be felt for such patients that sleep itself might be a specific aim of therapy. For certain patients, such as those with sleep disorders and the terminally ill, sleep induction may indeed be felt to be the main purpose.

Clinical trials of techniques relating to music and health and meditation and health have for a long time been seen to overlap within the (clinical) settings of healthcare and research shows positive outcomes, such as reduced psychological distress and stress symptoms and a reduction in the risk of a depressive relapse (Smith, 2008; Hanser, 1985).

Lim and Locsin (2006) argues that the development of use of RTs and RM has been stimulated by a movement to harmonise Oriental and Western therapies, using a combination of meditational techniques and receptive music and complementary therapies in medicine. Many studies are exploring RTs, MM and RM as practical applications in a variety of community and clinical settings in both the East and West within healthcare service (Wheeler, 2015; Crane and Kuyken, 2013; Chen et al., 2012; Kang and Oh, 2012; Kabat-Zinn, 2009; Grocke and Wigram, 2006).

The development of interventions may have followed a different course in Eastern and Western healthcare services. Theories and practice related to RTs, MM and RM have developed independently. Therefore cultural considerations may inform our understanding of RTs, MM and RM and their development in East and West.

In both East and West, RTs, MM and RM have been used as an integrated treatment approach by health professionals to bring the mind and body into harmonious alignment. It is believed that these can help manage stress, promote well-being and self-care; this has been supported by carefully researched methods. The use of RTs, MM and RM can be seen to be growing not only as for the relaxation intervention for mind-body health and well-being but also for people's spiritual well-being. Spiritual well-being relates to quality of life and many practitioners are exploring the link between relaxation responses and spirituality in practice. The spiritual aspects of RTs, MM and RM will be discussed in Chapter 2.13 and in Chapters 6 and 8.

In this section, the broad applications of RTs, MM and RM for health were explored. In the next section, I will focus on music in medicine and music therapy in health and in particular, the use of RM as a clinical intervention.

2.6 Music in Health

Throughout history music has been used as a healing force in both Eastern and Western cultures in their own way. Today there is increased recognition of the benefits of music for health and well-being and great deal of work is carried out by music in health practitioners, community musicians and various groups of healthcare practitioners and staff under the umbrella of ‘music in health’.

Dileo (1999) introduced the differentiation between *music medicine* and *medical music therapy*. *Music medicine* is practiced by a range of medical professionals (other than music therapists) using mainly recorded music (which is primarily receptive in nature) to reduce anxiety, stress and pain. In contrast, *medical music therapy* includes all types of active and receptive music experiences for varying therapeutic purposes by the music therapist (Aigen, 2013).

In this section, under the larger music in health umbrella, the use of music will be divided into two areas. My distinctions below of two areas is slightly different from Dileo’s:

- *Music in medicine*: involving healthcare professionals or music therapists in conjunction with others in a team. So *Music in medicine* refers either *music medicine* or to collaborations involving *medical music therapy*.
- *Music therapy in health*: involving only the professionally-trained music therapist. This corresponds to Dileo’s *medical music therapy*.

2.6.1 Music in medicine

Music in physiological and psychological medicine has been explored by many researchers and healthcare professionals including medical practitioners interested in the combination of music and medicine (Bunt and Stige, 2014). Music for health is continuously building bridges into the healthcare services and research conducted has explored the use of music in fields such as advanced nursing, hospice and palliative medicine in order to achieve a diverse range of outcomes.

Nilsson (2003) investigates the effects of music in surgical care through systematic review. She found that music intervention has positive effects on reducing patients' anxiety and pain. Nilsson emphasises the inexpensive nature of music interventions and potential ability of music to reduce distress. Similarly, Evans (2002) conducts a systematic review in order to investigate the effectiveness of music interventions for hospital patients. The general finding is that music produces a small reduction in respiratory rate but music interventions are effective in reducing anxiety, and improving the mood and tolerance of patients. This review concludes that the use of music is recommended as supporting treatment during normal care delivery.

Music interventions are non-pharmacological treatments, with a low cost of implementation and lack of adverse events in clinical trials. With recognised potential clinical benefits, music has been incorporated into holistic nursing approaches as an effective component of treatment.

Guzzetta (1991) describes the use of music in hospital with patients during surgery, childbirth, and postoperative recovery, how music can meet theoretical, clinical and personal nursing objectives and how a nurse can apply musical elements as a tool.

She explores questions such as how music works for nursing and how music affects discussions with clients. She presents examples of uses of relaxation music, including helping the client to achieve a relaxed and balanced state, inviting and facilitating more healthy thought patterns, and reducing stress and pain in hospitalised patients. She finds that combining music with nursing can lead to enhanced creativity, achieving a body-mind balance, releasing blocked (negative) energies, and greater awareness of body and mind.

In the hospital environment, music can be used simply for relaxation or recreational purposes, like at a Christmas party for parents and children. However, combining music with medicine, following a specific systematic approach may have distinctive health benefits too (Beccaloni, 2011; Guzzetta, 2000). In music therapy, ‘music as therapy’ and ‘music in therapy’ (See Chapter 2.7.1) provide effective tools to promote health and integrated care.

Developing these ideas, Guzzetta (2000) proposes that music therapy is one of the specific modalities which can be used in nursing activities and she emphasises the systematic application of music in medicine. The systematic therapeutic process of music therapy from assessment, treatment planning, therapeutic intervention, through to evaluation of each client (AMTA, 2016) can be used with particular therapeutic aims in medical settings in order to achieve better outcomes for individual patients.

Cochrane reviews testify to the increasingly widespread use of music in health, describing how music can be used in healthcare. Many studies investigate the clinical effects of music interventions by combination of *music medicine and medical music therapy* (or medical practitioners alongside working with music therapy).

Bradt et al. (2011) compare the effects of ‘music interventions with standard care’ versus ‘standard care alone’ in patients with cancer. They included 30 trials involving collaborations with both music therapists and other medical staff using music interventions with a total of 1891 participants. Their results indicate that music interventions can be associated with reductions in anxiety, cause moderate reductions in pain and have small benefits in terms of heart rate, respiratory rate, and blood pressure. Music interventions can have a positive impact on mood and may also possibly lead to improved quality of life in people with cancer. However, no significant evidence was found for enhancement of fatigue or physical status.

A later study (Bradt et al., 2013) examines the efficacy of music interventions, particularly listening to music, on psychological and physiological responses of coronary heart disease patients. 26 trials with a total of 1369 participants were included (3 trials of *medical music therapy* and 23 trials of *music medicine*). In this study listening to music has a moderate effect in terms of both anxiety and pain reduction. The effect on blood pressure, heart rate, respiratory rate was also more clearly seen.

The two studies show somewhat different results of music interventions effects on psychological and physiological responses. For example, with the heart disease patients, music interventions lead to beneficial effects on blood pressure, heart rate, respiratory rate but for cancer patients only a small effect on heart rate, respiratory rate, and blood pressure was found.

Apart from the patients’ conditions, factors may include the hospital and therapeutic environments, and how much the listeners liked the music or were emotionally engaged. The results cannot be directly compared because the proportions of music therapists and non-music therapists are different. Other unknown factors can also

produce bias, as is well recognised. Nevertheless, differences in emotions, behaviours, and physiology can be seen among patients who are offered music with standard care and those with standard care alone.

To conclude this section, medical patients suffer physical pain and emotional stress and this may affect their quality of life. Music interventions has been used to improve physiological and physical functioning in patients by healthcare practitioners or as part of a multidisciplinary team work with a trained music therapist. Research also shows that music can be useful in nursing activities and there is a gradual recognition of the benefits of a systematic use of music in the production of relaxation responses as well as positive changes regarding patients' emotional and physical states and distress levels.

2.6.2 Music Therapy in health

Music therapy means clinical and evidence-based interventions using a systematic therapeutic process (American Music Therapy Association, 2016). The music therapy profession is regarded as one of a group of Allied Health Professions (AHPs) “who deliver high quality care to patients” (BAMT, 2016; NHS, 2016). Music therapy has become a new interdisciplinary study for promoting health and well-being. With the growing interest in integrated health, music therapists are working with patients and clients as a part of an allied health team in the medical community.

Music therapy has been established as a clinical discipline in both the UK and Korea and its positive effects have been demonstrated with many client groups and health conditions.

Alvin (1975, p.156), the founder of the British Society for Music Therapy (in 1958) says through the centuries music has been used to treat all kinds of disorders:

The nature of sound and the psychology of music have never changed, nor have the basic physical and psychological characteristics of man. [...] The patient's recovery depends on how much he can draw on his own physical, mental and emotional resources, which are affected by music in a greater or lesser degree.

Over time the nature of the music therapy profession has changed and definitions of music therapy have been refined. The World Federation of Music Therapy (WFMT) defines the Music therapy thus:

Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimise their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts (Aigen, 2013, p. 4).

By 2000 music therapy had been significantly expanded and achieved its own identity. Its incorporation with other external disciplines has been a more recent trend (Aigen, 2013).

In the UK music therapy is a registered profession with approaching 1000 members (BAMT, 2016) and similarly in Korea more than 1000 certified Korean music therapists are working in various fields such as welfare centres, private development centres, residential institutions, schools, hospitals, rehabilitation centres, nursing homes, private music therapy centres (Goodman, 2015). In the UK the priority areas for music therapist work include: "hospitals (NHS and private), mainstream schools, special schools and pupil referral units, child development centres, children's centres, day centres, hospices, residential settings including care homes, prisons and forensic

settings, acute and post-acute rehabilitation centres, specialist music therapy centres, community spaces, [and] people's homes" (BAMT, 2016).

For the professional use of music, individualised music therapy assessment tools have been developed for establishing valid and reliable measures for music intervention (Kim, 2008; Wigram and Gold, 2006). A personalised approach is a key philosophy in healing practice and an individualistic approach encourages creativity, innovation and empowers the practice (McClean, 2005).

Personalisation of practice also connects to a wider body of literature on CAM, counselling and psychotherapy and mind-body medicine included RTs and RM (Cooper et al., 2013; Rogers, 2012; Kim and Pham, 2009; Millon and Grossman, 2007; Lambert and Barley, 2001; Wheeler, 1981). The standards of systematic assessment tools can provide professional credibility and independent identity and justify a music therapy service within the multidisciplinary team in healthcare settings (Kim, 2008; Baxter, 2007).

Through the process of evaluating clients' weaknesses and strengths, music therapy can support an individual client's potential abilities, approach to creativity and improve physical function and psychological well-being. In this way music therapy in health can be widely adapted. As such, practitioners as well as researchers have engaged in work that focuses on identifying music sources or activities based on EBP in order to provide professional credibility. This can encourage other healthcare professionals to integrate music into their practice and provide a multidisciplinary systematic process of intervention (See Chapter 8.3).

Specific therapeutic aims and a systematic process of music therapy have been shown to achieve better outcomes for individual patients. Marconato et al. (2001) investigate the effects of music for the cardiology patients. They stress that music does not cure effectively by itself, but when music is applied in a systematic professional way there are therapeutic impacts. They applied receptive music in internal medicine and cardiology procedures aimed at the “correction of habits and attitudes that cause health risks” (p.140) and produced evidence that receptive music can increase personal satisfaction, improve perspectives on life, lower desire for cholesterol intake and raise consumption of fibre-rich food. Music therapy is therefore shown to assist in treatment and prevention of various causes of health problems.

More generally, music as a resource for health, the role of musical activity and approaches and models of music therapy have been explored in a wide range of healthcare settings (Hallam et al., 2016; Edwards, 2016; Bunt and Hoskyns, 2013; McClean et al., 2012; Hwang and Choi, 2010; Jeon et al., 2009; Choi et al., 2008; Ruud, 2008; Hong, 2005; Park and Park, 2000). Various Cochrane reviews report clinical trials of music therapy and show evidence of the benefits of music as psychological and physical interventions (Kamioka et al., 2014; Bradt et al., 2013; 2011).

Current areas of practice and research the area of *music therapy in health* are broad and I will focus mainly on areas related to my study, namely music for stress and pain relief.

Music for pain management

This discussion will focus on the link between ‘pain management’ and the ‘music and medicine movement’. There is evidence that music can provide a momentary distraction from pain and this is often explained by *Gate Control Theory*.

Gate Control Theory was devised by Melzack and Wall (1967) and it proposes that “a mechanism in the dorsal horns substantia gelatinosa of the spinal cord acts as a spinal gating mechanism that inhibits or facilitates transmission of nerve impulses from the body to the brain on the basis of the diameters of the active peripheral fibers as well as the dynamic action of brain processes.” (Baum et al., 2012, p.160).

Gardstrom and Sorel (2015, p.120) says listening to music can “reduce the client’s perception of pain and anxiety related to pain, whether chronic or associated with specific medical procedures or surgeries.” This concept of music being associated with pain reduction is broadly accepted and has been widely explored in research (Ghetti, 2012; Kirby et al., 2010; Krout, 2007).

The purpose of the pain management research is improving health and quality of life for patients and the evidence for the use of music in pain management is clearly established (Bernatzky et al., 2011). Music interventions can play a role as a distractor and can possibly block pain pathways before pain signals reach the brain. However, feelings of pain are subjective and approaches to pain management may relate to various factors such as culture (Lasch, 2000), the actual level of pain or whether it is physical or psychological pain (Cepeda et al., 2006). In different situations the benefits of music interventions for pain relief can also vary.

Music as an auditory stimulus, “acts to divert attention away from the experience of pain by activating different areas of the brain required for processing auditory information” (Grocke, 2016, p. 688). Grocke (2016) refers to the link between *entrainment* (See Glossary) and the control of anxiety and pain. The level of pain and anxiety experienced can be altered by matching with music and this can be explained by the “*iso*” principle (See Glossary).

For example, relaxation can be increased by gradually reducing the dynamics and slowing the tempo, “until the patient’s physiological parameters are reduced”. Grocke also argues certain types of music (e.g., sedative music) can control levels of anxiety by inducing deeper breathing.

The ability of relaxation and sedative music to reduce pain and anxiety has been established through research (Nilsson, 2008; Good et al., 2005). Nilsson (2008) found that the tempo of the music is the most important factor in terms of relaxation and pain relief, and for music interventions in clinical practice she recommends: “a) slow and flowing music, approximately 60 to 80 beats per minute; b) non-lyrical music; c) a maximum volume level at 60dB; d) patient’s own choice, with guidance; e) suitable equipment chosen for the specific situation; f) a minimum duration of 30 minutes in length; g) measurement, follow up, and documentation of the effects” (Nilsson, 2008, p.803).

In order to measure the efficacy of music in adequate pain control, close attention to the actual outcome measures and ways of assessing them is important and these vary according to the research design and purpose. In assessing pain associated with clinical procedures, for example, pre-post changes with appropriate measures are recommended in music therapy.

In relation to breathing, the “iso” principle could be adopted in terms of “speed and depth of breathing”. For example, gradually slow breathing can reduce the anxiety level while faster breathing can induce higher anxiety levels. This is because faster breathing can result in unstable breathing and patients often experience unstable breathing due to severe anxiety and uncertainties regarding illness. Such feelings may also affect their control of pain. Arguably therefore both the gate control theory and the concept of entrainment could inform theory regarding RTs, meditation and mindfulness practice too.

Bernatzky et al. (2011) examine the relationship between the emotional foundations of music and the control of pain in modern medicine. Through patient self-reports and physiological measures they show that music reduces the perception of pain and the need for pharmaceutical interventions. Music can therefore contribute to pain-management programmes and music can help alleviate painful medical procedures as a non-pharmacological pain management tool.

Aside from this psychobiological account of music in pain management, musical activities in themselves can be thought to lessen feelings of pain and anxiety. For example, people are often moved while listening to music whether they are in illness or health and if the music is particularly meaningful people may experience a ‘chills up the spine’ response when listening to a piece of music (Grocke and Wigram, 2006).

In Korea, the medical community often ask music therapists to provide an evidence-based use of music interventions. The *Gate control theory* of control over the pain pathway (pain signals which travel through the body) provides the context for much evidence-based research into the use of music interventions in hospital settings and so this is often referred to. There are cultural differences in approach and adaptations of

use of music between UK and Korea such as the practical versus theoretical approaches. Therefore, in the UK and Korea the theory and application of music for pain management may show some cultural variation. There may be other culture-related differences too in experience and expression of pain, and the reactions and approach to pain on the part of therapists. However, pain is undeniably an unpleasant feeling and physical pain often leads to emotional pain too. For a better quality of life, music can play a part in pain management programmes and clinical and evidence-based use of music interventions will contribute to higher quality pain relief.

Music for stress management

Music has long been recognised as an effective intervention for stress relief (Thoma et al., 2013; Lehrer et al., 2007; Mandel, 1996). In particular, for hospitalised patients, one of the main stressors is surgery and playing music before surgery can reduce patients' stress response (Leardi et al., 2007). Bunt and Stige (2014, p.39) write:

Music can be used 'before, during or after' medical procedures, for example in reduction of stress and anxiety, as a means of distraction or as an aid to relaxation. [...] The use of music, for example, for pain control, both pre-and post-operative, has been gaining international interest during recent years.

In hospital environments, listening to music can be also used to mask hospital sounds or other unwanted environmental sound. Music can also be beneficial in the treatment of dental anxiety and dental care (Lahmann et al., 2008; Standley, 1986). Music and music therapy can be applied for managing stress and in this way contribute to healthcare whether as support for other treatments, to aid rehabilitation or as the main treatment. Outside of clinical settings music is often used for stress relief too. This will be further discussed in Chapters 2.11 and 6.2.

To conclude this section, music can play a part in healthcare from the early stage of people's life, school settings, hospital setting, social and community setting, through to hospice palliative care settings. In particular, music interventions can offer a valuable resource for improving psychological and physical outcomes in patients and music can reduce feelings of pain, anxiety and stress, whether chronic pain or during medical procedures. Music can be an effective treatment and support people with emotional, physical, and distress by creating meaning in their lives and improving their quality of life.

2.7 Collaborative and Multidisciplinary Approaches

The NHS England Service Component Handbook (2015, p.6) says integrated care and multidisciplinary team work is effective and it can accelerate shared learning and support the client's need for personal-centered and coordinated care which in the handbook is described as:

My care is planned with people who work together to understand me and my carer(s). Put me in control, co-ordinate and deliver services to achieve my best outcomes.

Client and patient groups vary and have different health conditions and needs therefore collaboration with other disciplines can extend the benefits for them.

Ideas of a shared knowledge base, agreeing and deciding responsibilities, learning together, shared value systems and the advantages of working within a multidisciplinary team are well recognised (Robinson, 2015; Twyford and Watson, 2008; Pethybridge, 2004; Ruud, 1998). For the use of RTs, meditative practice and music, in this section I will explore the multidisciplinary team work of music therapy and the ways of integrating music and meditative practice, relaxation techniques.

2.7.1 Music Therapy: Collaborating

Music can be used as a resource for health and well-being and collaborative interdisciplinary approaches with music therapy have been established in the healthcare service. These include collaborative teamwork with dental care, cancer care, paediatric palliative care, hospice care, in children's hospitals, psychiatric hospitals, as well as children and adults with emotional and behavioural disorders, eating disorders and learning difficulties (Bunt and Stige, 2014; Gale et al., 2013; Darsie, 2009; Leung, 2008; Watson, 2007; Sausser and Waller, 2006; Hilliard, 2001; Hills et al., 2000; Starr, 1999; Choi, 1997).

Collaboration can increase understanding of how music influences people's actions, emotions and health. Therapists need to consider philosophical and psychological aspects of 'music *as* therapy' (Bruscia et al., 1981) and this is enhanced through collaboration. For Bruscia music *as* therapy means seeing music itself as the therapeutic agent, not simply part of the therapy ('music *in* therapy').

Therefore music therapy with collaborative teams in various settings is a feature of the healthcare service. Music therapists often work with occupational therapists, physiotherapists, psychotherapists, art therapists, speech and language therapists, meditation therapists, medical practitioners and rehabilitation team members. This is a growing trend both in the UK and Korea.

Global networking between East and West has facilitated the sharing of information and collaboration work. Music therapy research and clinical practice have been shared across the music therapy community worldwide and the integration of Eastern and Western philosophies in music therapy has been explored. For example, in order to organise as a music therapy profession internationally, over 40 years of World

Congresses of Music Therapy have been held from the first one in Paris in 1974. Music therapists from all over the world have met and music therapy has been developed on a global level.

Collaboration and inter-professional teamwork can pose new challenges, and require careful management as well as a clear awareness of purpose. However, through these challenges, professional and personal growth can come about and meaningful collaborative sources for practice and research can be produced.

2.7.2 Combining RTs and RM in Music Therapy

The value of combining RTs and RM has often been discussed and RTs utilising music have been adopted in music therapy. Music Assisted Relaxation (MAR) - combining RTs with music - is discussed by Robb et al. (1995). MAR treatments can involve listening to music, deep diaphragmatic breathing, progressive relaxation technique (PRT) and imagery. In Robb et al.'s study, MAR was shown to be effective in decreasing levels of anxiety and was also observed to be an effective relaxation technique for other groups of clients in various settings. MAR can be used by music therapists to treat both situational and chronic stress conditions (Robb, 2000). Other studies have also shown evidence of how RM has been combined with RTs, such as PRT (Thaut, 1989), diaphragmatic breathing techniques (Wolfe et al., 2002) and guided imagery and music (Bonny, 2001).

Guided imagery and music is one of the types of RTs often used in music therapy. Bonny (the pioneer of GIM) says through music, people can experience new consciousness which is an altered state of consciousness and for this process, RTs can be helpful (Summer, 2002; 2015).

While listening to the music and creating imagery, the client reaches a deeply relaxed state in the 'here and now' and this can possibly expand our consciousness and lead to self-discovery. Through this process, the client can experience self-transformation. Bonny lists a number of RTs such as PRT, biofeedback, Zen meditation, music-chant, transcendental meditation and mind control (Bonny, 2001; Bonny and Savary, 1990).

The way music in combination with RTs has developed and been adopted in Western music therapy has influenced the development of music therapy in Korea. Many Korean practitioners look to international perspectives on music therapy in order to expand their knowledge of music therapy. A representative example is GIM. GIM has become widespread and used by many practitioners around the world, and has now become a popular music therapy approach in Korea too (Paik, 2010).

Thaut and Davis (1993) give examples of their strategies for relaxation with music such as listening to music, breathing techniques, PRT and visual imagery. For example, PRT is a frequently used RT that combines with music because it is effective, easy to learn and readily adapted for clinical use with the assistance of a 15-20 minute tape or the practitioner reading a guided script. For this reason, many practitioners have adopted it in their workplace. PRT was originally developed by Jacobson (1929), an American physician, and has been modified and further developed by many researchers (Cooke et al., 2013; Bracke, 2010; Singh et al., 2009; McCallie et al., 2006; Pelletier, 2004) and is in widespread use by healthcare practitioners in Korea. Therefore, the combination of RTs and RM has been developed in a way that allows any practitioner and client to use them easily and this is facilitated by the use of various types of guided script and other resources.

To conclude this section, integrated care has become an important theme within the modern health service. The literature referred to shows the value of the multidisciplinary team work involving music therapy and ways of combining RTs and RM in therapy.

2.8 Characteristics of RM

An understanding of the characteristics of music can affect practitioners' decisions whether to use an active and receptive approach, selection of instruments and level of involvement in composition or improvisation when using RM. These fundamental characteristics of music are generally considered when selecting music for therapeutic purposes.

Alvin (1975, p.62), a pioneer of music therapy in the UK, writes:

The character of music and the effects it provokes depend on the different elements of sound and their relationship. These are as follows: 1. frequency (or musical pitch) 2. intensity 3. tone colour 4. interval, creating melody and harmony 5. duration, creating rhythm and tempo.

These characteristics of music can help to understand the classification into musical genre and typical musical styles for sedative and stimulative music and the characteristics of RM. Many studies have been conducted on the particular characteristics of RM (for receptive approaches) which can enliven or relax the body and mind and this can be a core consideration in deciding whether active or receptive approaches are taken.

Choi (2006), a pioneer of music therapy in Korea, associates the following music elements with relaxation. Firstly, legato melody music can help to make people calm so this is suitable for RM and complex melodies are sometimes not suitable for programmes which require relaxation responses and stability, because complex

melodies can produce unexpected responses. Secondly, he stresses the importance of ‘melodic contour’ which is the ascending and descending patterns of melodic movement. Melodic contour with a stable structure is more suitable for RM rather than too much dynamic structure. Thirdly, in terms of the characteristics of rhythm, an underlying rhythmic beat and low rhythmic activity, such as that of a lullaby, which is calm, soothing and repeated monotonously, may be suitable for RM. Lastly, a slow tempo can have a calming effect. Besides listing the music features of RM Choi points to the characteristic differences between sedative and stimulate music and how these can affect physical and psychological responses.

Grocke and Wigram (2006, p. 46) characterise music for relaxation as follows:

Tempo is consistent, steady; Tempo is slow; Either duple or tripe time, as long as it remains consistent; Melodic line may be predictable [...]; Harmonic structure is typically tonal and consonant, with predictable sequences of chords, or suspended harmonies that resolve; Instrumentation is likely to include strings and woodwinds, and excluded brass and percussion. Predominantly legato [...]; Few dynamic changes; Repetition is a key feature; Texture likely to be consistent [...]; Supportive bass line; Predictable in melodic, rhythmic and harmonic features.

Grocke and Wigram (2006) and Choi (2006) show a certain amount of agreement on the characteristics of RM such as dynamic, melody and tempo, as well as pointing to variations, particularly those relating to personal and environmental factors. Selecting the piece of music for the purpose of relaxation may not be easy for the practitioners but nevertheless these basic music elements can be informative when selecting RM.

Wolfe et al. (2002) explore receptive approaches in which music is combined with other RTs such as PRT, yoga and deep breathing. Their study examines the use of RM with musicians and non-musicians in order to have participants identify the musical characteristics which can lead to relaxation. They analyse participants’ written

responses about which musical characteristics make them relaxed or not. Musical characteristics reported to enhance relaxation include:

‘The instrument played very softly’, ‘the speed was good’, ‘the horns were not relaxing’, ‘I liked the beat of the music’, ‘the harmony was good’, ‘the sounds playing together sounded nice’, ‘I enjoyed the melody’, ‘low volume’ (pp.46-49).

Musical characteristics which distracted from relaxation include:

‘Too loud’, ‘the tempo was too fast to be relaxing’, ‘the pulse was too strong’, ‘the notes were too shrill’, ‘too low volume’ (pp.46-49).

Here, the descriptions of relaxing included ‘low volume’, and descriptions for distracting music included ‘volume too low’. This indicates that volume can affect the state of tranquillity and a low volume can cause both a relaxation response as well as a distracting response if it is too low. Related to this, Staum and Brotons (2000) explored the effect of music volume on the relaxation response and found that ‘personal amplitude preferences’ can influence the relaxation quality (noting that males preferred louder music than females).

Therefore, it may be advisable in practice to set volume levels in accordance with personal amplitude preferences. To a degree therefore, personal preferences for volume level can influence individual levels of relaxation response. In a one-to-one session, matching the volume level to client may be possible and relatively easy, but in group sessions, matching the personal amplitude preferences with each person may be more difficult. Using personal speakers or portable CD players can make it easy to manage the volume level but in group sessions, if the practitioner needs to match the speaker and amplifier provided, more careful preparation may be required. Personal amplitude preferences may change depending on mood, session type or other factors.

At the same time it must be recognised that music can take many shapes and forms in terms of dynamic structure and these considerations regarding volume control are at best rough guidelines.

Not only volume, but also other musical characteristics can be adapted depending on the session type, client preference and situation. Client preferences may be affected by personal physical and medical conditions. For example, Robb et al. (1995) says everyone has a slightly different heart rate and what constitutes the ideal music for relaxation can vary according to heart rate too. He found that music which has a slower tempo than the person's heart rate tends to be relaxing and a low pitch is better than high pitch. Therefore, these studies show that client-centredness is an essential factor as regards selecting or adapting musical characteristics whether for active or receptive approaches.

It is generally seen that RM serves as a mechanism to bring relaxation and serenity to the mind and body and it leads to calm and physiological and psychological stability (Elliott et al., 2011; Krout, 2007; Bonny, 1975). Musical characteristics affect the state of relaxation and certain characteristics in music facilitate a positive mind too. For example, a medium musical tempo can lead to positive emotions rather than very fast or very slow music (Bruner, 1990) and music beyond a certain level of loudness may not induce positive emotions.

Lastly, in terms of sound volume level, Knight and Rickard (2001) used the *Canon in D major* by Pachelbel as a relaxation music intervention. They explored how loud and soft volume of music affected relaxation. They found that the volume range between 70-74 dB is suitable for inducing relaxation.

The ideal sound level for relaxation is debatable because it may differ according to personal hearing abilities and sensitivity to sound. For example, older people, tinnitus sufferers or others with medical problems of the ear may have different sensitivity to particular frequencies of sound and levels of loudness. Therefore music volume for relaxation responses can be matched to the individual client.

To conclude this section, the literature suggests that music with a slower tempo, lower pitch melodies, low volume, regular rhythmic patterns, an absence of extreme changes in dynamics and without lyrics is ideal in RM. However, depending on the client group, situation, the practitioner's purpose, and client preferences and condition, various types of music can be used for RM. Also for active and receptive approaches for relaxation, music characteristics may be adapted in different ways according to the situation and the practitioner's own perspective.

Finding suitable music for relaxation responses can be a challenge for practitioners and knowledge of musical characteristics will help when selecting suitable music for the right person in the right place at the right time. Therefore, determining the appropriate combinations of musical characteristics in order to achieve relaxation can better meet the individual client's needs.

2.9 Types of RM

Many genres of music are used in healthcare for relaxation (See Appendix 1 for all the music in this section used by researchers). In addition, a great deal of music has been composed specifically for relaxation (Thaut and Davis, 1993). Sedative music is generally regarded as RM and researchers focusing on RM often choose to look at sedative music rather than stimulative music (Scartelli, 1982; Borling, 1981; Taylor, 1973).

The word *sedative* means “tending to calm, moderate, or tranquilise nervousness or excitement”. And in contrast *stimulate* means “to make (something) more active: to cause or encourage (something) to happen or develop” (Merriam-Webster, 2016).

Lee et al. (2016) say stimulative music can lead people to more high activity and energy and sedative music offer to soothe people down. Taylor (1973) uses several types of sedative and stimulative music in his study and states that one of the specific characteristics of sedative music is ‘slow’ and ‘quiet’. By contrast, music which is constantly rushing and has a fast rhythm can be stimulative music (Gill, 2005).

Therefore, sedative music can be used to help make people smooth, and tranquil while stimulative music can be used to help make people be more energetic, or dynamic using a strong beat, rhythm, staccato or faster tempo.

Wolfe et al. (2002) examine the use of RM with a group of musicians and non-musicians in order to find music suitable for relaxation. They selected several pieces of sedative music especially for the purposes of relaxation from 10 CD recordings. They report that most pieces of music were unfamiliar to participants, especially the non-musician participants, but they found that unfamiliar music was nevertheless considered to be relaxing. Therefore, unfamiliar music or previously unheard music can be used as RM resources if the characteristics of music are suitable for relaxation. They asked participants what kinds of music used were the most relaxing and answers included:

Classical music (44 participants), Alternative music (33), Country music (32), Easy listening music (35), Soundtrack music (28), Jazz (26), Rock music (25), Pop music (23), Rhythm and Blues (23), World music (14), Latin music (11) and Soul music (11).

In their study, classical music is the most popular choice of music for relaxation. Wigram et al. (2013, p.112) says “Bonny found that when subjects listened to a carefully selected programme of classical music while in a relaxed state, powerful feelings and symbolic images were evoked, leading to significant insights into therapy issues.” The effect of classical music on attention, stress and relaxation as well as self-disclosure have been researched (Jensen, 2001; Scheufele, 2000) and classical music has been shown to be an effective resource for receptive approaches and for relaxation purposes.

Kim (2005) examines the link between the brain waves (in particular alpha waves) and musical stimulus and personal reactions. Faster alpha waves relate to more pleasant feelings, greater calm and concentration. Four pieces of stimulative and sedative music were selected and slow and fast alpha waves were compared before, during and after listening. Sedative music was seen to link to positive emotions and relaxation responses. Soothing classical music, in particular, was linked to the greatest level of psychological and physical stimulation of positive emotions and relaxation responses.

On the other hand, stimulative music caused unstable or not relaxed physical stimulation and unpleasant emotional responses, presumably because of the unforeseen dynamic structure of the music. Her study also found that RM and sedative music can positively affect emotions such as anxiety and depression. She identified specific attributes in sedative classical music, such as reducing tension and an association with positive emotions. Her study further supports the claim that the sedative classical music can be appropriate for relaxation and arouse feelings of peace, inspire positive emotions and help dispel anxiety, restlessness, unease, and irritation.

There are different types of brain waves (namely Gamma, Beta, Alpha, Theta and Delta). Among these, Alpha waves (8-13Hz) are produced when the body and mind is in a relaxed state. In Kim's study, only Alpha waves were explored and this is a limitation which Kim herself identifies.

It may not be easy to stipulate which types of music are suitable for relaxation purposes because responses to sedative and stimulative music can differ according to personal preference and age group. Grocke and Wigram (2006, p. 46), for example, mention "music that is relaxing for young children will differ in quality and style from music that is relaxing for adolescents, or older adults". Today young people are generally more exposed to highly stimulating music with a fast tempo and strong beat than older age groups. In certain cases, stimulative music makes people more energetic and lively. Therefore such music can be used for the purpose of raising energy levels, which will make mind and body more balanced and relaxed in an active way. Gill (2005) found that for some clients, stimulative classical music can help to control their emotions and achieve the positive emotions. Related to this, Hevner (1935) reports that fast tempo music can make people happy, cheerful and improve personal energy levels.

Feelings of happiness and cheerfulness represent an emotional state of well-being. In Buddhist teaching happiness is closely related to calmness because happiness (Sukha) is the proximate cause of concentration (Shankman, 2008; Buddhaghosa, 2005; Salzberg, 1997). Since pleasure and cheerful emotions generate tranquillity and relaxation, it follows that certain types of stimulative music can also be used for RM purposes.

Responses to music are subjective and even for the same person feelings may change depending on their physical and psychological condition, level of energy, their mood that day and even the weather. Therefore depending on the therapeutic purposes, psychological and physical aspects of relaxation, client group, both sedative and stimulative music can be possibly used for RM resources.

What is sometimes referred to as meditation music, including synchronised music, *brainwave music* (namely Gamma, Beta, Alpha, Theta and Delta waves music), (See Glossary) - and Indian music, is used for the purposes of relaxation both in practice and research. For example, Alpha meditation music can help to create the Alpha brainwave state (7.5-12.5 Hz) and it has soothing and calming sounds (Hill and Frederick, 2016; Vernon et al., 2014). In Korea, brainwave music has often been used for its relaxation response in school settings for Korean students with high stress levels, as well as to increase attention levels and memory during study.

Lee (2004) explores the link between meditation music and psychological changes using several types of meditation music. Her findings are that such music actively facilitates the exchange between left and right brain and helps to balance both cerebral hemispheres. These results are consistent with research of Campbell (1997). She also finds that meditation music impacts on the positive changes in emotions because it helps people to reflect and contemplate the cause of negative emotions, acting as a balance to calm the mind. Therefore, this study suggests that meditative music can be used as a supportive tool for psychological change because RM can bring positive therapeutic effects, bring a sense of comfort and tranquillity and reduce impulsivity.

Ha (2002) investigated the effects of meditation music on attention levels of 83 Korean elementary schoolchildren. The results are that meditation music helped to improve students' attention level, especially that of girls for whom the effects were more positive than boys. Several types of music were used in this study. Similarly, the effect of alpha meditation music on relieving anxiety among senior schoolgirls was investigated by Lee (2000). In this study, he measured physical and physiological changes and examined mind and body responses while using meditation techniques together with alpha meditation music.

His conclusions were that alpha music combined with meditation had the effect of reducing anxiety in this group of girls. Not only did it reduce worry and anxiety but it also led to positive psychological changes such as improving emotional stability and concentration levels, and promoting self-confidence, mental clarity and lack of confusion. This study suggests that meditation combined with music can be useful in school programmes and used to treat young people who have anxiety and emotional problems.

Lastly, in Korea, a wide range of music has been explored as a resource for RM, for example Eastern music, global music, traditional Korean music, newly-composed Korean traditional music, crossover music which combines Korean traditional music as well as Western music (Howard, 1997). Traditional Korean music often uses music instruments (Korean string instruments, bamboo and wind instruments and percussion instruments). In Korean traditional music sometimes the tempo can be connected to the length of the breath and certain types of music and instrumental playing facilitate a state of relaxation as they adjust music to breath.

Representative of Korean traditional music are *Gugak* (See Glossary), which includes a number of varieties of Korean folk music, Pansori, Pungmul, Jeongak, Nongak Nurseries Shinto music, and Sanjo meditation music. Not only Korean traditional music but also Korean meditation music which made by Korean instruments can contribute to the resources of RM as well as music therapy in Korea. This may better suit clients who do not identify closely with Western music. It may also contribute to the establishment of a distinct and more independent Korean style of music therapy. At the same time mixing Western with Eastern music and music instruments will increase Korean music therapy resources. Therefore, both Korean culture-based music resources and cross-cultural music resources may support both the national and multicultural aspects of music therapy in the future.

To conclude this section, the literature shows many genres of music are used as resources for RM. Responses to music are subjective according to the cultural diversity, personal psychological and physical conditions and preferences. Therefore, various types of music can be considered for use as RM, whether it is sedative, stimulative, Western, Eastern or cross-cultural. And through person-centered approaches, a wider range of RM can develop.

2.10 RTs and Meditational Practices in Health

The use of RTs (including meditational practices) has been developed in healthcare settings and benefits of RTs in health have been reported in many journals (See Appendix 2 for all the RTs in Chapter 2 mentioned by researchers). Arias et al. (2006) systematically reviewed the treatment of illnesses through meditative techniques, covering 82 journal articles and 958 subjects in total. Strong evidence was found for the efficacy of RTs and meditative techniques in the treatment of epilepsy,

premenstrual syndrome symptoms, menopausal symptoms, as well as for mood and anxiety disorders, autoimmune illness, and emotional disturbance. In a more recent article Larkey and colleagues (2012) report their use of meditative practices, such as sitting meditation and mindful movements, as an example of a cost effective low-intensity psychological intervention that has been shown to be clinically effective.

Hence RTs can support clinical treatments as well as helping to relieve and manage emotional difficulties. In the area of mental health for the young people, various self-regulation interventions using RTs have been explored to treat mental disorders, emotional disorders, conduct disorder, hyperactivity, and Social, Emotional and Behavioural Difficulties (SEBD), (Gootjes et al., 2011; Mowat, 2010; Gatward et al., 2003). Young people frequently suffer from both internal stress and outside stress from family, school life, peers and exams, and stress-related illnesses among the young have increased over time. Therefore, stress management training, coping skills, practical guidance as well as social and health practitioner's support are needed and relaxation training and meditation have been used for stress reduction and as emotional support interventions (Hanh, 2008; Jorm and Wright, 2007; McNamara, 2000). Hwang (1998) found that after six weeks breathing techniques with junior school students, anxiety and impulsiveness were significantly reduced. Kalayil (1989), conducted programmes using PRT and yoga with junior school students and found anxiety was reduced through PRT and yoga was effective for stress symptoms such as headaches.

RTs have long been explored in order to help people deal with negative emotions. Three decades ago, Dillbeck and Orme-Johnson (1987) attempted to measure how meditation can reduce anxiety levels. By dividing subjects into three groups: a meditation group, a group who simply closed their eyes, and a group without any treatment, results showed a significant difference among the meditation group

compared to the other two groups in terms of reducing anxiety, worries and feelings of fear. Davidson (1976) observed the effect of Zen meditation and Transcendental Meditation (TM) on concentration and positive emotional change. 58 university students participated in this study, divided into four groups according to length and number of practice sessions. Long-term meditators showed increased concentration levels and lower levels of anxiety than short-term meditators. Therefore, sustained practice of meditation can be associated with decrements in trait anxiety and increments in attention capacity.

The evidence of the effect of meditation on anxiety, depression, fears and mood disorder, as well as on learning difficulties, are a constant theme in the literature (Chen et al., 2012; Beauchemin et al., 2008; Toneatto and Nguyen, 2007; Lee, 1993). Today RTs and meditative practices are regarded as potential treatments for promoting people's well-being and health emotional and behaviour and these techniques have been adapted for various purposes such as increasing relaxation, reducing body pain, reducing fatigue, and stress relief by both East and Western healthcare practitioners.

Meditative practices are an ongoing subject of discussion among both Eastern and Western researchers (Hofmann et al., 2010; Weick and Putnam, 2006). In terms of bridging Eastern meditative practice and Western philosophes, Shapiro (2008) mentions that the first attempt by a Western practitioner to write about Eastern meditation was the foreword to D.T. Suzuki's introduction to Zen meditation by Carl Jung (1947) and subsequently altered states brought about through meditation have been noted by Charles Tart (1969) and Robert Ornstein (1972). Since then, combining Eastern and Western philosophy meditation has been widely explored.

Western healthcare practitioners and researchers took an interest in meditation techniques as self-regulation strategies and for clinical applications out of a desire to develop non-pharmacological solutions and non-drug treatments. They were impressed with the psychotherapeutic effects and benefits of RTs and meditative practice for stress related illness, positive mental health and relaxation responses (Shapiro and Giber, 1978; Shapiro and Zifferblatt, 1976; Glueck and Stroebel, 1975; Benson et al., 1974; Lesh, 1970).

The relationship between RTs and relaxation responses and their link to clinical applications and meditation interventions has been discussed (Dusek and Benson, 2009; Jacobs, 2001; Lazar et al., 2000; Benson and Klipper, 1992). It might be assumed that engaging in meditation and contemplation itself is not very relaxing, because it is not the same kind of relaxation as that experienced from a body massage, or watching TV sitting on a comfortable sofa. However, studies found that during meditation, a particular state of relaxation is achieved in which mind and body are more stabilised (and thus calmer) than before practicing meditation (Davis et al., 2008; Keefer and Blanchard, 2001; Lazar et al., 2000; Benson et al., 1974).

Williams and Carey (2003, p.1) explain what a relaxation response (RR) is:

The relaxation response is defined as your personal ability to make your body release chemicals and brain signals that make your muscles and organs slow down and increase blood flow to the brain.

The goal of the RR is to be physically relaxed and mentally alert. Therefore, the RR is not the same kind of relaxation as lying on the couch sleeping, being drugged or being lazy, but it is firstly “a mentally active process that leaves the body relaxed”.

Secondly RR is “best done in an awake state” (not in a state of drowsiness). Thirdly it is “trainable and becomes more and more profound with practice” (Williams and Carey, 2003, p.1).

Whether relaxation is the specific purpose of meditative practice or not, clearly meditation can be included as one of the techniques for achieving a RR. A variety of RTs have been recognised as achieving a RR, for example, PRT, guided relaxation imagery, breathing techniques, MM, Zen meditation, walking meditation, compassionate/loving-kindness/forgiving meditation, positive psychology technique (emotional freedom technique), autogenic training, meditative prayer, yoga and transcendental meditation (Wilson, 2013, Chiesa and Serretti, 2009; Mitchell, 2009; Jorm and Wright, 2007; Williams and Carey, 2003; Robb et al., 1995; Thaut and Davis, 1993).

To conclude this section, numerous studies have attempted to find the balance of treatment that works best for a client. RTs and meditative practices can have a part to play in terms of the positive effect of change in the physical and psychological state that they help to produce. RTs are useful resources in mind-body healthcare in terms of therapeutic treatments and self-help techniques in ways that range simply from for pure relaxation and techniques for psychological and physical well-being through to profound forms of interventions for numerous illnesses that may be otherwise difficult to treat.

2.11 Stress Management and Mind-Body Interventions

The effect of stress on the mind and body and the physiology behind RTs, MM have been examined by many researchers. It is recognised that managing stress can positively influence health and improve the quality of life. RTs, MM and RM are

among the effective interventions for stress management (Kang, 2010; Dusek and Benson, 2009; Lehrer et al., 2007; Scheufele, 2000; Mandel, 1996). Currently many health practitioners are involved in the development of stress management programmes and keen to learn stress coping skills.

Kuhlmann et al. (2015) provided relaxation training to medical students based on scientifically attested concepts of stress reduction, such as mindfulness-based stress reduction (MBSR) and autogenic training, and achieved positive results. They explain that stressful feelings often arise when people think about the future or the past. However mindfulness by definition focuses our thoughts and emotions onto the present moment not the future or past. Therefore through mindfulness practice, people can learn how to manage stressful thoughts, avert unnecessary difficult emotions and live less stressful lives.

Kang (2010) lists well-known effective RTs for patients and nursing students and says among these, in mainstream medical systems, 'Relaxation Response(RR)' and 'Mindfulness Based Stress Reduction (MBSR)' are the most widely used for relaxation and stress management programmes in Korea. He recommends that meditation techniques can be useful methods for coping with stress with various groups, including cancer patients and nursing students. He also emphasises the link between the relaxation programmes and preventive medicine, where mind-body interventions can be used to help change behaviour and bad habits.

In relation to this, Hubbard and Falco (2015) say improving clarity of thinking is one of the goals of RTs and it can help people overcome stress and to make rational decisions in the face of drug and/or alcohol relapse. In his view, RTs are a useful tool

for reducing stress and changing bad habits such as alcoholism, smoking, high fat intake leading to obesity and related illness.

Many medical professionals point out that bad habits like these often exacerbate illness and lead to risks to the patient (Jin, 2011; Kang, 2010). If people cannot manage their stress then the results often lead to lifestyles that are harmful to health. Similarly, as Hubbard and Falco (2015) point out, people with bad habits usually do not manage stress well. Through RTs, it is possible to change behaviour of patients so as to manage their stress. Some research shows positive outcomes of changed behaviour patterns, such as reduced psychological distress, reduced stress symptoms and a reduction in the risk of a depressive relapse (Smith, 2008).

Kang et al. (2009) report that *psychosocial interventions* (See Glossary) reduced the subjects' perception of stress levels, but were less effective in treating anxiety and depression in nursing students. On the other hand, the meditation-based stress management programmes in their study resulted in reduced levels of stress, anxiety, and depression more effectively. This study shows that psychosocial interventions are also useful interventions for stress. However, encouraging meditation-based practice can not only reduce stress but it also has additional benefits in terms of emotional support for nursing students. Similarly, Shapiro (2008) found that medical students who performed MM experienced reduced psychological symptoms associated with anxiety and depression, as well as increasing their levels of empathy. These positive results were maintained even during examination periods.

Healthcare practitioners' stressors such as responsibility for patients, burdensome clinical practice, and conflict with clients or family are often reported (McCarthy, 1992). For stress management among human services professionals, Dobkin (2008)

reports positive results when using mindfulness-based therapeutic interventions to resolve long term stress-related problems and to improve life satisfaction. McCarthy (1992) found RTs combined with RM were able to reduce overall stress levels among staff who reported stress-related headaches and tiredness.

Selye (1973) describes three phases of stress on the mind and body, the third of which can cause stress-related illness:

The first phase is an alarm phase in which the fight-or-flight response is elicited for mobilization and gearing up for fight or flight. A second phase is called a resistance phase in which the organism fights the stressor, but the acute fight-or-flight response ceases. And then, a third phase, which he termed the exhaustion phase, in which the organism can no longer adapt to the stressor (Jacobs, 2001, p.85).

Therefore, stress-coping skills are important to prevent illness and by finding a healthy balance of mind and body, people work more efficiently and occupational stress may be reduced. In addition, through stress management, work capacity and quality will increase. Therefore, to manage work-related stress, RTs, MM and RM interventions as self-help techniques can benefit practitioners themselves and as a result their clients too.

To conclude this section, many studies have examined the effectiveness of mind-body interventions for stress management and the use of RTs, MM and RM to resolve stress related problems, support behavioural change and improve life satisfaction. The literature points to the value and positive effects of including relaxation programmes as a part of stress management. Stress reduction programmes which include RTs commonly report significant improvements in reducing anxiety and depression levels and in the treatment of mood disorders. Such programmes also have an important

preventive role and can improve quality of life and quality of work for those who experience stress in daily lives.

2.12 Mindfulness-Based Practice in Health

Currently there is growing interest in mindfulness-based practice, which is actively promoted in community settings and clinical practice (Hanger, 2015; Weick and Putnam, 2006; Kim, 2004).

The literature on mindfulness-meditation based interventions comprises more than 300 studies published in the UK databases (e.g., NHS Evidence in Health and Social Care, Healthcare databases advanced search). Most of these studies report that MM has general mental and physical health benefits including stress management. There is evidence of the effectiveness of MM (Crane and Kuyken, 2013; Piet and Hougaard, 2011; Hofmann et al., 2010; Speca et al., 2000; Williams, 2008) and the National Institute for Clinical Excellence (NICE) and National Health Service (NHS) both regard MM as evidence-based treatment and recommend mindfulness courses for patients living with various conditions. For example, The NICE Guideline (CG90) on the ‘Treatment and Management of Depression in Adults’ (2010) priority recommendations says:

Mindfulness-based cognitive therapy to prevent relapse should be considered where there have been three or more previous episodes of depression.

Williams (2008, p.721), a leading pioneer of MM in the UK, explains *mindfulness*:

Mindfulness is a translation of the Pali word *sati*, originating from the Sanskrit for *remembering*. It came, in the ancient Buddhist texts, to refer to the awareness that may accompany any thought or action.

He says mindfulness awareness emerges as a by-product of cultivating skill such as:

Intentionally paying attention to moment-by-moment events as they unfold in the internal and external world. Noticing habitual reactions to such events, often characterised by aversion or attachment.

Siegel (2010) claims that through intentional mindful awareness practice (MAP), people can create well-being in their bodies and minds. Examples of MAPs comprise: *active* forms of MAPs (e.g., mindful movement, yoga) and *receptive* forms of MAPs (e.g., breathing techniques, sitting mindfulness meditation). He emphasises that MM is intentional mental practice, staying in the present moment and is performed without any judgmental attitudes.

MM is originally based on Buddhist meditative practice (Kabat-Zinn, 1985; 2009). Kabat-Zinn writes that one of the contributions of Buddhist traditions is to recognise that people have the ability of mindfulness and that it can be cultivated and refined for all mankind and the advantages it brings to modern life through its practice.

Mindfulness-based meditation was introduced by Thich Nhat Hanh and further popularised and clinically adapted in the Western world by Kabat-Zinn (Kang et al., 2009). Kabat-Zinn learnt mindfulness practice from Zen meditation masters (e.g., Sung san) and systematised it for clinical purposes. He developed a mindfulness-based stress reduction programme (MBSR), an 8-week stress management programme in US hospitals for chronic pain treatment. More than 240 hospitals have adopted this MBSR programme in the US (Kabat-Zinn, 2009; Baer, 2003). He collaborated on developing MM programmes with UK practitioners and has written a book with the British professor Mark Williams, both of whom have worked in Britain. Much of the research of Kabat-Zinn (2009) and Williams (2008) reveals that MBSR can reduce anxiety, depression and change negative emotions to positive ones.

Mindfulness-meditation based interventions in the form of the 8-week MBSR programme have been systematically used (Davidson et al., 2003). The programme can significantly decrease perceived stress, anxiety and depression. Mindfulness has been found to be a wide-ranging and effective treatment, for example for cancer patients, sleep disturbances, improving health-related quality of life and the ability to concentrate in class (Krusche et al., 2012; Vøllestad et al., 2011; Kang et al., 2009; Winbush et al., 2007; Carlson et al., 2007; Paul et al., 2007).

MM has been widely adapted both in the form of formal traditional meditation practices, including such as body scan, mindful movement, sitting meditation and breathing techniques, and more informal practice. Informal MM, such as eating meditation, mindfulness driving, tea meditation, washing meditation, can be incorporated into daily life activities and into a busy schedule (Crane et al., 2010).

The practice of MM pays attention more to the present moment, trying to live more in the here and now. It might be argued that focusing on the present moment is not very relaxing for someone and especially people overwhelmed by stress or distress. However, MM can help us to be in better contact with the present moment and by doing this, it can help stop overthinking which causes tension or stress and sets off emotional triggers such as anxiety and fear. Meditation positions (e.g., sitting meditation) may not seem relaxing but practice of mindfulness has been found to result in beneficial changes and to help cultivate a personal ability to relax body and mind. Despite difficulties initially encountered, the more one is in contact with the present moment by practicing mindful meditation, the more relaxation will be achieved.

Currently, MM is a well-known form of meditation among healthcare practitioners and known by Korean practitioners as well as many Western practitioners to have scientific

backing. MM has been adopted in a variety of healthcare services and short-term and more regular workshops have been developed. One of the reasons why the MBSR programme has successfully been adapted in Western medicine is the fact that the standardised programme and systematic guidance make it easy for practitioners to follow and use. MM has roots in Vipassanā meditation and Zen Buddhist practices (Speca et al., 2000). In Korea, MM related to Zen meditation, is one of the fundamental traditional forms of meditation and because of the long history and cultural influence of Buddhism, meditation has long been studied and commonly recognised as part of Korean culture and meditative practices naturally utilised in the health context (Pihl, 1995; Buswell, 1993).

In the UK, MM is increasingly used for health and well-being purposes despite there not being a historic or religious tradition. There are a number of differences in the use of MM in Korea and UK nevertheless. In Korea, the use of meditation for health has evolved gradually over a long time, while in the UK it has developed more rapidly during a single decade. In Korea, meditation has been developed in the academic world, notably by Dongguk University since 1906 and been the subject of theoretical research. In the UK, practical issues are to the fore, and recently MM has attracted a large amount of publicity and interest in the national media in MM (BBC, 2012; 2016). Following on from the public interest, a number of universities in the UK have started up degree courses in MM (FindAMasters, 2016) while 8-week MBSR courses are being run for staff and students. Having said this, it is fair to say that today there is considerable public and academic interest in MM in healthcare both in Korea and the UK.

To conclude this section, meditation is a way to inner calm and clarity and this tranquil state is one of the important factors which can lead to the balance of mind and body.

That is why so many relaxation programmes and mind-body interventions have incorporated meditation skills including MM. MM is a popular, simple and effective technique and its benefits have been recognised by practitioners who have adopted and adapted it. MM helps people deal with their health problems and conditions, to manage pain and stress and this idea has been developed in both Korean and UK over a different time period. As EBP, MM as mind-body medicine is set to expand in scope within the healthcare service. Community programmes incorporating MM may well play a bridging role in terms of its acceptance and in sharing the wealth of spiritual experience between East and West.

2.13 Creativity and Spirituality

Many studies have explored the link between creativity and spirituality and mind-body interventions. There is growing interest in the use of RTs, MM and RM for the purposes of cultivating creativity and spirituality in the current healthcare environment (Bazzano, 2011; Wlodarczyk, 2007; Valente and Marotta, 2005; Longa et al., 2001; Borling, 1981; Goleman, 1972).

A great deal of research has focused on the relationship between RTs, MM and RM and relaxation responses, but these interventions have also been recognised as a legitimate means for cultivating self-reflection, self-awareness, self-regulation strategy, self-development, creativity and spirituality, and self-transformation. And through these processes of positive personal change, a wider range of levels of consciousness can be experienced such as altered states of consciousness, high level states of consciousness, pure consciousness, and movement towards enlightenment, otherwise known as higher class realisation (Aldridge, 2003; Lipe, 2002; Sahn, 1997; Shapiro and Giber, 1978).

Sahn (1997, p.25) writes:

Human consciousness is composed of three parts: emotions, intellect, and will. Every kind of pain or pleasure comes from our emotional nature; understanding comes from our intellectual nature; and action comes from our will.

Through the harmonising of these components of consciousness, people can act in a way which benefits themselves as well as others. He emphasises in times of inner conflict, our mind and body lose balance and this causes us to experience suffering and it affects people around us. Therefore, experiencing self-exploration, developing the balance of consciousness and cultivating the higher states of consciousness all contribute to a healthy and balanced life.

Mind-body interventions including RTs, MM and RM are often used to promote creativity and spirituality among healthcare trainees. Kang et al. (2009) argues that for student nurses, important educational goals at university level include cultivating students' creativity and promoting continuous self-development alongside theoretical education and practical education. To develop these, he advocates RTs and MM for nursing students. Similarly, Hall and Mitchell (2007) emphasise the importance of education in aspects of spirituality and creativity and that giving opportunity for self-discovery of creativity and spirituality is valuable for student midwives. In order to promote understanding of the concept of spirituality and foster the midwife's mind and spirit, they have developed classes which illustrate various creative approaches using music, aromas, storytelling and video.

Therefore cultivating creativity and spiritual care may be considered significant goals for the healthcare practitioner and the healthcare service trainee. There has also been much exploration of self-development tools and resources designed to foster

understanding of the concept of creativity and spirituality and RTs, MM and RM have been adapted in various settings for these purposes.

The spiritual dimension and creativity have been considerations in developments in music therapy. Daykin et al. (2006, p.364) explored service users' perspectives on the role of music, creativity and healing in cancer care settings and suggest that "music and creativity can be powerful and complex resources in the construction of healing among people with cancer".

In order to address clients' spiritual and healing needs, various musical activities and resources have been identified that bring about experience of certain states of mind (spiritual consciousness and altered state of mind) through music therapy programmes. One such example is GIM which is described as a 'depth oriented music psychotherapy method'. Bunt (2010, p.2) says "GIM provides many instances where clients' deep connections with music enable glimpses of these timeless zones beyond words to occur, meetings with the numinous, and again within the present moment and in individually unique ways".

Aesthetic music experiences are able to conjure images and can be a powerful and subjective spiritual experience which frequently cannot be expressed verbally. There are many types of images including visual, auditory, tactile, kinesthetic, and *noetic* (See Glossary), which may convey very powerful messages. Summer (2011) finds that people can experience two types of process, the transformation of consciousness and a transpersonal music experience through a GIM session.

Apart from GIM, other music therapy approaches and techniques have been developed to support people's spiritual well-being. Music therapy itself can be regarded as creative therapy based on the healing properties and therapeutic activities.

Music can be a means to exploring a deep sense of the presence of inner creative spirit and people are given the opportunity to meet deeper levels of consciousness and their own *true self* (See Glossary). Moreover, within the therapeutic relationship, carefully chosen music (according to individual client history and their present mood) can create a positive mind, induce relaxation and support spiritual experience (Bonny, 2001).

People can realise their own true nature and experience a higher level of consciousness and what is called 'pure consciousness' by self-exploration practice and intentional effort. Sahn (2006, p.10) describes this intentional effort (when practising meditation) as the 'Try-mind' and continues:

Try, try, try means persevere, from moment to moment. It is sometimes called *Right Effort*. It is the mind that always tries, no matter what, in any condition and any situation.

People may misapprehend or misunderstand meditational practices because of feeling afraid of silence and the process of connection with an image of the inner self, but through the intentional practice of exploring the inner self, people may feel freedom which emanates from the inside rather from outside environments and events. Thich Nhat Hanh describes this state of mind as:

I have arrived, I am home,
In the here and in the now.
I am solid, I am free,
In the ultimate I dwell. (Hanh and Kohn, 2012, p.36)

During the practice of meditation, mindful awareness arises moment by moment and mindful exploration of the inner world takes place, in place of wandering judgments and thoughts about the outer world. For help along this spiritual journey, meditation objects are needed such as feeling the breath carefully, and mindfulness on the four

objects (body, feelings, mind, and mind objects).

Walsh (1983, p.18) says:

We know the outer world of sensations and actions, but our inner world of thoughts and feelings we know very little. The primary purpose of meditation is to become conscious of and familiar with our inner life. The ultimate purpose is to reach the source of life and consciousness. Skill in meditation affects deeply our character.

Through mental practices, altered states of mind or certain types of pure consciousness can be experienced and this creative process may nourish our spiritual dimension. Individuals have different realms of spirituality and creativity, which is individualised and made subjective through the challenge of their personal search. A psychological space of freedom will be found, consciousness will be developed and through doing so people may find a wealth of resources for health and well-being.

Walach et al. (2011, p.298) write that “consciousness is mediated by the brain, i.e. it takes place with the help of the brain but is not within it; brains are transducers of consciousness”. Through meditative techniques, the brain is activated in a way of high level introspection and self-awareness and people may experience different levels of self-discovery. This spiritual mind and state of concentration through meditation are noetic and ineffable (Johnston, 1967), the same experience as a noetic self-modification experience achieved by a music therapy process. As mentioned, a deepened level of consciousness can also be gained from musical experience. For example, GIM is for those “seeking fuller experience and insight in the areas of the humanistic and transpersonal” (Bonny, 1980, p. 25).

Such transpersonal experiences do not lend themselves easily to everyday language. Therefore experience of music can be described through metaphors such as “even if the client’s eyes are closed, he/she sees, hears, smells, tastes, feels and moves with the music” (Bonde and Wigram, 2002, p.104). Noetic experience is generally considered transpersonal experience, one that takes us into a realm beyond normal sensory experience, such as a sense of oneness with the universe or God, or profound insight or understanding. Abrams (2002; 2016) explores the verity of similar words for transpersonal experience in his literature review. These include noetic quality, cosmic, mystical, numinous paranormal, peak, religious, spiritual, transcendent, ultimate, deeply positive affect, transiency, spiritual sense, unity, ineffability meditative phenomena, meditative states, being in a deep state, transcendent awareness religious phenomena, and intense spiritual experiences.

Normal consciousness can be transformed to deeper levels of consciousness, such as an *altered state of consciousness, pure consciousness, or transcendental consciousness* (Goleman, 1972), (For a discussion of states of consciousness See the Glossary). The realisation of this new awareness can be stimulated both meditational practice and music and both types of intervention can be foster a sometimes new sense of spirituality that gives a healing benefit. Therefore, the noetic value of meditation and music can contribute to the growth of personal spirituality and nourishing creativity. In relation to collaborative multidisciplinary approaches already discussed (Carr and Wigram, 2009), it is felt that meditation and music collaboration may provide a distinctive or special resource for discovering the people’s authentic identity and spiritual self.

To conclude this section, exploring higher states of consciousness is a process of seeking freedom. Goleman (1972, p.152) says “in the realm of mind, the method is the seed of the goal: the state of consciousness one reaches is contingent upon how one chose to get there”. There are many ways to experience the realm of mind (to experiences of levels of consciousness) and knowing the potential inside our minds may depend on personal choices and decisions. RTs, MM and RM can offer a vehicle to develop an ability to experience new levels of consciousness, a special experience which can give lead to a transformative change of life.

Concluding comments

The focus of this chapter has been on RTs, MM and RM, how these interventions have been used in healthcare services as EBP and their therapeutic value. Topics explored have included: the development of RTs, MM and RM in healthcare contexts, multidisciplinary approaches, the characteristics and types of RM, RTs and MM, stress management and mind-body interventions, creativity and spirituality.

My study will explore healthcare practitioners’ understanding and use of RTs, MM and music in the UK and Korea. The assumption has been that there may be different rationales and ways of adapting RTs, MM and RM and this may reflect in the use of interventions in the respective healthcare services. I have drawn on literature from Korea and the West as a background to my study, but have generally taken this literature as a common starting-point. In this sense there is a general and common understanding of RTs, MM and RM and their way of use in both East and West.

I have also pointed to certain differences - in terms of categorisations and terminology, for example. However, there has been no discussion as to actual differences in practitioners' understanding or practice in Korea and the UK.

This exploration of the literature will nevertheless inform my discussion as to how RTs, MM and music are perceived and applied, and will give insights into the different cultural assumptions that underpin these practices. There are clear links between each of the key issues discussed in this chapter and the discussion regarding my own findings in subsequent chapters. These issues include the adaptation and the use of RTs, MM and RM in the healthcare environment; ways of incorporating RTs, MM and RM into integrated healthcare; the rational use of the physiological and psychological features of RTs, MM and RM for health and spiritual well-being; the benefits of mind-body interventions as psycho-physiological therapeutic treatment; and cultural differences and similarities in the use of RTs, MM and RM between the UK and Korea.

My qualitative study therefore concerns cross-cultural perceptions of RTs, MM and RM and how the use of RTs, MM and RM relates to the different cultural models of care of Korea and the UK. Comparing case studies from both countries will contribute towards cross-cultural healthcare research and supporting the assessing the practical value of mind-body-spirit interventions in healthcare settings as well as facilitate the sharing of information between East and West.

Chapter 3: Methodology

3.1 Introduction to Research Design

This study makes use of a qualitative case study methodology, particularly as it is understood and used by Robert Yin (1984; 1994; 2003; 2009) and Robert Stake (2000). Research procedures have been devised with specific reference to the guidelines and protocol for case studies put forward by Yin. He describes a case study as an approach to research that facilitates exploration of a phenomenon within its context using a variety of data sources in order to explore individuals or organisations, simple through complex interventions, relationships, communities, or programmes (Yin, 2003). Below I will discuss why I have used qualitative research rather than quantitative research and in particular why a case study approach has been adopted as opposed to another qualitative methodology.

The case study strategy is used to explore the cultural differences in understanding and use of RTs, MM and RM within health contexts in Korea and the UK. The context of health practitioners in the UK and Korea acts as the ‘cases’ in this study, and therefore the methodology aims at a comparative approach to case study methodology. The cases are analysed in relation to main themes and broadly speaking a thematic analysis (TA) was used to provide the theoretical framework for qualitative analysis of in-depth interview data. This will be further explained in Chapter 3.4.2.

This study used in-depth semi-structured qualitative interviews. Preliminary findings from the pre-interview process were followed up by individual face-to-face in-depth interviews and the recordings of the interviews were transcribed in full. The research focused on professional health practitioners rather than healthcare clients and the data were gathered both through interviews and the collection and analysis of documents.

Three practitioner groups were identified and selected participants from the UK and Korea were interviewed. The general focus of the research was to explore the ways in which professionals understand and use specific kinds of interventions and thereby to seek to uncover cultural differences that might lie behind their thinking and choices.

3.2 Reflection on Case Study Qualitative Methodology

Since the research design for this study is a qualitative case study methodology it is necessary to address the question of why qualitative research and case study methodology has been chosen and what the philosophical roots of my study are.

3.2.1 Case Studies

Case studies have been used when a holistic, in-depth investigation is needed (Feagin et al., eds., 1991) and “case studies are designed to bring out the details from the viewpoint of the participants [...]” (Tellis, 1997, p.1). Case study methodology is one of the approaches to qualitative enquiry and it has been tested and developed by researchers and robust procedures have been established.

Yin (2003, p.1) says “case studies are the preferred strategy when ‘how’ or ‘why’ questions are being posed, *when the investigator has little control over events*, and when the focus is on contemporary phenomenon within some real-life context.” Like Yin, Rowley (2002, p.17) states:

Case study research is also good for contemporary events when the relevant behaviour cannot be manipulated. Typically case study research uses a variety of evidence from different sources, such as documents, artefacts, interviews and observation, and this goes beyond the range of sources of evidence that might be available in historical study.

It is generally recommended that case studies focus on one or two issues in order to understand the phenomenon and this method allows investigation of the meaningful characteristics of real life events, for instance, a single organisation, a particular community, an individual issue, a particular event, a decision, a small group behaviour and a particular group issue.

However, there is some feeling that it is difficult to develop general theories from case study research and case study results cannot be widely applicable in real life. Also case studies can encounter criticism from those who hold that only general, theoretical knowledge is valuable rather than concrete, practical knowledge. Addressing the issue of the generalisability of case studies, Hartley (2004, p.325) points out that “case studies have an important function in generating hypotheses and building theory” and the process of building theory from case study research has been described and illustrated (Eisenhardt, 1989). In particular, Yin presents a well-constructed explanation of the difference between *analytic generalisation* and *statistical generalisation*:

Case studies [...] are generalizable to theoretical propositions and not to populations or universes. In this sense, the case study [...] does not represent a “sample”, and in doing a case study, your goal will be to expand and generalize theories (analytical generalization) and not to enumerate frequencies (statistical generalization). (Yin, 2009, p.15).

He stresses that in analytic generalisation, previously developed theory is used as a guide in order to compare the empirical results of the case study (Yin, 2003).

Bromley (1990, p.302) states that a “case study is a *systematic inquiry* into an event or a set of related events which aims to describe and explain the phenomenon of interest”.

At the outset of my case study, in order to ensure a systematised approach, I investigated techniques for organizing and conducting the case study in relation to

planning and design, preparation, data collection and the generation, analysis and interpretation of data. Stake and Yin both offer useful and practical advice and guidance for case study research.

Yin (1994, p.20) emphasises the importance of five components of a research design: “a) a study’s questions, b) its propositions, if any, c) its unit(s) of analysis, d) the logic linking the data to the propositions and e) the criteria for interpreting the findings.” Stake (2000) identifies three different types of case studies - intrinsic, instrumental, and collective - based on the particular generalisable features of the case research. He considers case studies to be reflective, can accommodate views other than those of participants and recognise that reader and investigator can be influenced by their own experience. In his view data produced by case studies can often resonate experientially with the readers, thereby facilitating a greater understanding of the phenomenon through seeing something from the point of view of another. He introduces the term *‘naturalistic’ generalisation* (See Glossary) and emphasises the harmonious relationship between the reader’s experiences and the case study itself. During the course of my case study, I needed to take account of ‘the extent of investigator’s control over behaviour events’ (Yin, 2003, p.1) and Stake’s ‘naturalistic approach’.

A case study can be defined in a variety of ways but the main important principle is exploring the specific phenomenon in depth and in its natural context. As mentioned, a case study is ‘naturalistic’ in approach and design and distinct from an ‘experimental’ design or type of research in which there is high investigator control, random sampling such as randomized-controlled trial and the investigator maintains control over the variable(s) of interest.

My study is an in-depth investigation of the cultural differences in understanding of use of RTs, MM and RM within health contexts between the UK and Korea (with three professional healthcare groups). My study is based on the naturalistic approach and involves the researcher's reflexivity. Mills et al. (2010, p.788) say:

Reflexivity is the process of becoming self-aware. Researchers make regular efforts to consider their own thoughts and actions in light of different contexts. Reflexivity, then, is a researcher's ongoing critique and critical reflection of his or her own biases and assumptions and how these have influenced all stages of the research process.

As a Korean practitioner and researcher, exploring different two cultures provided the grounds for reflexivity, in that what might be taken for granted (Barbour, 2000) can become a focus of analysis, and this self-awareness allowed me to think more creatively about the UK, to probe Korea practitioners' perspectives and explore professional understanding of use of interventions - to "study the interplay of 'multiple' views and voices" (Barbour, 2000, p.156). Therefore, involving my own reflexivity as the researcher afforded certain advantages during the process of this study (See Chapter 3.6) and my reflections played a part at every stage. Of course, this may have influenced the co-creation of the data during interviews, and my subsequent analysis and presentation of the data in discussion chapter too. As already explained, my own part in the whole process needs to be acknowledged and recognised.

To conclude, case studies "offer insights that might not be achieved with other approaches" (Rowley, 2002, p.16). A case study arises out of a need to understand complex social phenomena and this approach tends to be an exploratory and descriptive one. Yin sees a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of

evidence are used” (Yin, 1984, p.23). In my study the ‘phenomenon’ is the emergence of RTs, MM and RM as healthcare interventions and practitioners’ reflections regarding their practice; the ‘context’ is that of healthcare practice in various fields in the UK and Korea. Part of my task is therefore to identify the boundaries (where contextual and cultural differences do and do not impact on the phenomenon itself). Evidence both from a wide range of literature and from the interview data as well as my own reflections on the issues that have emerged have enabled me to explore a complex of issues relating to healthcare contexts, the approaches and practices of different practitioner groups, cross-cultural factors, and historical developments.

3.2.2 Qualitative research

This study research design is a case study that is analysed through qualitative methods. Silverman (2000) argues that selecting the qualitative and quantitative study should depend on the what researcher is trying to find out and “if you are concerned with exploring people’s life, histories or everyday behaviour, then qualitative methods may be favoured” (Silverman, 2000, p.1). Qualitative research was considered more appropriate for my study and it offers a better chance of gaining an understanding of a phenomenon related to my area of interest.

Alternative approaches, such as quantifiable survey-based evaluations, were felt to lack the opportunity to gain real or first-hand understanding of practitioners’ thinking, or to explore complex issues in great enough depth. Barbour (2013, p.13) points out that a qualitative study may not answer questions such “How many?; What are the causes?; What is the strength of the relationship between variables?”. However, a qualitative study, through the process of in-depth understanding of participant’s experiences, recognises that individuals are grounded in the social world and through

the process of engaging with their experiences it is possible to achieve the one of the tasks of qualitative research which is to try to access certain meanings and meaning-making.

From a personal point of view, one of the attractive characteristics of qualitative research to me is its 'humanising effect' brought about through in-depth conversation on the research topic. Moreover, these conversations and my subsequent thinking, processing and analysis have the direct advantage of making it possible for me to find insights into my area of study and professional life.

3.2.3 Philosophical Assumptions

Empiricism, induction and constructivism are the underlying philosophical assumptions behind my study. Firstly, empiricism is a starting-point since I am concerned with capturing subjective experience in a naturalistic setting, in other words investigating a certain phenomenon with three groups of practitioners. Secondly, the philosophical roots of my qualitative approach are more inductive than deductive. My study is based both on existing previous research findings and the findings from the data collection, from which with the themes emerge. This allows me to take a flexible and holistic view of a situation throughout the coming chapters. Thirdly, my qualitative research paradigm is more constructivist than positivistic. My approach is to try to uncover meaning from data and follow how the participants construct meaning in the context of talking about their practice. Meaning is therefore found through engaging with realities in the context of a discussion rather than the process of gathering specific data in order to find a solution or solve a problem.

3.3 Research procedures

3.3.1 Fieldwork and Interview

Prior to the in-depth interviews, several steps were followed (Detailed information is given in Appendixes 3 to 9).

1. Arranging pilot interviews
2. Preparing an acceptable consent form (Appendix 3, 3-1)
3. Preparing a detailed information sheet to send to interviewees and topic guide (Appendix 4,5,6,7)
4. Arranging and conducting pilot interviews internally in UWE
5. Refining topics and questions based on data from pilot interviews
6. Submitting the ethics application to the Faculty Ethics Committee (Appendix 8)
7. Sending invitations (pre-interview letter containing information sheet) to 12 interviewees explaining the aims of the research (Appendix 9)
8. Fieldwork in Korea and the UK
9. Sending additional questions after the interview (where applicable)

Before invitations were sent out contact was made with suitable participants so as to assess whether participants would be available for in-depth interviews. The invitation letter then explained the nature of the research study and invited participation in the project as well as providing an information sheet about the project.

3.3.2 Sampling and Size of Groups

In order to achieve a basis for comparative analysis of participants' understanding and use of RTs, MM and RM in the UK and Korea, the main participants in the study were purposively sampled according to the three population groups across both countries -

those professionally engaged in medical practice; in meditation; and in music therapy. The proposed number of subjects was 12, six from each country.

Below are details of all the Korean and UK interviewees' professional areas:

- Music therapists working in university and various settings (hospice, community, school) (5)
- Medical practitioners with an interest in RTs, MM and music in healthcare (4)
- Meditation experts working in university and community settings (3)

All participants are professional experts from their respective three areas with a depth of understanding of RTs or meditation/MM or RM. So through these 12 professional healthcare practitioners, a rich and reliable data source was found. The 12 participants were contacted by email or phone and asked whether they would be available for face-to-face in-depth interviews.

The intention was to achieve a richly interpersonal exploration through spontaneous discussion on prepared topics focusing on participants' personal experience, approaches and outlooks. Choosing the participant sample is one of the important aspects of conducting in-depth interviews and in this qualitative research, one of the challenges was the sampling. Patton (1990) stresses that purposeful sampling is a non-random sampling and the researcher selects information-rich cases for study in depth. Therefore, in order to seek an in-depth and 'thick' dialogue and sharing a core experience of the phenomenon, purposeful sampling was the chosen method and a sample of participants was selected who might most contribute to the key issues for the purpose of this study.

3.3.3 Information about the 12 interviewees

Participants were selected on the basis of the number of years of relevant experience (RTs or meditation/MM or music therapy) and their interest in RTs, meditation or music in teaching or healthcare in various settings and programmes. Of the 12 interviewees, six are professors or senior lectures in university, seven are therapists, eight routinely teach RTs or meditation or music therapy in university and community settings, eight are female and four are male. (Experience was a more important consideration than achieving a gender balance). Information regarding the interviewees is summarised below:

South Korea (position of interviewee)	The UK (position of interviewee)
Lily (Music therapist, University Professor)	Edward (Music Therapist, GIM Practitioner)
Rosie (Music Therapist, PhD student)	Olivia (Music and Sound Therapist, GIM Practitioner)
Jessica (Music Therapist, GIM Practitioner)	Isabel (Nurse turned Psychotherapist)
Jacob (Cardiac surgery specialist, University Professor)	Violet (Nurse, University Senior Lecturer)
Georgia (Nurse, University Senior Lecturer)	John (Meditation Expert, Sound Therapist)
Adam (Meditation Expert, University Professor)	Anna (Meditation Expert, University Senior Lecturer)

All participants have been anonymised and their names changed.

3.4 Data Collection and Data Analysis

3.4.1 Interview Data Collection

Data were collected through an audio-taped interview with each of the 12 participants. The semi-structured interviews consisted of both direct and indirect questions and ranged from 70 to 90 minutes in length. I chose semi-structured interviews because it would allow the participants a certain degree of freedom to explain their views and

give a more comprehensive account of their understanding and use of RTs, meditation and RM. The flexibility in semi-structured interviews would allow me to remain open to ideas which I would not be able to predict (Horton et al., 2004; Radnor, 1994). There would also be a possibility of new topics and points of cultural comparison.

Based on the prepared interview topics and questions, participants were first asked about their use on the RTs, meditation and RM both in their practice and their personal lives. Then specific questions (See Appendix 10, 10-1) were posed in an attempt to identify and clarify the understanding of use of RTs, meditation and RM. The 12 interviews were transcribed over two months and translations from Korean into English were made (over three months). In preparation for analysis hand-coding of the (English language) transcriptions was carried out over a period of two months. The total preparation period before data analysis was therefore around seven months.

3.4.2 Data Analysis

In my data analysis, I used thematic analysis (TA). I found TA a suitable approach to identify important themes and patterns within the interview data and to research practitioners' understanding and use of RTs, meditation and RM. There are many types of analysis for qualitative study data for example, grounded theory (Strauss and Corbin, 1998), discourse analysis (Burman and Parker, 1993) or narrative analysis (Murray, 2003). Among these, TA is a widely used qualitative analysis and it can enable provision of a theoretical framework for qualitative analysis of in-depth interview data (Marks and Yardley, 2004; Boyatzis, 1998; Miles and Huberman, 1994):

(a) Familiarisation with the data

- involving reading and re-reading the interview data; starting to identify the potential codes.

- (b) Coding
 - involving generating initial codes; organising all the codes.
- (c) Searching for themes among codes
 - involving selecting important codes and reducing codes (through merging or discarding); identifying possible potential themes and patterns.
- (d) Reviewing themes
 - involving checking potential themes, combining some, discarding some, finalising the list in line with research aim and objects.
- (e) Defining and naming themes
 - involving finalising the list in line with research aim and objects; determining the scope of significant themes for analysis of research questions; naming each chosen theme for the purposes of writing; completing data analysis within each theme.
- (f) Producing the final report
 - involving contextualising the analysis; writing up.

Each of these phases builds step by step on the last. However, during the analysis process, I had to return to the different phases and move back and forth while developing and expanding my ideas. Analysis was therefore a recursive process and it completing the whole process took over four months.

There are three main reasons for selecting the TA method. Firstly, the data can be analysed and categorised into separate themes so that the main themes related to my research aim and questions can be identified. Secondly, TA is an effective and systematic way to determine important main themes from collection of a large body of data (the 12 interviews). Thirdly, the TA model can provide a structure for my case study analysis and interpretation of cultural differences and similarities of the UK and Korea. It was apparent too that the process of TA enabled me to better understand diverse aspects of the interview data and to discover new potential broad issues related to UK and Korea healthcare services.

Hand-coding of the analysis of interview data was carried out rather than using a software system such as NVivo, or ATLAS.ti. (Data analysis by NVivo was tried, but

it was felt that sometimes important detail interview data could be lost). As described, key categories and relationships identified were used to produce a thematic framework that could fully take into account the data as a whole. The details of the analysis (list of codes, and development of thematic categories) are included in Appendix 12, 12-1 to 12-6. Also included are reflections and observations on the interview process in the UK and Korea in the Interview diary and reflections in Appendix 11.

3.5 Ethical Considerations and Application

When conducting in-depth interviews for research purposes, there are particular ethical issues to consider. In this research confidentiality was the issue and care needed to be taken to preserve confidentiality at each stage of the process.

In this research particular attention was given to ensuring the confidentiality of participants' responses. The preparatory guidelines letter described the purpose, method, and procedures of the study were reviewed so as to conform to the university ethical guidelines. The note-taking and recording facilities to be employed during the interview were clearly explained to participants and consent for these procedures obtained. The letter assured interviewees that the all information gathered, the tapes recording the interview discussions and the resulting data, are subject to rigorous safeguards so as to preserve their anonymity. Interviewees were given formal assurances of confidentiality and anonymity. These assurances provided information about secure storage of data. A document was prepared for each participant, guaranteeing present and future anonymity, confidentiality of information received and acknowledging the use of note-taking, or audio or video recording equipment at the sessions. These ethical considerations were in the ethics application passed to the Faculty Ethics Committee on June 2013 (See Appendix 8). Care was taken in

designing the questions: none of my questions ask for confidential information. I did not reproduce any data which had the potential to breach confidentiality or anonymity offered to me during the interview.

3.6 Engagement with the Research Process through Reflection

The process of qualitative research and conducting an in-depth investigation into a specific topic area with professional experts permitted a dynamic exploration of subjective aspects of human experience. At each stage during the study I could engage through reflection and the personal journey during the research processes led to a new self-awareness. At the same time, as a UK PhD student from a different cultural background, my reflections provided an opportunity to generate new understandings about the cultural differences between Korea and UK and make my own connections between them. In fact, the novelty of the experience not only enabled, but forced me to reflect constantly through the whole process. And for these reasons I have included reflections on my chosen methodology (See Appendix 11).

3.7 Reflections on Quality Criteria

This critical reflection on the study considers its strengths and weaknesses and quality criteria. I will follow the four seminal measures proposed by Lincoln and Guba (1985): (a) Credibility, (b) Adaptability, (c) Consistency, (d) Neutrality.

a. Credibility

Credibility and trustworthiness may be difficult to pinpoint but nevertheless essential and worthwhile. The fact that my study has obtained first-hand accounts and rationales for practice from experienced and knowledgeable professional interviewees actually working in relevant fields of research is what primarily gives my study credibility. I was able to gain insights into the rationales, outlooks and cultural differences and

similarities between the participants in their use of RTs, MM and RM. In addition, the sources themselves enabled me to clarify the scope and limitations of the study.

I took pains to describe and transcribe all the 12 interviews as truthfully and accurately as possible. Perhaps this should go without saying, but understanding what was said is not always as straightforward as it might seem. So, in the case of my fieldwork in Korea, if during the transcription of the interview I did not understand well or required further explanation, I directly contacted the interviewee (by phone and email) and asked again in order to clarify my understanding. In the UK too I used email in order to clarify anything I was unsure of (As a second language interviewer, it was very useful to have a written answer).

In the case of interviews conducted in English, when there was anything that puzzled me, I asked my supervisors and a third British person and went through the process of reaffirmation. Sometimes these questions were culture-related and the supervisors and British person acted rather like an anthropologist's informant. Finally, I checked two or three times to make sure the recorded files and the interview transcripts were accurate and complete. I think all of this process is connected with part of internal validity of my research.

b. Adaptability

As regards adaptability, the key factor is transferability or external validity defined as “the extent to which the findings of a study can be applied to other situations” (Merriam, 1995, p.57). How the findings of the study can be applied to the other situations and populations is the test of generalisability and whether the results of a single study adequately reflect conditions that apply across various situations that healthcare practitioners find themselves in relates to its applicability. (Generalisability

is usually a feature of a quantitative approach but my data too contain trends that could be applicable to other contexts and for other similar groups of professionals).

My belief is that for healthcare practitioners working in many differing environments and for those whose situations are similar to those in my study, my findings will be relevant to their situation, areas of interest and concerns. Moreover, the participants were selected not only for being typical of those working in their fields, but more generally representative in other ways of the healthcare profession (in terms of their backgrounds, working lives and contexts). Therefore, I would argue that the research has meaning and transferability beyond the interviews I undertook. Qualitative research cannot generalise in relation to populations (because the samples are too small) but it can generalise to existing theory or conceptual frameworks.

The results of my study may be of interest to a number of groups. The first group is music therapists, other therapists, meditation practitioners and healthcare professionals too who have an interest in the use of RTs, MM and RM. Secondly, there is widespread interest in alternative, non-drug treatments and among these RTs, MM and RM deserve consideration due to their evidence base for effectiveness and applicability. Thirdly, my research concerns cross-cultural comparison within an area of healthcare and will be of value to others concerned with understanding and differences in outlook and approach between cultures, particularly East and West.

c. Consistency

Consistency may be regarded as the reliability of the study as a piece of quantitative research. The concept of reliability in a qualitative study is a somewhat difficult, since in the case of quantitative study, if the study were repeated, with the same methods using a software programme, it may possibly obtain the similar results. However, in

the case of qualitative study, for example, if my research were carried out again in South Korea and the UK even with the same participants and same approach and study aim, it is questionable whether it would produce very similar results. (Conversations tend not to repeat themselves). My interview data were seen through a constructionist approach, rather than a realist approach. The interviewees were giving a version of events as opposed to simple truth statements and since interviews are constructed dialogue I was not necessarily looking for factual statements. Rather, I was looking at how my interviewees construct meaning in the context of talking about their practice.

The several levels of checking and revisions - from my supervisory team, the UWE Research Committee and UWE Research Ethics Committee - all in some way relate to its reliability. At the same time, the concept of reliability in a qualitative study is a somewhat difficult topic, since I am myself a participant in the research, which ultimately relies on my individual interpretations and commentary. With this in mind, at each stage I have tried to test out my ideas and discuss them not only with the supervisory team, but with friends and colleagues in the UK and Korea whilst of course protecting the anonymity and confidentiality of the interviewees.

d. Neutrality

Neutrality relates to the objectivity of the research. Complete objectivity may prove difficult and the researcher's biases (or in the case of qualitative research - 'reflexivity') cannot be ignored because interview questionnaires are made by researchers and the whole interview process may be designed by the interviewer. However, qualitative research is process of self-reflexivity "considered to be honesty and authenticity with one's self, one's research, and one's audience" (Tracy, 2010, p.842). Therefore, in the entire process of the study I have tried to avoid any bias (because of any personal

preconceived ideas) and being reflexive as interviewer and practising reflexivity in order to minimise such issue in interview situations.

And I was very concerned with how my personal ideas, preferences and characteristics might affect my research. For example, during the course of analysis and transcribing, I blocked out from thinking about the individual interviewees or their characters or beliefs to try to avoid distortion due to any subjective view or personal preconceived idea.

During the process of research, I have written a reflective diary in order to see my own predispositions and this was beneficial for me in terms of distancing or detaching myself in order to be an objective researcher. It has been habit since my training in music therapy to write a logbook after each session. And out of that habit, I believe one of my personal strengths is being 'objective' and 'neutral' and this is a quality needed in a therapist, and so I feel I am already practised in this way of working. However, a more difficult issue is adopting a position of 'neutrality' when it comes to cultural difference. Sometimes answers are puzzling and it is necessary to keep questioning in order to understand something from another person's perspective. Sometimes, too, it is possible to understand something in a rational way, but not in an emotional way. Corbin and Strauss (2008) state that undertaking qualitative research means seeing the world with the eyes of participants (taking an 'emic' - insider - as opposed to an 'etic' - observer - perspective). So I have tried my best to be 'neutral' in the process of research in the UK and my supervisory team and pilot interviewee gave me advice which was helpful to maintain my position with respect to neutrality.

To conclude this section, when I undertook quantitative research during my master's degree, computer software programmes (e.g., SPSS, STATA) were one of the main

tools and made it easier to represent reliability and validity through producing statistical results. However, with qualitative research, I think software programmes (e.g., CAQDAS) can assist the analysis interview data but these programmes do not take over the role of the researcher and the qualities of trustworthiness and credibility emanate from constant deliberation and reflection on the part of the researcher. In order to enhance quality criteria in my research, I have considered four points: credibility, adaptability, consistency, and neutrality and these were useful validation procedures during the process of my qualitative research.

3.8 Reflection on Cross-Cultural Interviewing

Cross-cultural interviewing can be defined as “the collection of interview data across cultural and national borders” (Ryen, 2001, p.336). Little attention has been paid to the use of second languages in qualitative research interviews. Welch and Piekkari (2006) emphasise that in qualitative interviewing issues related to second language interviewers are often neglected in the English-dominated environment of international research. Some studies report the researcher’s perspective but there are few studies focusing on the second language interviewer’s side. So here I will present my reflection of my experience of interviewing in a second language (English).

Interviewing in a second language brought different issues to light. In doing cross-border fieldwork (in the UK and Korea), the interview process and the data collected were different in certain respects, which brought about challenges and disadvantages as well as advantages.

Firstly, in terms of challenges and limitations, compared to the interviewing in Korean, having English as my second language, in the UK interviewing was a hurdle to be overcome. Second language use in qualitative interviewing to some degree affects the

research process not simply in terms of linguistic understanding, but also the interview process and procedure, rapport-building, construction of shared understanding, translation and seeking for equivalence of meaning between the UK and Korea.

It will be argued that ‘culture’ should not be regarded as ‘one thing’: cultures are constructed discourses that although often represented as homogenous, are in fact multiple systems of thinking and being. In broad terms, however, UK culture is very different from Korean culture and having grown up in Korea, my own cultural background and limitations in my cultural understanding about the UK in some cases influenced the interview process. Lack of cultural understanding can lead to misunderstandings. The UK interviewees were also aware of that possibility and consequently simplified accounts or spoke in a way that was different from the Korean interviewees. Sometimes interviewees took time to explain aspects that were unfamiliar to me. For example, unfamiliar aspects of the hospice environment, such as the layout of the building and organisational aspects, the style of living spaces and wards within a UK hospice and the non-uniformed staff (all different in their way from Korea) were explained. However, at times it was necessary to seek clarification by email after the interview had finished.

Such limitations were at least to some degree expected before starting the UK field work and I took certain measures to ensure that this level of cultural familiarity was enhanced before embarking on research. For example, I attended meditation residential programmes, sound therapy workshops, and retreats in the UK. Nevertheless, I recognised that the cultural gap was sometimes wide and understanding another cultural context took time.

Working in a second language sometimes offered advantages, however. The UK interviewees went to some lengths to be accurate, simple and clear in the way they spoke. Besides the advantage for comprehension and transcription, this made the interview atmosphere feel calmer and more mindful than talking with native interviewees.

In many ways, the character of the interviews in Korea and the UK differed. In the UK, the interviews felt formal in comparison with Korea. There was a much more direct focus on the interview questions and less casual chatting in the second language interviews. Interestingly though, both interview situations felt comfortable to me, but for different reasons. In Korea the situation was relaxed and there was generally no pressure of time. We often had tea and chatted informally. In the UK, although agreed times were adhered to, the interviewees showed a great deal of patience in their approach and understanding that my language and culture were different. They took pains to explain things in a simple and unhurried way.

There were therefore certain advantages for me when it came to the analysis of the UK interviews. Because the interviewees had taken more time and effort to organise their thoughts the analysis task was often more straightforward. The formal language itself made interview analysis easier too. On the other hand, with the Korean practitioners, the manner of the interviews was at times formal and at times not. We took breaks during the interview or after interview we looked around together and even met their clients and patients. So the interview data extended beyond the interview questions per se and at times referred to actual situations. The quantity of Korean interview data was twice that of UK interviewees and correspondingly complex too.

Issues can arise when doing cross-border fieldwork. In my case, difficulties and limitations forced me to be creative and to make decisions during the process of interviewing. In order to develop rapport with UK interviewees and to understand more fully, I sometimes had to alter the interview structure and style of the interview questions. Also I had to calm my nerves. The process of creating rapport with interviewees was different therefore from that in Korea.

Nevertheless ‘language boundaries’ and ‘sense of the unfamiliar’ can bring advantages as well as limitations. These allowed me to gain new levels of understanding and provided insights in my attempt to understand as a researcher the different culture(s) of the UK. It made me more engaged in the reflection process during the process of interviewing and my subsequent analysis. Welch and Piekkari (2006) note a possible ‘outsider’s advantage’ in second language interviewing. From my experience, being the cultural outsider brought a measure of freedom to probe and explore UK culture(s) and to ask critical questions about practices and beliefs that others more rooted in the cultural setting may not have considered. The cultural distance permits space for reflection about a culture and the results of these benefits have sometimes been incorporated as additional insights into the findings.

To conclude, this chapter 3 has outlined: (a) research design, (b) research methodologies used in the study, (c) research procedures, (d) data collection and analysis methods, (e) ethical considerations, and (d) reflections on this study. The following finding chapters (4-7) will discuss key themes found from the data analysis. I will explore interviewees’ use of RTs, MM and RM, their approaches and how they view RTs, MM and RM in health contexts and finally cultural similarities or differences will be discussed.

Chapter 4: Finding Chapters: Music and Health

4.1 Introduction to Finding Chapters

A number of key themes were identified from the interview data and these will be explored in the finding chapters 4, 5, 6 and 7:

- Music and health (Chapter 4)
- RTs and MM and Health (Chapter 5)
- RTs, MM and RM Applications and Responses (Chapter 6)
- Cultural Context (Chapter 7)

This chapter will look at the three key themes which emerged from data analysis: the practitioners' personal approaches to using music and music therapy, how the practitioners use music for health and well-being, and what the practitioners perceive as qualities and abilities of the practitioner.

4.2 Music and Music Therapy Approaches

The three groups of practitioners have adopted music widely in different healthcare contexts (in education and preventive medicine, music therapy, meditational practices or personal self-help techniques). Depending on the practitioner's specialism and personal mind-set and attitude, the three groups of practitioners have different approaches, procedures, aims and perceived benefits. Some participants used music more actively (rather than receptively) in their actual therapy and some use music to support their specialist work. Therefore, different opinions are held as to the use of music in healthcare service. Several important elements emerged from participants' accounts, including purpose of use of music, range of client groups, range of settings,

background music, music genre and characteristics, and instruments and live and recorded music.

4.2.1 Use of Music

a. Purposes of Music

Participants' key purposes which emerged from data analysis (and which sometimes overlap) are given below:

- To quieten groups down and stop chatting in group sessions (Olivia, Violet)
- To build rapport, focus the mind, get the client to calm down and reduce physical tension (Lily)
- To create a relaxing environment (John)
- To make people more calm, creative and open (Violet)
- To promote creativity and relaxation (Isabel)
- In order to motivate and create the will in clients to do relaxation exercises with music by themselves (Lily, Jacob)
- For self-help techniques (Lily, Jacob)
- To enable clients to open up their inner feelings (Rosie)

Music can be used as the main purpose (in other words using the physical, emotional, cognitive, social, aesthetic, and spiritual facets of music itself as a therapeutic intervention) or as a support to their work. Apart from the music therapy group, most other groups seem to use music in the background. It seems to me the interviewees are looking to expand their therapeutic toolkit and eager to find various new ways and they use music for those reasons. Therefore, practitioners considered a mix of possibilities (music and their specialism) for their own different purpose in order to serve clients. Between the Korean and UK practitioner groups, there is no particular cultural difference in terms of purpose of the use of music. Generally speaking, the

only difference is between the professional groups and whether they use music as the main purpose or support to their practice.

b. Range of Client Groups, Settings and Specific Functions or Stages within the Process

A range of client groups and settings were identified among the interview groups. They use music in cancer wards, hospices, midwife training, maternity courses and with women in labour, stress management programmes for workers, youth violence work and university courses. Practitioners use music with Parkinsons patients, MS (Multiple Sclerosis) patients, ME/CFS (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome) patients, hospice patients, stroke patient groups, schoolchildren, university students, medical trainees and children and adolescents with autistic spectrum disorder.

Many interviewees mentioned their use of music in teaching sessions for trainees, whether in public settings or private settings. In public settings, the trainees were clearly identified: music therapists, trainee nurses and medical staff, and meditation practitioners. However, some practitioners operate in private settings and run outside workshops where there are a variety of client groups. John listed: amateur and professional musicians wanting to branch out, healers or therapists wanting to complement their work, and music lovers who feel they might personally benefit.

Interviewees also discussed the appropriate timing and staging of the use of music and sound. John mentioned individual sessions at the introduction stage, where he uses recorded music in the background when a client arrives or during the initial consultation. In later stages he uses live music, such as crystal bowls or Tibetan bowls, for relaxation. In group settings, he often uses meditation techniques in conjunction with music or sound. Olivia on the other hand uses sound healing tools at the beginning

of a session with noisy children in order to quickly bring them into focus. Edward said when he uses music he chooses the timing and stages based on the knowledge of how clients are and what they need on the particular day:

It depends whether I'd met the person before or if I'm meeting them for the first time. If I'm meeting them for the first time, a lot of it would be listening to them, getting a sense of what the problem is or where the anxiety is, and then trying to find something that might be helpful for that person. If I have met them before, and they are coming back for a second or third or fourth session, they might just want to relax, and I must just play some music to them. And that would be - I'd maybe see them for long than half an hour. I'd maybe see them for an hour. So we'd have ten minutes or a quarter of an hour talking at the beginning, then a bit of relaxation, and then a bit of music, and then talking at the end - to see how it was. So the talking at the beginning would let me tune into them, find out where they're at that day, what's happening for them (Edward-UK).

Lily emphasised the idea of rapport and she said the appropriate timing or staging of her use of music depends on how rapport developed between client and practitioner:

If a client already has a good rapport with me, I can use relaxation techniques and relaxation music at the end of the session, but when I first meet a client, or if we don't have any particular rapport yet, I suggest receptive techniques are used at the beginning of the session (Lily-Korea).

Rosie said she often does relaxation sessions with hospice patients and her purpose in the session is to enhance relaxation to promote stable breathing. She says about 20 minutes is suitable for session for hospice sessions.

In this way, music is used with a wide range of clients, in different settings and at various stages of their programmes and both in public and private settings. Interviewees recognise the value of music, but the specific value may vary according to client group or the time at which it is used. Exposure to music can be relaxing, but for some clients it may also be tiring (just as all activities may be). Sensitivity is

required as to the length of exposure and clients' physical health and receptivity on any one occasion.

c. Music as Background

Music enables clients to open up their inner feelings. It helps my main therapy to proceed smoothly (John-UK).

As mentioned, music can be used as a main purpose of a session or a background to other activities and non-musical tasks. Isabel and Violet said music can help people to express their emotions as well as improve performance and memory recall, so they use music in combination with their creative activities including art therapy and play therapy:

If I use music in the big group sessions, it keeps the noise down, it keeps them to task. If I use it in the creative sessions, it seems to allow that feeling of allowing their minds to open up, to be creative and when I do relaxation techniques with students, I will use music (Violet-UK).

Likewise, Jacob showed how he uses music:

If you're thinking about an individual session with clients, then I always have recorded music playing when people arrive. It's relaxing music. When we're doing the initial consultation, the music is there. When we're doing the relaxation techniques, the recorded music is there, still playing so all that time in that process, the relaxation music is in the background. It creates the environment for which people enter into the space. It's really important (Jacob-Korea).

Most of the music therapy group used music in both ways. However, compared to this group, the other practitioners described their use of music as background music in order to assist in their own specialism. The interviewees are clearly interested in using music in combination with their work and they recognised that background music is an important support and impacts with non-musical tasks.

d. Music Characteristics

Many genres of relaxation music and music characteristics were mentioned. As regards music characteristics, Lily suggests that music with a regular beat is suitable for a relaxation session:

In my last relaxation session I chose Kenny G's *Spring Breeze*. Why I chose that music is the beat is very regular and I can detect an Oriental mood in it (Lily-Korea).

John maintains that certain types of music tempo are more effective than others at inducing relaxation:

There is a lot of evidence about that now. Music that has generally a slower tempo, a slower rhythm - typically maybe in the region of 50 to 90 beats per minute - is going to be the one that has this effect (John-UK).

Olivia says her choice of tempo depends on the client group. For example she considers tempo when she combines breathing techniques and music when working with autistic children and in hospices:

I just encourage them to follow their breathing. I might use my voice to follow their breath. "Can you close your eyes? Would you like some music?" [...] I'll choose a tempo which matches their breath. And that's similar to some hospice work I've done (Olivia-UK).

Here, she shows how she selects music tempo which matches clients' breathing in her therapy. Likewise, Rosie also spoke about matching the music tempo with a hospice client's breathing and pulse:

If the purpose of session is a relaxation session, I should observe the client's breathing condition first. [...] However, the condition of hospice patients can change rapidly so I am always aware of the fact that their condition might suddenly deteriorate. [...] For example, this morning I brought along a guitar and prepared to play and sing one particular piece. But the client's breathing and pulse was so weak that I upped the tempo in order to make her respond and speed up. On the other hand, if someone is breathing too quickly and cannot recover their normal

breathing, I choose or perform calm and gentle music and, then despite their pain, their breathing may improve depending on their condition (Rosie-Korea).

In general, when asked about how fast or slow tempos can help achieve a state of relaxation, music and sound professionals saw the value of both fast and slow tempos in their relaxation sessions, depending on individual needs and the client's age. For instance, young people feel relaxed listening to fast and dynamic tempos and beats rather than soft relaxing music. Compared to the other practitioners, the music therapy group focused more on musical characteristics and quality when choosing music. However, client-centred considerations are the most often mentioned criterion for choice of music and musical characteristics.

They prefer to vary the tempo of music depending on the setting, client and purpose. Some, however, said that using slow tempo music may be better for a relaxation session and they prefer to use relaxing music which is slow or moderate in tempo.

In terms of volume of music, Isabel uses music, but says it must not distract her counselling and conversation with clients. Soft and gentle music is preferred. Violet also says she does not use loud music, but she changes the volume in a number of different ways. For example, in teaching groups of trainee midwives, where music is played in conjunction with other activities, she turns the volume up to stop the trainees chatting, but if it is for a relaxation exercise, then it will just be playing quietly. In general, therefore, the volume, like the tempo, may be adjusted to suit the setting, client and purpose.

Another practitioner, Olivia, says she generally prefers using slower music which does not have predictable phrase lengths, or else slow music with a drone and no clear underlying pulse. Sometimes, however, she uses music which has a more predictable beat for gentle stretching exercises. It is clear therefore that practitioners consider

individual needs, the physical and psychological condition of clients and client's age, as well as the active and receptive purpose of activity, when they choose the music characteristics.

A large amount of music has been composed especially for relaxation and studies undertaken about musical characteristics, such as dynamics, tempo, instrumentation, rhythm, harmony, melody and how these can lead to relaxation. Having a knowledge of music characteristics may be helpful for those who would like to use music in their work.

During the interview process, it was clear that some participants understood the specific musical characteristics that can enhance or distract from relaxation and some are exploring what kinds of musical characteristics may suitable for relaxation. Even though not all the interviewees are music experts, they use a wide variety of music generally depending on their personal preferences and seem to have an understanding of musical characteristics and how they influence the relaxation response.

As discussed in the literature review, the common characteristics of relaxation music are a slower tempo, lower pitch melodies, regular rhythmic patterns, and the absence of extreme changes in dynamics and of lyrics. However, interviewees highlight client-centredness and it seems that they feel that a variety of characteristics of RM may be possible depending on the situation and clients.

e. Live and Recorded Music

Different effects and benefits were attributed to recorded and to live music. Most in the music and sound therapists group preferred live music because it is possible to match music to each patient's specific biorhythm and physical condition. Examples of live music are song writing, improvisation, singing and playing instruments or playing

to patients. They said that, depending on the condition of the patient, practitioners can adjust the tempo - slowing it down, speeding up, accentuating rhythms, and producing a steady beat, whereas recorded music cannot be adjusted in the same way:

Live music is more powerful in reaching patients, because the power is more dynamic, so it is more effective on patients. [...] Also using some musical elements we may change breathing speed and heartbeat in a desirable way (Rosie-Korea).

However, unlike the music professionals group, who use both recorded and live music, most of the other practitioners only use recorded music, though in a variety of ways:

I don't know much about music because I am just working in a hospital as a doctor. However I reckon that the music always plays an important role in my relaxation sessions. In my case, I choose music which gives comfort to me and I use it as background music by using the CD player (Jacob-Korea).

The most common way is listening to music on an iPod through speakers, playing music on a portable CD player, sometimes as background music to their own spoken guidance during the relaxation session. The music therapy group more often focus on the client's own choice of music and it seems that client-centredness is a fundamental aspect of sessions. The other practitioners also consider clients' preferences but often play music that they themselves enjoy.

4.2.2 Criteria for Choice of Music

The criteria for choosing music for RTs and RM were considered important. For the choice of music, several practitioners mentioned 'matching skills' - how to match music to a client's preferences (Edward, Olivia, Lily, Rosie, Jacob):

I normally use music for my relaxation session, but it really depends on the client's condition. I often have a pre-session and during this time my client talks about their personal history. Sometimes it is a sad story or a trauma etc. I normally plan my session depending on the clients' stories and my assessment during the pre-session (Lily-Korea).

In response to how the client's educational background and socio-economic status affects her sessions Rosie said:

I work in quite a variety of places, one where patients are well-off, another where patients come from poorer backgrounds. Before going to sessions I have to prepare recorded or live music and this is always quite different for these different groups. With the better-off patients in the private hospice, there is preference for classical music, Italian and French songs and opera. With the less well-off patients in the state-run hospice, the preference is for easy-listening music rather than Western classical music. Some of the old people are illiterate and cannot read the words of the songs. Their musical knowledge is limited too, their patience and attention span can be limited and so there are many difficulties in running sessions and they are not always successful (Rosie-Korea).

Rosie feels that there are certain differences between more educated patients and less educated patients. For example, when she plays music, if they are not familiar with the music, the client may seem stressed, which may also be due to the pain they are in, whereas the more educated patients, even if they are mentally preparing for death, are more open and often show interest in less familiar music.

Checking the personal background of client carefully before a session is clearly important for any practitioner. Rosie often runs sessions for less well-off patients in state-run hospices. She talked more about client background when discussing the international workers there:

I go to another hospice-hospital where there are only international workers. [...] The patients have language difficulties when speaking Korean and their background is very different too. So I sometimes simply use very simple breathing techniques and music - but not songwriting because it is too problematic. These sessions are very difficult to run, I find (Rosie-Korea).

In other ways, the clients' physical condition may determine the selection of music. Sounds themselves can cause problems, for example with patients who suffer from

conditions such as tinnitus or other hearing problems. Jessica talked about how to match the music to a client's condition, especially in her work with old people:

It's absolutely necessary to check a patient's hearing and sensitivity to sound. One time I didn't do this rigorously enough and the patient was very uncomfortable. I had brought some little drums, but this patient couldn't stand the sound and the patient wanted to stop the session. I also brought a softer 'ocean drum', which was better, but I should have brought other instruments (Jessica-Korea).

In a therapy session often there are unexpected things that happen and practitioners cannot expect to stick to a single plan and they always need alternative back-up plans. The interviewees have all different experiences with various client groups and they are concerned with matching the music to a client's physical or psychological condition and socio-economic and educational background.

Other considerations were how to match the music in individual or group sessions. When considering group and one-to-one sessions, Olivia and Edward emphasised that music should be suitable for the majority of the group and in a one-to-one session, the choice of music may be tailored to that person. In a group session, practitioners need to consider the general feeling of the group, their energy levels and mood at the moment. The Korean music therapist participants said before starting the group session they usually have ready various genres of music which people of that particular age generally like. This may be a special focus of concern among Korean music therapists. The UK participants did not make any similar comments.

Client-centredness was stressed and many practitioners said music which is chosen by the client is a major criterion in their choice of music:

When I play the music which a client prefers, this music can make a client calm much faster and it leads to stable relaxed breathing which can address the respiration problem (Rosie-Korea).

John mentioned too that client preference is important and if clients relate to a particular kind of music, then that will affect them more. He emphasised that practitioners need to find out what sorts of music clients like or not. For instance, if a client personally does not like a particular kind of music, the client will find it difficult to relax, even if it is calm music. Therefore, assessment of client's musical preferences is a very important step at the beginning of session.

Lily and Jacob both mentioned that a client's preferred music can trigger happy memories and facilitate a feeling of connection between client and therapist and thereby it can help develop a rapport too. When recounting an incident in a hospice, Lily explained:

He [the patient] chose music called *Barley Fields* and during the time listening, his wife was sitting on the side of the bed and she sang together with me. I asked the client what he was thinking about when he closed his eyes and he said "When I was young, I walked together with my wife through a barley field. Walking with her is my happiest memory." So I asked him to sing together with us. He suddenly sat up and clapped his hands while singing and went into a smile (Lily-Korea).

This story reveals how the client's choice of music facilitates relaxation and feelings of connection within relationships and how he was able to recall a happy memory.

In terms of how to match the music with a client's physical or psychological condition, Isabel said depending on the client's anxiety levels, emotional levels or stimulation levels, she may decide whether to include a relaxation session or not in her psychotherapy work and then will select the music accordingly. If a client seems very tense, she will first ask "Would you be OK if we put on a bit of relaxing music now?" instead of saying "What kinds of music do you like?" She is sensitive to individual needs and whether relaxation music would be useful or not:

We practice lots of the basics - It is called *person-centred counselling*. The client is in charge. I always ask: "Is this OK? Can we have some music maybe?" (Isabel-UK).

Lily suggested that when a practitioner chooses music for relaxation sessions, it might be helpful to consider the clients' physical condition as well as socio-economic and educational background too, particularly when considering using classical music. As discussed earlier, this kind of advice is mainly a feeling among Korean practitioners and this will be considered again in Chapter 7.

Another *matching skill* is how to match the musical rhythms and beat with relaxation techniques. Rosie works in a hospice-hospital and her choice of music tends to depend on the characteristics of music, such as rhythm and beat. Many in her hospice suffer from respiratory problems, so she usually has available various genres with different rhythms in order to match the condition of the patient's breathing. If the breathing is too slow she uses a fast rhythm in order to up the breathing rate, whereas if breathing is too fast, she uses music with a slow rhythm in order to relax or stabilise their breathing. She said that when singing, the practitioners can adjust the speed of rhythms too.

As to other matching skills, one practitioner mentioned matching the effects of weather or season with music. Olivia believes that weather affects people's emotions and energy levels, so whether it is bright and sunny or dull outside influences her choice of music. For instance, in winter it is very dark and cold so she uses more energetic music such as Latin music:

I use a variety of music - and really it sometimes depends on the time of year, because in winter now, for instance, in January, it's very dark, it's very wet, it's very cold. So I might use music which is more energetic (Olivia-UK).

Several practitioners discussed emotional responses to music (Georgia, Lily, Rosie) and when they chose music it was first of all to help clients relax both physiologically and psychologically. Lily and Rosie both said music which does not stimulate the emotions too much is preferred for relaxation sessions.

Music without lyrics is sometimes preferred for RM because in some cases patients focus on the lyrics only and not the sound or tune and sometimes this causes an unexpected sensitivity to verbal stimuli and the relaxation response is not achieved:

I prefer music without lyrics rather than with lyrics. Sometimes that music is more effective when we do a relaxation session (Georgia-Korea).

In conclusion, when practitioners choose music for relaxation, there are several matching factors that are considered important:

- Client-centredness and music preference
- The genre and the characteristics of the music
- Type of session (individual or group session) and purpose of session
- The season
- Illness, state of health, and physical and psychological considerations

And even though practitioners' own music preferences were varied, there was a general agreement that music should be chosen on 'client-centered' grounds, depending on the client background, client's physical health, type of illness and physical condition.

4.2.3 Music Genre

In terms of music genre, many types of RM were mentioned and these were often closely related to the practitioner's own musical preferences and clients' preferences or whether these genres had worked for them before or not.

Jessica said if the session is related to inner psychological therapy, classical music is more appropriate because classical music is more well-structured than other kinds of music:

In the first, second and third session, I use classical music rather than New Age music or other types of music, but after the fourth session I choose music depending on the client's preference or my preference (Jessica-Korea).

Olivia uses a variety of music such as the waltz, or lullaby for relaxation sessions, Latin music for more energetic activities and Indian flute music (*Ravathi Mystical Power or Für Alina* by Arvo Pärt) for deep meditation:

Playing relaxing music while encouraging bodily focus such as breathing - including imagining the breath moving into all parts of the body and the brain can have an amazingly positive effect (Olivia-UK).

Edward's relaxation music includes light music, classical music and Indian music. Violet prefers to use music such as South American panpipes and songs by Enya, or a mixture of classical pieces or just 'quiet calm relaxing music' rather than 'relaxation tapes with sounds, like birds, sea and whale sounds'. Rosie's examples of relaxing music were *Salut d'amour* by Edward Elgar, *Canon* by Johann Pachelbel, religious songs (gospel music) and Korean traditional music. The music therapy group, in particular, often have a fuller list of relaxing music due to their training or experience.

Isabel uses music without a strong tune, or with 'no obvious melody that is not too invasive', such as the recordings on *Mozart Effect* for different types of clients.

I use different music depending what we want to do. If my client is very busy emotionally and so overwhelmed or very anxious then I use relaxation [CD]. If I see the clients need to be stimulated, then I use the creative one [CD] (Isabel-UK).

Regarding the *Mozart Effect*, there is some controversy among Korean and UK practitioners. Regardless of one's opinion, it is easy to understand the appeal of this

for Isabel (who is not a trained music therapist), particularly since she said she personally likes classical music. Besides the *Mozart Effect* she uses other kinds of classical music for her session rather than using other genres of music.

Olivia said sometimes she uses music which can help and encourage gentle stretching exercises and reduce stress and make movement easier. For example, *I Giorni* by Ludovico Einaudi, *La Calinda* by Frederick Delius, *Slow Movement from the Guitar concerto in D* by Antonio Vivaldi, *Le Jardin Ferique* from Mother Goose by Maurice Ravel.

In general, interviewees use a variety of music genres and they seem to have their own list of RM and their own musical preferences. Choice of music genre may depend on the practitioner's musical background. In the case of the music therapy group, they were generally interested in the GIM course and since GIM core repertoire is mainly classical it may encourage the choice of classical music in their work. The music they choose may be the music they encountered through training or their own preferences.

The musical preferences of clients may not always be an overriding factor. It may not always be the case for all clients, but some clients at least who are unfamiliar with classical music may nevertheless experience feelings of relaxation through listening to classical music. Other typical types of music may also lead to relaxation depending on the situation. There are links also between music preference and cultural factors and this will be discussed further in Chapter 8.

4.2.4 Musical and Sound Instruments

A variety of musical and sound instruments for RTs, meditation and RM were mentioned. Some of the interviewees explained why they use a particular instrument; Olivia uses the small Tibetan bowls in classroom settings when a child needs calming

and in this way she can easily bring the children into state of calmness and it helps them focus on their work more:

It's a lovely tool. [...] A Tibetan bowl will have maybe different musical tones in it, some of which are very close together, and this causes like a low beat frequency - and because of the frequency, the brain wants to match that. And so the brainwave has to slow down to match it. It's what I would call entrainment (Olivia-UK).

However, several participants (Lily, Rosie, Edward, John) emphasised that practitioners need to consider the client's limitations such as physical handicaps, mobility, motor skills, mental conditions, age and client preferences, when they choose instruments. For example, for young people and workers, activities using percussion and drums are often a great way for them to release stress using their gross motor skills (Rosie, Lily) and if the session time is over 30 minutes, Lily uses a mixture of the two types of instruments together, requiring fine motor or gross motor skills alternately.

For work involving fine motor skills, Rosie recommended egg shakers, wind chimes, ocean drums and such like. For activities involving gross motor skills, instruments such as a drum are desirable. However, for hospice activities, musical instruments should be easy to hold and play and consideration needs to be given to this. Compared to the criteria for choice of music for listening, physical mobility or limitations are always of concern when they choose instruments for clients to play for the purpose of relaxation:

The body tambura is used in hospice settings for relaxation because it has a beautiful calming sound and is not too big or heavy (Edward-UK).

Interestingly, John makes the point that, when he chooses the instrument, he focuses more on the client's health, emotional, psychological, physical conditions and energetic states rather than client preferences. He emphasised the practitioner's

intuition concerning the need of the client at that moment. For example, in live sessions, many instruments are used either individually or together and during the session practitioners have to be sensitive when choosing instruments depending on the client's conditions and needs:

In order to choose the right instruments and the right sounds to work on that vibrational level, then that's often intuitive choice. That's about being very present and aware in the moment. It's almost like a spiritual practice in itself, whereby we as the practitioner, we need to let go of our own ego, of our own self and allow for a real connection to be present between us and our client (John-UK).

John and Olivia said sound (in particularly Tibetan bowls, crystal bowls) can be played live with a full spectrum of frequencies and resonance so the effect of sound is more 'available' (stronger and more direct) and practitioner and client can both share the benefits from the sound experience too.

In general, very much like with music genre, interviewees use a variety of instruments depending on the practitioner's personal background and personal experience. Some were used in individual sessions, some in group sessions and others in both. Most interviewees have some of knowledge of RTs and some prefer to include music instruments in their relaxation sessions. The music therapy group uses many kinds of instruments depending on the clients' situation and the other groups use a more limited range for their own purposes during sessions. Many of the instruments listed above are clearly appropriate for active relaxation interventions, such as releasing pent-up stress. But the particular instruments that were discussed (body tambura, Tibetan bowls and crystal bowls) are examples of instruments with subtler and softer tones that might be used within a more receptive approach, such as for the purposes of entrainment and mental calming.

4.2.5 Receptive and Active Approaches

Different ways of making clients relaxed through receptive and active approaches were discussed. As regards the receptive approaches, Lily said, depending on physical health, type of illness and psychological condition, receptive methods can be more appropriate and useful for certain clients. For instance, for elderly people or clients whose physical mobility is restricted, receptive methods achieve better results than active music therapy methods.

However, when using receptive approaches Edward emphasised that practitioners should consider the situation and client's personality and degree of openness, their acceptance or resistance, since these can affect the success of receptive practices.

For example, Edward said in mental health settings or with younger people, especially if they are traumatised, there might be a lot of resistance to calming down and they may feel scared to slow down and to quieten down, so he found that using active music therapy techniques as well as active meditational techniques, like walking meditation more effective for them.

Several practitioners mentioned that active music therapy can make some people become calmer because they can vent a lot of energy through playing musical instruments, and shouting and singing, and hitting drums and playing pianos (Lily, Rosie, John, Olivia). At the same time, active music therapy may help promote self-confidence. The effect of active approaches in various settings was discussed. In mental health settings, active music activities can reduce agitation levels (and the effects of psychosis) by giving clients an outlet and an opportunity to express themselves through playing music. Edward said "Clients can go from a state of great agitation to one of comparative relaxation" through the active music therapy activities.

Olivia found that active music therapy could relax clients because it can create a point of focus, especially in children who are quite scattered or isolated, when they get fixed on one thing. Therefore, by keeping people active and keeping things moving through active music therapy techniques, some clients feel safe and relaxed.

Interviewees used many types of active techniques for their relaxation sessions as well as receptive methods in many settings and they are open to the both active and receptive approaches when they use RM.

In terms of using both receptive and active approaches together, John found that these can work together depending on the situation, the groups and workshop type. For instance, if the workshop is more than four hours, he may use active techniques first, and then receptive later or vice versa. He says this can make the mind more relaxed.

Jessica said she personally feels that students have different concentration levels and some lack powers of concentration. She talked about how receptive music affects concentration in school settings:

In my experience, music can make them concentrate more on their study. It is not exactly therapy but it is a kind of role of music for Korean students. I focus in my therapy on how concentration can be increased when using music. Students often say music (when they like it) can help their concentration, especially during the late evening study periods in school. Some say when they start the study, even though they are not actively listening to the music, music just erases the other noise from the class, so music through earphones is helpful for their study. Also during the evening school time they really need to rest during the break time, so stopping studying and just listening to their favourites songs can be a real break time for them. However, some students don't feel that music can help while they are studying. So personally I think the effect of music on concentration (for the student) rather depends on the individual (Jessica-Korea).

Korean practitioners are frequently engaged in education and schooling itself (in order to promote learning, for example). It may not be the same situation for practitioners in

UK schools, even though they may employ music for other therapeutic reasons. Consequently both cultural factors and individual differences have a bearing on the use of music and whether receptive or active techniques are chosen.

To conclude, this chapter has explored interviewees' understanding of the use of music in different healthcare settings. In general, participants have different aims and approaches with respect to music depending on their specialism. During the analysis, the receptive and active uses of music, and practitioners' criteria for their choice of music and instruments were discussed and many genres of relaxation music and relevant musical characteristics were identified. Even though practitioners have different approaches and specialisms, firstly they highlight that when they use music, they consider the client's individual differences and subjective factors and what do they do to make these client-centered. The interviewees are sensitive to individual needs and they understand how the knowledge of a client affects the session and why assessment of clients is important. Secondly, they are all interested in the link between the use of music for the client's health and they seem to recognise the benefit of music for people's well-being in many ways.

4.3 Music, Health and Well-being

The interviewees described in detail how they view music in health contexts. The main points discussed were: the practitioners' personal motivations for using music in health and how the practitioners perceive the value and benefits of music and employ music for people's health and well-being.

4.3.1 Personal Motivations in Using Music in Health

The interviewees' personal motivations to engage music in health were varied and they used music for different purposes relative to their professional backgrounds. Across

the professional groups, the medical professional participants expressed similar motivations and interests and they were clearly open to using music in a range of health and well-being contexts. Their motivations arose from seeing their patients suffering from physical and psychological stress and the ways in which this affected their health. As such, they had developed an interest in relaxation interventions for stress management and emotional care.

In this group, personal 'inner motivation' was the driving force behind employing music and RTs in hospital settings. Jacob showed how he is interested in spiritual medicine and has become convinced by RTs, MM and RM.

I realised that to find inner happiness is much more important, rather than outer achievement or success as a specialist in medicine (Jacob-Korea).

These convictions have influenced his career over a long period and he runs relaxation programmes combined with music for patients and other medical staff once or twice every week for 30 minutes.

Georgia uses music as an intervention with clients suffering emotional difficulty. A relaxation programme that she attended helped her develop a new awareness of emotional control and how to cope with emotional difficulties. For Georgia, such a programme broadens the scope and focuses not only on medical and physical care but also *emotional care* (See Glossary) for patients. In particular, she showed her enthusiasm for selecting appropriate music and she has created a CD for her relaxation programme with patients. When she talked about the music and her CD she was particularly animated, smiling a lot. Clearly she took pride in the CD and enjoyed using the music.

Overall, during the interview process I was under the impression that all the medical interviewees proceed from their personal interest in music and they seemed to value the part of music in their relaxation sessions. For example, in Jacob's office there were many sizes of Tibetan bells and *tingshas* (See Glossary) that I did not expect to see inside a hospital. A collector of bells, he showed me them to and then played them. I felt peaceful because he was playing the bells very calmly and with joy. This experience may not represent the general attitude of other medical professionals either in the UK or Korea but it shows how someone's personal engagement and interest can have wider significance for the professional work they do.

One of the medical professional interviewees expressed a particular interest in the connection between CAM and music:

My interest in relaxation music comes from my interest in complementary therapies and from my professional life. [...] It's hard to separate them out and when I practice complementary therapies I always incorporate music and some sort of relaxation session (Violet-UK).

Violet's case highlights an example of combining complementary therapies with RM and RTs and she uses these in nurse teaching as well as her personal life.

The relationship between music and human health has been a constant focus in music therapy and was a concern of the music therapy interviewees. The music therapy interviewees expressed a similar interest which was identifying music sources or activities based on EBP, even if they approached music therapy in different ways.

For example, Edward tries to measure and document the effects of music therapy in hospices in order to gather evidence, and here he explains in some detail what he is doing in his work:

For my own work, I am gathering evidence regarding the effect of listening to 10 minutes of Tambura music. I ask patients to rate their distress level out of a max 10, before and after the music, and then 1 hour later. I have gathered 35 readings to date, which indicate that the average level of distress beforehand is 7/10. After 10 minutes this reduces to 2/10. Statistically this data is 99.99% significant. Also, 1 hour later, many people are still at a very low level of distress. In terms of qualitative signs that patients have relaxed, you can look for the breathing rate, which tends to decrease in someone who is deeply relaxed. They also breathe more regularly and more into the deep belly. Muscle tension decreases and sometimes people also shift the position and angle of their head as they relax more (Edward-UK).

The *body tambura* (See Glossary) is an instrument used in receptive music therapy. Edward showed and played the tambura to me and let me try it. Edward explained that it can be helpful in reducing anxiety, distress and fear. Clearly Edward is interested in gathering and accumulating evidence and is committed to an EBP approach. As he points out, the evidence he has relating to stress reduction is impressive (even if the sample is not necessarily representative across a wider population). The desire to gather ratings and evaluation of data and methods is an interesting trend among practitioners in both UK and Korea. The use of RTs and music needs to be evaluated and guided by evidence of its own effectiveness within the context of the treatment situation, I would argue, and in this respect, Edward shows his own approach to EBP. Similarly, Edward and Rosie are interested in using music in hospital settings, and they also work in hospices and cancer wards. They conduct relaxation sessions in conjunction with music therapy activities:

I am working in a hospice and palliative hospital and one of my interests is how to use music activities in order to relax them (Rosie-Korea).

In the hospice environment, I use a modification of relaxation method - a very small container - like a water-downed version - so a short relaxation - one bit of music, with a little bit of talking at the end. So it's a much smaller profile - much shallower. Otherwise it can be too deep, if someone is physically unwell, or

they're near dying - it's too vulnerable to go into deep heavy emotions (Edward-UK).

Besides this, all the music therapy interviewees showed considerable interest in GIM and one said:

In my opinion, in South Korea, music therapists who want to study about relaxation techniques in association with music look towards GIM or MI training courses. [...] I think many music therapists prefer these programmes and hope to complete the training because we think it relies on EBP (Lily-Korea)

Both Lily and Edward mentioned that, even though there are limited places on the GIM courses and strict entry criteria, there is growing interest in joining these programmes among music therapists:

Well, the GIM training is a very good training - in how to combine relaxation techniques with music. That's what you learn - you learn how to do an induction - which is a relaxation technique, you learn how to choose a bit of music to suit someone, but it's a long training - it takes three years minimum to train in the GIM method, and there is training available in many places (Olivia-UK).

Olivia, a music therapist, discussed the combined use of sound and music in her current work:

After reading a lot about resonance and the effect of sound - I understand that all of creation is, in some sense, music-related. It's as if the human body is designed to respond to sound and resonance. [...] Sound can transcend cultural barriers - there is not necessarily an emotional effect or associative connections or preferences to be considered. It can offer more of a blank canvas. Sound sources such as Tibet bowls and crystal singing bowls can be played 'live' and therefore the full spectrum of frequencies is available to client and therapist. I believe that even sounds we can't consciously perceive do affect us (Olivia-UK).

Here Olivia is suggesting that there is something universal, objective, and not culturally bound that sound accesses, even if our current state of knowledge is incomplete. Through her training courses in both music therapy and sound healing she has come to believe in the therapeutic effects of sound as well as music on people. To

my mind, when it comes to working with music and sounds therapy, evidence is necessary and the evidence base is growing. Recognised evidence is especially important for practitioners working within the medical profession, with medical doctors and with the hospital. There is already an accepted evidence base for music and instruments being effective in therapy for certain kinds of conditions, or medical problems and acceptance of music therapy in public settings in hospitals and with the medical profession is more general. Sound healing is more controversial even though evidence exists of its effectiveness. Sound therapists are also aware of the importance of EBP with regard to sound healing but, since they often operate outside of mainstream medical healthcare and academia, face practical difficulties such as obtaining financial support for scientific experimentation with sounds. However, sound therapists are aware the need for EBP and bringing their own profession in line with music therapy.

In the meditation expert group, Adam said he considered for a long time how to develop meditation skills for people in combination with other treatments or tools and it was the start of his becoming interested in different kinds of relaxation music and art.

As a professor in a meditation department, Adam is interested in combined approaches in University settings and he emphasised that in order to develop both meditation and music across the two departments, (meditation and music therapy), exploring the combination of meditational skills and relaxation music together is highly desirable.

Another meditation expert said that her motivation for using music comes from the personal impact it has had at particular critical moments, so it feeds into her work, where she uses music as a support in her meditation sessions:

Around 12 years ago, I was invited to a music concert and for the first time I was strongly impressed by the ‘power of music’. I had never felt like this before and it was a strong motivation for me and I wanted to combine music into my area of work (Anna-UK).

John, who studied meditation and sound therapy, said he is interested in combining sound with guided meditation for relaxation. He emphasised the link between clients’ intentions for self-healing and the use of meditation and music:

When people are more relaxed, they’re also more open to working and activating the power of their intention. And activating the clients’ intentions for self-healing, or for therapy is as important as the music and sound itself. And so I do the relaxation session with this intention-setting process - and it’s a kind of guided meditation as well - so it’s a whole kind of package that’s there [...] (John-UK).

Many participants talk about ‘combining’ and bringing together different approaches. John said this ‘kind of package’ is based on research as well as his own experience. What comes across here is John’s perception that his work should be about both scientific evidence and personal practice.

Across these motivations, specific themes can be identified. Participants spoke of the personal ways in which they used RTs, MM and RM in their own lives, but as well as in their personal life, RTs, MM and RM are used professionally in various ways. The desire to gather evidence and to base their work on evidence is itself a motivation. Beyond this, they are continuously exploring other area of treatments beyond their major specialisms, recognising not only the value of alternative approaches, but the combination of approaches. This combination of approaches and collaborative work are commonly discussed, which shows that professional boundaries are not fixed and that this is a means of innovation. Indeed, some degree of branching out is important to show wider professional engagement.

Unlike many colleagues within the same specialism, most of these practitioners are interested in working beyond their boundaries, and this is what triggered the use of music in their work. In this way the specialists step beyond their particular specialism and thus gain a new perspective on it. In collaboration work, practitioners usually meet other specialist professionals who have a different educational background and terminology. Therefore, in order to develop rapport and bridges between each other, an understanding beyond their own professional boundary is necessary although it may be a constant challenge. However, through those challenges, constructive and collaborative approaches will be achieved, finally creating an expanding toolkit to bring to the service of their clients as well as service providers. In Chapter 8, I will discuss more about the potential benefits of collaborative relationships and transdisciplinarity in research.

4.3.2 Use of Music in Health Contexts

Coming now to the topics of how practitioners use music for people's health and well-being and how practitioners perceive the value and benefits of music for health, the following uses of music were identified:

- as a nursing intervention for emotional care (Georgia, Violet)
- as a music intervention in hospital (Jacob, Lily, Rosie, Edward)
- as a relaxation intervention for their relaxation programmes (Isabel, Anna, Olivia)
- as an intervention for self-help techniques (Lily, Jacob)
- as a combined intervention with music and complementary and alternative medicines for nursing education (Georgia, Violet, Jacob)
- as background music for psychotherapy (Isabel)
- as a combined intervention with music and meditation (Adam, John, Anna)

Several practitioners highlighted the power of music for sick people and how music has a special meaning and value for their sick clients:

I really believe in the power of music. When people suddenly become sick, the feeling they get from music is quite different (Edward-UK).

Music therapy has been shown to be ‘well suited and applicable to hospice settings’ (Teut et al., 2014) and the interviewees who work in hospital settings use relaxation sessions in conjunction with music therapy activities. For instance, Rosie tries to help hospice patients relax through respiratory stability and she also tries to help them relax using music. She uses musical activities together with breathing skills and this is one of the relaxation methods in her sessions. She said listening to a song or singing, (both of which induce relaxation), and using the rhythm of the music or guided breathing skills, often helps the patient to breathe steadily. Rosie added that from her own experience in hospices, in order to receive these beneficial effects from music, it is better for the patient to choose their own music:

When I play the music which a client prefers, this music can make a client calm much faster and it leads to stable relaxed breathing which can address the respiration problem and I can check it by using the stopwatch (Rosie-Korea).

Olivia talked about her work with patients with Parkinson’s disease in collaboration with the speech and language therapy team. She uses a variety of music with RTs, such as guided visualisation and body awareness:

They often are almost at war with their bodies, because they feel their bodies are letting them down - they’ve got this trajectory of the condition which will make things more difficult (Olivia-UK).

Olivia works in order to strengthen their voices and give them a sense of well-being:

I run a group for people with Parkinsons [...] and maybe who have other neurological problems which have affected their voice. We do voice exercises and sing-songs and also have a sharing time. [...] I use some of techniques for guided visualisation, relaxation, breathing exercise. [...] When I use calming music, I might focus on much more on the breaths and really on a more inner process - coming into themselves and feeling the quality of the breath going through the

body and focusing on the body in a positive way and giving it a bit of love if you like (Olivia-UK).

Currently many healthcare service providers, particularly in hospitals, ask music therapists to show scientific evidence. Therefore, some music therapists are concerned about how to match hospital organisations' requirements with their work. However, the need for evidence is not only due to outside pressure, but because practitioners too think it is important to find a basis in evidence before they use a technique. Practitioners themselves therefore are constantly concerned about and engaged in scientific testing for music therapy. Several interviewees said they feel keeping abreast of the latest thinking including reading journals is important:

Evidence-based practice is seen as important and gathering evidence for large scale studies is a continual challenge. [...] It is not quite like in medicine where drug trials are essential before licensing a drug. However, research and evidence is an important factor for our music therapists (Olivia-UK).

In fact, large numbers of music therapists are currently engaged in gathering evidence in order to address the needs to promote evidence-based practice. However, finding and providing evidence in terms of using music therapy is still a challenging thing, as will be discussed.

The music therapy group is practically interested in how to reduce the perception of pain through music and in the 'pain pathway' which means how pain signals travel through the body. The 'Gate control theory of pain' (See Chapter 2.6.2) is broadly accepted by therapists and has been widely explored (Wheeler, 2015):

When I work in hospitals, they would want to show the evidence for my practice. For me, gate control theory is the rationale of my music therapy and I firmly believe music therapy is evidence-based practice (Rosie-Korea).

Similarly Lily has this theory in mind when talking about pain management:

Music for relaxation is very meaningful and worthwhile because by singing together or listening to music (when they really like it) they can sometimes forget their pain (Lily-Korea).

Through the accounts of interviewees, music can be seen to be influential in affecting the processing information with regard to pain and music is involved in the regulation of pain. Lily recommends patients use music as part of their self-help techniques:

I would like to give an opportunity for patients to use music when they return to their ward (after the session) or when they are discharged from the hospital (Lily-Korea).

Music can change people's moods in a special way and music can also bring a pleasurable experience and sometimes happiness and a positive frame of mind, which is source of well-being. Therefore, music can support emotional care in patients who are undergoing or recovering from medical procedures. In this way listening to music and/or relaxation skills can be regarded as a kind of self-help technique and so patients can simply be advised to listen when they are by themselves and given guidance in doing so. As a self-help technique, Lily uses the PRT along with music therapy. And she said by showing them the relaxation methods, clients will remember the relaxed state of body and mind. The PRT with suitable music is a way to make a client feel relaxed and clients can practise relaxation exercises when they go back home:

So sometimes I ask to my clients to focus on the feeling of tension and I induce tension deliberately during the relaxation session. The reason is that if client remembers the feeling of tension, they can easily appreciate what is happening to their body and mind such as "I feel the tension now", "I've got stress" so they immediately look for ways to experience a relaxed state and try to make themselves relaxed. [...] I try to give many chances to my clients to get more experiences of the feeling of being relaxed. [...] These experiences may give patients the motivation and will to continue to have experiences of relaxation themselves in their daily lives (Lily-Korea).

Several interviewees talked about family care for patients and one was particularly engaged in family care in her music therapy practice. Rosie emphasised the importance of family care thus:

Over time my concern has focused particularly on the patient's family and emotional care for them (Rosie-Korea).

Rosie said when she runs music therapy with the hospice she shares what she does with the family and invites family members along to a session (See Appendix 11-Reflections following interviews).

She often conducts relaxation sessions with many kinds of musical instruments, such as egg shakers, wood blocks and choir chimes, and when using RTs for imagination (such as imagining the sea) she employs wind chimes or ocean drums. This is individualised in relation to client needs and sometimes she gives egg shakers to family members too.

After the interview, she invited me to sessions with families and I was able to join all her afternoon sessions on that day. Below is from my reflective notes:

There was a young daughter in her twenties together with her dying mother. The planned purpose of the music therapy was not only for the client, but for the daughter to benefit from the therapy too. The therapist asked the client what she would like to listen to, but the patient was not in a state to answer. The daughter said that her mother would like a gospel song. The music therapist played guitar and sang 'Amazing Grace' and the patient started to cry a lot. The daughter started to cry together with her and daughter and mother held hands. The daughter started to sing along and after a while the mother opened her mouth and very faintly started to sing too.

I felt it was a healing experience for the daughter and possibly in some way for the mother too. Especially when a doctor gives up medical treatment, there is a limit to what can be done and the patient's family stress may increase. They may be depressed

and frustrated observing the dying of a loved one. Music used in this way can help redress these feelings.

In fact, in the case of hospice patients, a 24-hour day is much more precious than for normal healthy people. The same goes for their families. So just 15 or 20 minutes of music therapy may equate to a much longer time spent with healthy people. Medical care is very oriented around physical care and it is difficult to find space for emotional care in hospital and, particularly in the case of long-term hospitalisation, this emotional care is needed. Therefore if they receive warm-heartedness and mental comfort from these sessions, it can be of great significance for a patient at the end of their life as well as their family who may need emotional support and are distraught because medical treatment has come to an end.

Not only the music therapy group but also the other practitioners use music for health and well-being. Some practitioners discussed how they use music combined with CAM and/or for nursing:

I think music is a non-pharmacological treatment so it is safe compared to the pharmacological treatment. [...] My nurse colleagues often use it for depression, or with cancer patients (Georgia-Korea).

Some interviewees consider that music alone or together with relaxation sessions are suitable nursing interventions and it can help improve the quality of life of the trainee nurses themselves as well as the clients:

In the creative session for nursing I play music while students are doing the activity. I find this helps to keep them on task. We ask them to do it in silence, the music fills a space. I also use music with relaxation techniques in a variety of sessions. I might be teaching students to help mothers relax, or for use during antenatal classes or I might use music and relaxation exercises in other sessions if I feel students are very stressed or anxious (Violet-UK).

Much research has already been conducted into the use of music in fields such as advanced nursing, hospice and palliative medicine. Chapter 2 has discussed how music can be applied using an organised approach in nursing as well as in general healthcare settings.

Isabel uses music before starting her session (while the patients enter the therapy room and look for their chair wondering what they have to do). She plays music in the background or as an ice-breaker in order to make them feel comfortable, so it helps them start talking easily to each other. She said most of her clients suffer from depression and anxiety disorders and they find it hard to start talking, even just simple conversation such as 'Hi', 'Good afternoon' or talking about their own feelings. However, when she plays music she finds that clients become calm and relaxed and they more readily talk about what happened last week or about their feelings today. This is one of the ways she uses the music in her psychotherapy.

To conclude, even though practitioners have different aims and specialisms, they all agree that music helps people feel more relaxed as well as making them feel positive and lifting their mood. Some differences between the uses of music in health among the three groups were identified. For the music therapy group music is the primary tool of treatment. Their planning, preparation and consideration of music quality is evident. The other two groups tend to use music as a background to their main work and practicalities are important when they want to use music. For example, one showed me a small CD portable player which he uses in session because it is easy to carry and also said he personally likes small Tibetan bells for the same reason and because the sound is deep. So they are more concerned about portability and other practicalities when they use music. However, even though interviewees have different outlooks as

regards using music they share the common attitude that music has health benefits for patients as well as for the practitioner themselves.

4.4 Qualities and Abilities of the Practitioners

The qualities and abilities of the practitioner and how to cater for the individual were highlighted by interviewees, and practitioners' maturity, intuition, flexibility, level of competency and range of qualifications were discussed. This section will look at the key aspects which emerged from data analysis: what the interviewees understand to be the personal qualities and abilities of practitioners, their level of competency, qualifications and relevant training.

4.4.1 Personal Qualities and Abilities of the Practitioners

Both inner qualities and skills acquired through training were considered by practitioners. The value of qualifications was widely recognised. However, several participants focused on practitioners' personal qualities and they felt these are the basic requirement of a therapist. In terms of inner qualities, the words *intuition*, *maturity*, *insight* and *flexibility* were frequently mentioned. These words may, of course, have different personal meanings to different practitioners.

Just as important as the professional qualifications themselves, or everyday practical preparations for the session, the practitioner's mind-set also plays a key role in the meeting with client and this can easily be overlooked. Making time to relax was also an issue referred to.

Lily said music therapists are particularly concerned about enhancing the quality of their musical skills and it may be difficult for them to find time to think about the inner quality of themselves as practitioners. As in many professions, maturity is necessary

when working with clients as well as collaboration work with other professional experts:

Mature means two things. One is the ability to use musical skills with clients, the other is the inner quality of the therapist. So many times I've seen practitioners who have wonderful musical abilities but have not matured inside, so during the session the personal feelings of the therapist are transferred to the client, so there is transference from the therapist to the client and we need to think about the counter-transference aspect too. In my opinion, therapists must heal themselves and have a healthy mind (Lily-Korea).

The notions of *empathy* and *empty mind* were mentioned by one interviewee:

Work with empathy and an empty mind and try to understand and accept what they are now. Work with your open heart is important (Rosie-Korea).

In this context, 'empty mind' means the same as 'letting go'. There is a famous old Zen story called *Emptying Your Cup*. The point is that if we are full of our own ideas, like a full of cup of tea, it is difficult to receive other things. And if our mind or thoughts are in the state of an empty cup, this may permit real connection with other people. So this story tells us to 'let go' and develop 'non-attachment to our own ideas', which is a core of Zen meditation.

Rosie said many times that she felt difficulty doing music therapy and she learned empathy and an empty mind through her sessions and her clients, in particular the international workers referred to above. She said if she had not had an empathetic mind and understanding of their situation, she felt it might have been difficult to continue the sessions every week and so this mind-set helped to sustain her work.

Most clients, especially elderly and sick people in hospital, feel lonely so just being with them may relax them. So if the therapist works purely out of duty because they have a job to do, but without compassion, empathy and understanding, it may be hard to interconnect and form a rapport with a client and that may affect the achievement

of their therapeutic goal during a session. Hence, the personality of the therapist and hidden factors within their practice need to be considered and this was also emphasised in the participants' accounts.

One interviewee said creating a comfortable atmosphere for the client is one of the abilities of the therapist:

When someone first attends a clinical session, at the beginning they are generally very tense and wonder what it is all about. So a therapist needs to create a comfortable atmosphere before actually starting. At that time we can turn on peaceful music, for example, to have in the background (Lily-Korea).

Here, she uses simple peaceful music as a background; other techniques too, such as three or five deep breaths just before starting the session, will make a client feel relaxed and this will help the main session run smoothly and make the client comfortable.

Some interviewees referred to the benefits of practitioners' first-hand experience and practitioners' own experience as being necessary prior to practice:

Before applying relaxation techniques with clients, you should have a wide experience of using relaxation yourself. Therapists should try to enrich their own experience of relaxation in order to think about the techniques that they can use in practice. Therapists who practice themselves will be able to share much more with the patient. It will make the quality of their sessions better (Jessica-Korea).

Other types of qualities, including the flexibility and imaginativeness of the therapists, emerged from participants' accounts:

I hope that the practitioner would have their own perspective regarding relaxation skills and music in order to find what is the client's problem and what might be the most appropriate approach for them. In a session, if the practitioner is overly attached to the plan they have prepared, sometimes many mistakes occur (Adam-Korea).

Likewise, Rosie mentioned working with flexibility rather than the rigidity of a set plan of order:

Don't get too fixed on your therapy plan. If the practitioner only sticks to the plan they prepare, the session can be ruined. Flexibility is important. Don't be so attached or obsessed by the results of the therapy or the session plan which you have (Rosie-Korea).

In planning the session practitioners try to match the appropriate treatment at the right time to clients and often practitioners need to change their original plan and have to use an alternative therapy plan during the session. A therapist's flexibility and spontaneity is an important quality. For example, if a therapist has much clinical experience and has run many sessions, then the therapist may have developed spontaneity or flexibility. Also flexibility may relate to the practitioners' musical skills. For example, if the music therapist has highly developed musical skills or talents, they can adapt music to suit a client's preferences and create a variety of rhythms and beats. Thus a practitioner's flexibility and spontaneity may be considered in various ways. Flexibility and spontaneity also depend on planning and the availability of alternative plans. Currently, many music therapists are trying to compile lists of 'models of treatment' and it may be worth building in optional treatment types, alternatives and combinations for practitioners and trainees.

Next, as I discussed in the previous section, catering for and adapting to the individual is one of the major sub-themes in the interview data. And interviewees reported using different types of RTs and RM depending on the illness or client's physiological condition and their emotional and energetic states.

The interviewees frequently alluded to the ability of the practitioner to cater for the individual. Practitioners' resources for catering for individuals may be seen to include qualifications, interventions training, workshop programmes, and their own personal experience among other things.

Several interviewees emphasised their own intuition itself as being an important resource. Edward said that he needs to possess intuition to see the client's immediate needs:

If intuition is considered to be a combination of learnt knowledge and experiential knowledge together with observing and listening to the client on the day, then intuition informs me the most (Edward-UK).

John said that when a practitioner's intuition comes into play, it may not be based on scientific evidence or expert knowledge or skills and in his case intuition arises when he trusts something in his own heart as a practitioner. For example, the choice of instruments or music is made on the basis of the client's situation and everything can be tailored to that person but he often needs to use his own intuition:

In order to choose the right instruments and the right sounds to work on that vibrational level, then that's often an intuitive choice. It's almost like a spiritual practice in itself (John-UK).

In fact, during a session, often a practitioner is very sensitive to the needs of the client in the moment. This emphasises the importance of being present and aware at that moment. I would call this 'the mindful moments' and 'the moment of interconnectedness' between client and practitioner.

Sometimes practitioners need to let go of their own ego, of their own self and allow for a real connection to be present. Those present awareness moments and connections between practitioner and client may well be very special moments. It is hard to explain when we need our intuition or to write session plans which include intuition but practitioners' intuition is certainly needed at some point in the session.

The practitioners' cross-cultural communication skills in the context of an increasingly multicultural society was discussed. Adam often mentioned cultural factors and the multicultural society:

We can think about this in many ways. We can think about a society of many countries coming together, so we need to understand the variety of cultures and accept a variety of therapeutic approaches. That means we may need to use a mixture of therapeutic tools and we need to think widely about resources of meditation and music too (Adam-Korea).

Understanding the cultural differences and people's personalities are also among practitioner's abilities:

Currently we have accepted a PhD student from America who would like to learn Eastern meditation. He has a problem adapting to the Asian way of learning and relationship with people. Studying meditation and the traditional way of practising Zen meditation feels strict to him and he cannot keep up with the course. So we have recommended mandala drawing meditation classes to him. Now rather than attending the 2 hours sitting meditation class, he very much enjoys the mandala drawing class. So when we use a relaxation method, some people (through music or through drawing or meditation or a mixture of these) feel more happy and depending on the person different approaches are needed. Therefore practitioners need to have the ability to see what they need and how to adapt to the individual (Adam-Korea).

This section has discussed interviewees' feelings about the inner qualities of practitioners and the ability of the practitioner to cater for the individual. The interviewees were generally concerned about how they can approach their sessions in a more client-centered way and how to adapt to the individual and how to take into account client states such as physical mobility, physical handicaps and limitations. Interviewees consider such client-centered practice is related to the ability and (inner) resources of the practitioner.

Many studies have examined improvements in clients' abilities through various approaches but here interviewees' accounts redress a balance by focusing on

practitioners' own inner personal qualities and pointing out the necessity of personal development as a practitioner. These are often ignored due to pressures of work. However, those qualities certainly improve professional work and will impact on a client's health and progress too.

4.4.2 Level of Competency and Abilities of the Practitioners

During the data collection, the connection between the depth of relaxation sessions and the abilities of the therapist was identified as one of the major concerns by the interviewees. Lily said there are various music therapy approaches using receptive techniques and practitioner needs to recognise their level of proficiency and how to use a technique in a deeper or simpler way:

In some cases, depending on the therapeutic purpose, we may take a psychological approach. Then receptive techniques are more needed and sometimes we need to go deeper in terms of the level of relaxation. If the practitioner lacks experience in this area, the client may lose faith in the therapist. This kind of thing often happens in therapy sessions. It would be better than to use simpler techniques (Lily-Korea).

Sometimes interviewees described a session with a client in connection with how deep a practitioner goes and they think about how they work at their levels of comfort in terms of differing depths of RTs (sometimes in conjunction with RM):

I very often work with children who are quite scattered or isolated - they get fixed on one thing, or they're seeking stimulation in some way. And music is providing some kind of a structure, like a container. And if they're a bit agitated, you need to match that in the music somehow and help them to express it in a more structured way. For example, in working with many complex autistic children, I feel I now adapt my improvised music in a simpler way and include times where students may lie down with a blanket and simply listen to gentle improvised music (Olivia-UK).

She perceives the value of knowledge of breathing techniques and meditation in her work but she feels that those techniques would be more appropriate in a modified form

and she uses a combination of music and breathing skills in a very simple way in order to reduce her clients' hyper-aroused state:

Many of my clients suffer high anxiety levels (including people with autism). I tried to help to them to reduce their levels of cortisol by slowing down their breathing. I used very slow tempo music and simple breathing skills as part of this process (Olivia-UK).

The practitioner's level of competency was also mentioned in relation to their limitations in terms of practice. Some of the meditation and medical interviewees said they see the value of using music in their relaxation sessions but lack professional knowledge of music so they use music only as background. Likewise one interviewee said she did not have a broad experience of meditation or RTs and so when she runs relaxation sessions, if she feels a deeper sense of relaxation is needed for clients, sometimes she is unable to cope with this demand and she often wonders if she should use receptive techniques in any way at all and, if so, how she can guide clients into a state of deep relaxation.

Adam said the practitioner needs to recognise that clients differ in the level of meditation skills that they need. When practitioners have to choose between simple and advanced meditation methods, they must consider the client's difference in experience of meditation and familiarity with these techniques and take into account the client's preferences. So deeper levels of RTs need to be approached with caution, depending on the person and this judgment may be considered a first step when practitioners combine meditation skills with music.

In relation to this, Lily said in her experience caution is needed when the trainee uses RTs. An experienced therapist may be able to hold or contain the client's emotional

feelings during the session, but a trainee therapist may not, so using other music activities is safer:

One time when I attended a session as a supervisor a trainee, who had seen me work before, tried using the same technique, but when the client revealed her trauma, the trainee was at a loss to know what to do. So when I followed up the session with the trainee, I advised the trainee not to use these techniques before becoming more experienced (Lily-Korea).

In fact, when discussing the depth of receptive methods used together with music, the music therapy group interviewees often talked about GIM and they were concerned about the quality of therapist and levels of practice.

You can take someone deeper and further into their subconscious in a one-to-one session but special training and experience are needed (e.g., GIM Level 3 and above). [...] GIM training is quite good for people relatively healthy psychologically - with quite a good ego strength - that are able to work with thirty minutes of music - classical music - some of which can be quite strong. And that can be very good in other contexts. I often use a modification of that method - a very small container- and that's a way of keeping safe (Edward-UK).

Edward described how he uses GIM techniques in a simple way:

20 minutes of talking to tune in to the client and see whether I feel music and imagery may help them. If so, 10 minutes of guided relaxation. 10 minutes of music (may be a little more for a psychologically strong client) and then 20 minutes of processing at the end and talking things through (Edward-UK).

Currently many practitioners use different levels of breathing techniques combined with music and Adam emphasised the practitioner's abilities to adapt and modify techniques:

I think we need to find some skills which can easily be accessible and if practitioners can find ways to simplify the methods and they can be used for healing, it will very useful to reduce stress for busy modern people as well as patients (Adam-Korea).

Several interviewees agreed that they prefer to use RTs in a simplified way rather than the more authentic and deeper level of techniques. In this context, ‘a simplified way’ means several things including ‘a familiar way’. For example, combining music with RTs, Adam said he uses music which is familiar to him because it gives him a feeling of comfort in his work:

The combination of music with my work is not the conventional way and I don’t have much knowledge of the music but I am familiar with Korean meditational music so I often use these kinds of music for my meditation sessions and it seems to help to create a calm mind and uplift people’s spirits (Adam-Korea).

Adam, Jessica, Lily, and Edward all strongly felt that practitioners have to know how deep they go in using RTs and RM. And practitioners need to gain confidence through training courses or clinical experience in order to tailor their use of RTs and RM based on clients’ levels of stress, levels of anxiety, their preferences, interests and energy levels. They claimed that this is safe for the client as well as practitioners:

[...] unless you’re someone who’s done, say, a lot of meditation in the past, or has a lot of personal experience of relaxation, you need to get trained to use music in a receptive way, because it’s a different sort of work to more active music therapy work. So you need to look out for some more training. Like the GIM training level one, which is a very basic week of how to use relaxations, and how to choose some music for groups. There’s quite a few things to know when you’re relaxing someone - to do it well, to do it safely (Edward-UK).

It seems that the interviewees may have their own limitations in using music or RTs because of their different educational background, specialism or degree and type of training. And they suggested that recognising their level of competency and using the intervention according to their abilities may be considered one of a practitioner’s strengths.

In most of the accounts, interviewees emphasised that being a skilled practitioner is the fundamental thing and acquiring skills through training is the way of building their

level of capacity. Therefore, next section will focus on the qualifications referred to by interviewees.

4.4.3 Qualifications and Interventions Training

In the analysis, several interviewees addressed the importance of learnt knowledge from training, qualifications and degree of study in order to become a professional practitioner.

I am teaching the methods of relaxation techniques to my university music therapy master course students and we practice these together in class as well as in clinical settings too. If the student would like to learn more about the relaxation techniques and music personally, they can practice more through outside the regular classes run by outside experts - either private or publicly funded and I encourage this (Lily-Korea).

Here in terms of qualifications, most of the music therapist group talked about the GIM training course:

In Korea, if the music therapist wants to study further about relaxation techniques and receptive techniques, the most popular workshops and training courses are the GIM or MI training courses, many therapists are keen to join this programme. [...] In my opinion, receptive music therapy techniques are widely being developed and still a matter of interest to a lot of music therapists. Also people who are trained in GIM or MI are trying to interact with other therapists and attempt to widely apply receptive methods and acknowledge the clinical value of music and relaxation techniques (Lily-Korea).

In fact, when I went to Korea for the fieldwork, the interviewees recommended I join a GIM level 2 course (as part of their summer programme) and meanwhile my music therapy friends joined the level 1 GIM training course. Even though there are still issues about the entry criteria and limited places on the GIM courses, among music therapists GIM counts as an example of EBP and there is growing interest to join these

courses. GIM is an example of the use of receptive techniques and RTs combined with music in music therapy.

In some accounts, practitioners' voice quality and tone of voice were discussed. Jessica said many trainers lacked the confidence and control to produce a good quality of voice and they often experienced difficulties, for example during guided visualisation and guided relaxation sessions, when they had to use their own voice. So she recommended that practitioners who are interested in voice and receptive techniques, attend training programmes such as vocal psychotherapy:

I attended an interesting training programme in Vocal Psychotherapy and in this workshop, the trainer mainly used vocal methods but also used breathing methods (breathing in and out). Personally, I was very relaxed doing this course and we learnt many things through this programme, so I would like to say it can be useful as a source of relaxation techniques and music (Jessica-Korea).

Vocal Psychotherapy also deals with the use of breathing techniques. After finishing the interview, I looked back at my reflection note about a Vocal Psychotherapy workshop I attended (See Appendix 11 for the complete reflection):

[...] Breathing is a tool to enable you to find your strong points. [...] Someone who has a trauma cannot get in touch with their own true self because of their sickness. They need some power to face and deal with their own trauma. Breathing is a very important tool in preparation for working to cure yourself and breathing can return you to the state that was your true self before you had any trauma.

There are some concerns regarding the use of breathing techniques in connection with trauma and this kind of focus requires caution with clients who have had traumatic experiences. Here, in this workshop, Dian Austin who is vocal psychotherapist uses a breathing method and not only Austin, but many practitioners use breathing techniques in combination with music. For example, Dag Korlin, uses breathing work in his work as GIM primary trainer, and works with people with complex trauma (PTSD, post-

traumatic stress disorder) and other stress-related disorders. He uses his knowledge of meditation in his practice, using music and breathing work too. However, he recommends caution when working with patients who have suffered trauma and a few clients seem to react negatively, or panic, or relive their trauma when asked to perform specific breathing techniques.

The link between collaboration work and practitioners' qualifications was also discussed by interviewees. Rosie talked about how she works together with hospital staff in hospice settings:

There are many things we have to discuss with the hospital staff before starting the session in a hospice. We first check together the hospital charts and we check the patient's personal history, possible adverse reactions, temperature, pulse, breathing rate, physical state of body when tense or relaxed, degree of pain, medical conditions, drug type, treatment they are undergoing, when they underwent surgery, the records of the medical team, the nurse team, the community service team, and the music therapy team, drug prescription history, the reason for ICU admission etc. (Rosie-Korea).

Rosie goes on to say that the most difficult thing about collaboration work was the communication issue because of the different terminology used, especially medical terminology. In fact, these communication problems often occur when two experts from different fields work together and Rosie pointed out that if practitioners have knowledge of basic medical terminology it may be helpful for working in a hospital setting. In a music therapy degree course, trainees typically have to learn medical terminology, psychology and neuroscience. Many trainees take courses in order to increase their knowledge about those areas. However, more specialist knowledge and language knowledge may at times be needed in collaborative work and those who take part need patience and communication skills.

Lily said currently, specially trained professionals are required for hospice settings in Korea so some music therapists have trained for hospice care and they are gaining the necessary qualifications. In fact, there are strict regulations about the qualifications needed for a therapist working in a hospice because of the risks involved. After completing the 16-week training course before starting work in hospice, practitioners can more effectively work together with hospital staff as well as clients.

Lastly, in terms of the link between relaxation programmes in CAM, several interviewees debated about the academic qualifications for CAM, because it is still an issue that many alternative therapists employ various RTs without adequate training and qualifications. However, they said if the CAM is carried out by qualified and well-trained practitioners and it has more EBP, many people will see the benefits of CAM.

Unfortunately some surgical doctors do not consider treatment beyond medicine such as CAM, but I think that these treatments are efficacious for some patients for whom medicine and surgery are not enough (Jacob-Korea).

Financial support is clearly important in order to continue to develop and widen the use of relaxation programmes including CAM in hospital settings:

In my case, in my occupation as a doctor, I have used relaxation techniques as a rehabilitation activity programme. I obtained funding from two places - one, the Centre for Myocardial Infarction Diseases, the other The Hospices and Palliative Services Centre. Therefore there is no great difficulty in terms of my position. Music therapists also, working in the area of music therapy, are using the relaxation programme so also their position is not the problem. However, these CAM therapies are not considered an essential part of healing in hospital and if practitioners don't have any standard qualifications such as diploma, it is much more difficult to support these programmes in the hospital settings. [...] I'm hopeful though that the government will provide funding and support for this kind of programme in future (Jacob-Korea).

Violet spoke about how she combines CAM with RTs and RM in her professional work:

So I have a number of qualifications in complementary therapies, so when I practice complementary therapies I always incorporate music and I nearly always incorporate some sort of relaxation session. So, even when I'm doing a foot reflexology, I will use music and I will use relaxation techniques (Violet-UK).

When she does a training session on complementary therapies, she looks at the theory and the evidence behind RTs and explains the benefits of CAM to her nurse trainees:

I tend to come from that evidence base – with the students at least - because I need to show them it isn't attached to any particular religion - it isn't attached to any particular spiritual belief - and one way I've found of doing that is coming from an evidence base. So they see the benefits (Violet-UK).

To conclude, this section has explored interviewees' views of practitioners' qualifications (both the formal qualifications available to them and the more personal inner qualities that are desired) and how interviewees considered practitioners' awareness of their own level of competency and abilities. It is clear that the three groups are concerned about their abilities and qualifications when they use RTs and RM regardless of whether they train in public or private places.

In general, in professional development courses, practitioners will learn basic skills first and people develop and grow naturally once they begin work and the interviewees agreed with this normal process of acquiring specific skills. However, they also emphasised and recommended personal development of inner qualities mentioned. If practitioners have those abilities, the confidence and the space to let things flow naturally and quietly watch the whole process without sticking religiously to a treatment plan, this mode of working may be more desirable for practitioners.

During the analysis, practitioners' inner reflections were also identified as important elements such as how to remain neutral as a practitioner and maintain a healthy mind and body and how to gain a deep understanding through Loving-Kindness and a warm heart while listening to the client's issues and conflicts. Those inner reflections may nourish maturity and practitioners' repertoire of skills and also may lead the client to a better place, or a better state of mind, body and spirit.

It seems to me that the interviewees connect those inner qualities with spirituality too and during the interviews we discussed how to develop the mental maturity of practitioners themselves in relation to the spirituality. The subject of spirituality will be returned to in Chapter 8.

Chapter 5: Finding Chapters: RTs and MM and Health

My discussion in this chapter will focus on how the interviewees have adopted RTs and MM for health and well-being and how the interviewees understand their use of RTs and MM. Before starting the fieldwork, the range of study was RTs (including meditation) and RM. However, unexpectedly, many interviewees emphasised MM during our discussions of RTs. MM therefore emerged as one of the main themes during the course of my fieldwork (See below Chapter 5.1.3). So this was later reflected in the change of the title for my thesis from “Health practitioners’ understanding and use of RTs and RM in the UK and South Korea” to “Health practitioners’ understanding and use of RTs, MM and RM in the UK and South Korea”.

In this chapter a number of questions will be discussed: Firstly, what are the practitioner’s approaches in their use of RTs and MM in different healthcare settings? Secondly, how do practitioners simplify or adapt RTs and MM into their specialism and what considerations do practitioners give to the levels/depth of practice? Thirdly, how do interviewees perceive the benefits of RTs and MM and which types of RTs and MM have been adapted for health and well-being? Lastly, what are the practitioners’ concerns or advice when using RTs and MM in health contexts?

5.1 RTs and MM Approaches

The three groups of practitioners have different approaches to using RTs and MM and they have adapted them in various ways depending on the practitioner’s specialism. Several important elements emerged from participants’ accounts, including purpose of use of RTs and MM, the participant’s personal motivations, and range of RTs and MM.

5.1.1 Purposes of RTs and MM

The participants discussed a variety of purposes for their use of RTs and MM and five main purposes are identified here.

Firstly, some regard RTs and MM as types of emotion regulation and control strategy. For example, Olivia uses breathing techniques together with music and she focuses on a more inner process in order to help people feel positive and lift their mood by feeling the quality of the breath going through the body.

Secondly, stress management is a prominent reason for the use of RTs and MM. Stress in clients is a major issue and RTs and MM are an important part of their stress management programme. For example, Georgia, Anna and Olivia all use RTs and MM in order to help clients deal more positively with stressful feelings or sensations of pain and try to provide support for clients with psychological problems, including even quite disturbed people. Edward uses meditation as a distraction technique during music therapy sessions with clients who are disturbed and cannot control the floods of thoughts in their minds. The link between stress management and use of RTs, MM and RM was highlighted by the majority of interviewees and this will be discussed further in Chapter 6.

Thirdly, some use RTs and MM in order to support clients who have experienced episodes of depression, relationship difficulties or are recovering from drug or alcohol addiction or recovering from cancer. For depression, Anna, Georgia uses MM as a relapse prevention intervention so as to help prevent people from becoming depressed. So these interventions may be to help people who are currently experiencing a problem, those who are susceptible, or who have experienced problems recently.

Fourthly, RTs and MM are used as a self-development tool for clients including those engaged in a self-transformation process.

Lastly, interviewees use RTs and MM as calming techniques in order to slow down clients' thoughts and mind, to help them to feel calmer and more in control of their lives.

However, generally in healthcare settings, RTs are used by all groups as relaxation components for exploring the inner self or to achieve an altered state of consciousness for the practitioner's therapeutic goals.

Most of the meditation group seem to have a similar purpose and they place more emphasis on the non-judgmental and being in the present moment:

I think, for me, mindfulness meditation is practised to try and become more present - moment - focused - try and live in the present moment more, rather than wandering in the past or future (Adam-Korea).

Other interviewees too, who have strong personal experiences of meditation, also talked about being in the present moment, mind awareness, personal spiritual development, and inner stillness, as well as stress reduction and relaxation responses.

They are interested in well-being at a different level - of personal spiritual growth:

The purpose, from my experience would be to bring someone - make them more aware - of their own being, their own stillness on the inside. So, by aiming to slow their thinking mind down, and thoughts down, where often the anxieties and fear lie, by slowing that down, and by giving someone - talking through a technique - you might move from a point of more thought and more processing, to a place within them cognitively, to a much stiller point where they're hardly aware of any thought at all, and they're much more closely aligned and they're much more closely aware of their beingness and of their body. They're much more in that moment - right there with you in that room, rather than in their past. That's for me the ultimate purpose (Edward-UK).

Except for the meditation group, the other groups of interviewees often use RTs before starting the session or class in order to make clients feel safe, relaxed and freed of worries.

[...] by using the 5-minute relaxation techniques before starting the session it allows clients to be relaxed and open (Isabel-UK).

[...] it benefits them and just helps them to take those few minutes to get rid of all the worries from their head (Violet-UK).

John was particularly interested in clients' intention processes and he believes a client's mind becomes more open through the RT experience. In this way John uses RTs for activating the client's intentions and self-healing.

Georgia applies MM to stress management, keeping healthy, and addiction control. Currently, for alcohol-dependent people and high school students, she has started to run an eight-week MM programme for the purposes of health improvement and habit change. Similarly, Jacob uses RTs for habit changing and stress management in rehabilitation programmes. After realising the importance of rehabilitation programmes in preventing recurrence of myocardial infarction he combined RTs into his rehabilitation programme and he expanded the use of RTs with other types of patients.

Therefore, similarities and differences have emerged between the practitioner groups. The meditation expert group use MM in a particular way so as to focus on the present moment and awareness practice, cultivating more freedom and insight. In the medical and music therapy groups, RTs are used to achieve a state of relaxation and a positive change of mind and body condition through the relaxation response to counteract the stress response. However, both groups believe RTs and MM can be adapted to different client groups and can enhance quality of life and help them manage stress

better than before.

The most noticeable difference between Korean and UK practitioners was their preconceptions about meditation and RTs. UK interviewees considered RTs and MM as self-development techniques and self-help skills rather than being associated with religious practices. Only Olivia, really expressed such qualms about the use of RTs and MM. However, most Korean practitioners saw meditation and MM as connected with religious practice and they expressed concern about the resistance of client's responses, because they felt some clients associated their own religious beliefs with use of meditation. Korean practitioners therefore appear more cautious in their use of meditation with clients who are not Buddhist compared to UK practitioners. However, apart from upsetting clients' feelings, practitioners in both the UK and Korea generally perceive the benefits of RTs and MM for a client's health and well-being.

5.1.2 Practitioners' Personal Motivations in Using RTs and MM

Across the three professional groups, participants' personal backgrounds and their motivations to employ RTs and MM varied. Several participants first became interested after attending RT programmes, workshops or MBSR courses themselves. Others talked at length and with enthusiasm about their early encounters with meditation.

In terms of MM, three of the meditation group of interviewees said their own practice is based on Thich Nhat Hanh's teaching and Zen meditation techniques. In their use of MM, it is clear that the interviewees' personal training and workshop experience has affected their professional work. They mostly practise MM and adapt it as form of Kabat-Zinn's MBSR rather than following the longer traditional practices of Zen mindfulness meditation. For the other groups of participants, in particular, UK

practitioners, their motivations arose from Mark Williams and Kabat-Zinn's MBSR methods and these affected the interviewees' personal and professional use of MM.

Edward spoke at length about his time in India and how his personal interest in RTs began with his study and training in meditation and later music therapy and GIM developed. Anna expressed her interest in Eastern philosophy and religion and insight-focused mindfulness meditation, which she uses in her psychotherapy. Georgia talked about how she came to be interested in RTs and MM through her encounter with MM. She saw the potential in this to help patients who suffer physical and psychological stress.

John showed his interest in the PRT and combination of breathing process with muscle tension and releasing. He said it is his favourites RTs and one that he finds to be effective himself as well as his client.

Olivia's motivation to include RTs in her music therapy arose from her personal practice and training. She studied music therapy, Eastern meditation, sound therapy and GIM. For example, she practises several breathing techniques with flexible movements such as Tai-Chi movements which make her relaxed and those experiences affect her work combining the breathing work and music therapy.

Jessica incorporates RTs, imagery and breathing techniques, which began with GIM training. She said she felt that the particular benefit of combining RTs and music, and this enhancement through combination was a trigger for her use of RTs in her music therapy. She found even simple RTs make the session calmer and help the client to absorb the music much better. Also in senior school settings, the approach helps to increase young people's concentration levels and elsewhere RTs can release clients' tensions quickly and effectively.

Several interviewees have a strong personal desire to explore creativity and spirituality and some believe that creativity and spirituality facilitate performance in their professional work. For example, Anna spoke of her interest in spirituality and health psychology as well as in meditation techniques, so she uses MM as part of her psychological therapy process.

Across the interviews, common themes can be identified. Firstly, of the several interview questions, greatest enthusiasm was shown in replies on the topic of personal interest in RTs, MM (and RM), and this was clear from their facial expressions and the length of replies. Most interviewees enjoyed telling their personal stories. Their personal passion for RTs and MM has affected their professional work. Secondly, most interviewees are open-minded and interested in new and combined approaches to support their work and/or as their main purpose. A third theme was the relationship between RTs and MM and spirituality. In some cases, because of their personal interest in spirituality, interviewees bring RTs and MM into their professional work. In other cases, because of professional training courses undertaken, an interest in spirituality has been awakened and has led to the use of RTs and MM in their work. In either case it was clear that a spiritual interest connected both the personal and professional work.

5.1.3 Types of RTs and MM

RTs and MM of various kinds, and for many therapeutic purposes, have been widely researched (Shapiro, 2008; Arias et al., 2006; Davidson et al., 2003). The three groups of interviewees also mentioned many types of RTs and MM and how they have adopted them to their own approaches, procedures and aims in different healthcare contexts.

Depending on the client group and setting, all three groups of practitioners used RTs and MM in receptive and/or active ways. Most interviewees discussed meditation and breathing techniques for both professional and personal practice. In both Korea and the UK, MM and breathing techniques were clearly the most popular techniques. Therefore, my discussion will therefore centre on these.

Jacob described several types of RTs which he uses with patients:

Guided Abdominal Breathing, body scan, visualisation and Autogenic Training, diaphragmatic breathing [...] have the benefits of relaxation which can easily remove the tension of body and mind. There are many ways to mix the abdominal breathing, body scan, visualisation and autogenic skill etc. together (Jacob-Korea).

Olivia often uses receptive approaches such as RTs and calming techniques. For example, she plays music to match her clients' breathing and she chooses a music tempo which matches their breath:

I remembered a Scottish song and I just tuned into the husband's breathing (on the bed) and I was playing my harp and singing the song and it just felt like he was included and so they were able to really touch in together through his breathing. And then, I would say, that sometimes - in a completely different setting - working with children, or adolescents with autistic spectrum disorder. It's not always appropriate, but - there are times when you feel that they are getting a little bit overloaded, it's too intense - I have a couch - in the music therapy room - and so I can offer them time out and they have a blanket and pillow - and then I can just play music to them, like on the cello, the piano, the harp or something like that. And just encourage them to think about their breathing and close their eyes and - for some children, that can work really well. So they're feeling safe - they're not on their own - they're feeling safe. They can just lower their arousal level (Olivia-UK).

She said receptive methods such as meditation, guided visualisation, breath-holding techniques, sound therapy, body awareness practice and body scan may offer useful tools for clients when they feel overloaded or intense, since such techniques can reduce their arousal levels.

John often uses mixtures of active and receptive techniques because these can release the body's *stuckness* (See Glossary), and allow the mind to relax more easily. John first uses active techniques such as yoga, walking meditation, mindfulness meditation movement, Tai-Chi and rotating the key joints (shoulder-neck-hips-knees-feet-hands) before going on to receptive techniques, such as guided meditation or PRT. I attended his workshops and in group sessions he typically combines receptive and active RTs in his approach.

Turning to MM, Anna mentioned a range of practices using MM which she practices herself and with patients or students on courses. It seems therefore that her personal practice is closely related to her professional work and she discussed a range of MM techniques:

What I actually use in my own personal practice would be a combination of *mettā* practice - you know - a combination of loving kindness practices and mindfulness of the breath and mindfulness of the body and now I'm practising Buddhism in the insight tradition (the *Vipassanā* meditation). And in class or sessions I use many mindfulness meditation techniques, such as mindfulness movement, sitting meditation, lying meditation, breathing techniques, body scan, three-minute breathing space, Loving-Kindness meditation, etc. (Anna-UK).

Like Anna, Georgia also uses body scan, sitting meditation, mindfulness movement, yoga and breathing meditation as MM at work. Personally she recommended forgiving meditation because forgiving yourself as well as others brings a wonderful experience.

There are 40 traditional Buddhist meditation subjects (*Kammatṭhāna*, 業處, or the place of work) and among the 40 subjects, there are four divine abodes (*Brahma-vihāra*) or meditational practices, namely Loving-Kindness (*Mettā*), compassion (*Karunā*), gladness (*Muditā*) and equanimity (*Upekkhā*), (Bhadantachariya, 1971). Forgiving meditation is often used connect with *Brahma-vihāra* practice. Forgiving meditation is

cultivating forgiveness through practice and setting our intention to forgive through forgiveness for ourselves, forgiveness of others and forgiveness for those who have hurt or harmed us. Therefore through this practice, forgiveness will come naturally to those who cultivate this quality.

The most unexpected finding was that most participants (in both the UK and Korea) referred to MM and they are familiar with the concept of present-centred awareness. They have adapted MM from Jon Kabat-Zinn's version into their work and use it either in a simplified or in the original way or else simplified versions of Zen meditation. Interviewees seemed to have both personal and professional interests in MM and some practise themselves on a regular basis. Personally, I had not expected this depth of understanding of MM.

During the accounts of interviewees, many types of RTs and MM were mentioned and their use of it was clearly related to people's health and well-being. Therefore, how the practitioners use the above types of RTs and MM will be discussed in Chapter 5.3 in detail.

5.1.4 Adaptations of RTs and MM

Participants mentioned that RTs and MM were readily accessible to and understood by clients and that the techniques were accepted by them. They also spoke about clients with conditions which might prevent them from engaging in certain activities.

Such notions of accessibility, acceptability and practicability were discussed by participants. For both UK and Korean interviewees, regardless of the practitioner's level of practice, their major concern was how to adapt RTs and MM in order to suit each client. Another finding was that many interviewees use RTs and MM in order to support clients to continue self-directed practice by themselves at home. Therefore

they are focused on achievable effective methods, whether simplified or at a deeper level of practice.

a. Simplified RTs and MM

The simplifying of RTs and MM was often mentioned:

These kinds of difficult long time meditation techniques are too difficult for beginners. Thus I've chosen easier relaxation techniques and it has been by and large successful for [cancer] patients so far. For example, the simple guide meditation, diaphragmatic breathing, body scan and autogenic training are good examples to use with patients (Jacob-Korea).

Like Jacob, several of the interviewees prefer using simplified techniques especially in rehabilitation programmes. These may constitute more readily understood and accepted approaches for clients not familiar with RTs and MM and also for teenagers, who would be less likely to want to engage in lengthier practices.

Young adults are still in the process of developing emotional maturity and at the same time they are likely to be more energetic, active and restless. If they are beginners or do not have the motivation to do meditation, lengthy practice sessions may provoke feelings of resistance. And if they do not have any personal experience of the positive effects of MM, meditation which focuses on observing the inner self and exploring inner levels of consciousness may be difficult to understand and uncomfortable.

Breathing techniques were discussed by Adam, who described an easy way to apply 'diaphragmatic breathing exercises':

Breathing consists of two phases, inspiration and expiration. Diaphragmatic breathing exercises can induce good deep breathing for the client. Most people habitually breathe without any consciousness. Breathing techniques is an easy method to follow and all we need to do is focus on awareness of the breathing in and out. Even just one minute, if you concentrate your breathing in this way, you may notice that how your quality of breathing is changed. Try to guide like this -

‘begin by exhaling deeply while contracting the abdomen, then inhale slowly as the abdomen expands and continue inhaling as the chest expands. Simply try to be mindful of your breathing.’ Then repeat the ‘exhale’ and ‘inhale’ instruction again several times following this pattern - of slowly releasing the shoulders, relaxing the chest and contracting the belly. This simple technique will help clients to relax and cope with their own stress (Adam-Korea).

Many studies focus on breathing meditation and diaphragmatic breathing techniques in both East and West and different levels of practice have explored by researchers (Hanh, 2008; Paul and Verhulst, 2007; Fried, 1990). And here, Adam describes how to use breathing meditation in a simple way.

Likewise, Anna explained her way of simplifying MM and as an example she mentioned the *3-minute breathing space* which is one of her clients’ favourites meditation techniques, along with *mountain visualisation* techniques, from their feedback. She normally does longer practices from 45 minutes to 2.5 hours in her MBSR course but sometimes she does shorter practices because it can help some clients such as those with mental health problems, for whom longer sessions might not be appropriate, and she uses MM as grounding techniques with them:

Particularly if you’re using shorter, more concentration-focus practices, as opposed to more insight-focus practices, these can help in shorter bursts - these can help people to feel more grounded. So if they’re feeling flooded by overwhelming feelings, negative thoughts, if you’re just doing very short practices, where they’re just really feeling their feet on the ground, their body on the chair, it’s helping them to ground themselves into the here and now - into their bodies, you know, and out of their spinning heads for a slightly perhaps different intention, focusing more on the concentration-building aspects and on the grounding aspects of the practices (Anna-UK).

In this way she uses both longer and shorter practices depending on the client. Here, she talks about the link between shorter practice and grounding practice:

What I mean by that is just feeling a connection with the body - with the ground. So when someone is feeling very upset and distressed, overwhelmed by feelings,

again they usually lose contact with their bodies. They can't feel their legs on the floor, their legs on the seat, their feet on the floor. So if you do short practices with them - you just ask them "Can you feel the points where your feet are contacting the floor and the points where they're not? Can you feel your toes? Can you feel your heels? Can you feel the balls of your feet?" Then that helps them to come out of those difficult feelings and to feel more solid and grounded really (Anna-UK).

Yoga was also mentioned by several practitioners. Adam said yoga stretching exercises and easy Zen mindful movement practice can be useful because they bring a tired body and a busy mind back into balance within a short time. He personally often practises yoga at the end of the day, because it is an effective way to deal with his physical tension. John also uses simple yoga breathing techniques during workshops. Anna often co-works with a yoga expert in her MM practice. She uses it both for long or short periods and recommends it to clients so as to practise active mindfulness exercises at home.

An informal way of meditation was discussed by Georgia in the form of eating-meditation to cultivate positive emotions in clients. She also uses compassion meditation (*Karuṇā* meditation) and Loving-Kindness practice (*Mettā* meditation) in a simplified way, for example with depressed clients with breast cancer, who have negative feelings about their illness and predicaments. In the classical meditation sutra, *Mettā* meditation is much longer than the form she uses; her 2-3minute shortened version would seem more practical to use with breast cancer patients rather than the longer original.

The traditional method of *Mettā/Karuṇā* meditation is used to cultivate concentration and insight and it is a profound kind of mental discipline and requires self-discipline involving lengthy periods of concentration without distractions. Therefore shorter practice is often more desirable for sick people, because of physical incapacity and pain. However, compassion and Loving-Kindness meditation can be adapted and

practised in a more comfortable and relaxed manner in order to support people, so as to foster well-wishes towards themselves and open their minds to love and kindness.

Likewise, Jacob uses Loving-Kindness meditation with cancer patients and their families, because of positive reactions. He himself practises Loving-Kindness meditation and he finds it beneficial. So he has made his own version of Loving-Kindness meditation for patients. He simplifies the traditional script for the Loving-Kindness technique, changing some words to suit the specific situation. I was impressed by his way of adapting it because it seems accessible and practical, as well as beneficial not only for patients but their families too. Family members frequently become stressed and depressed in different ways from actual patients and Loving-Kindness meditation may help them to accept the current situation and control their negativity.

To conclude, when the interviewees use RTs and MM in a simpler way, their major focuses are accessibility or practicability rather than achieving a higher state of awareness or cultivating a quality of spirituality. Many practitioners have a degree of knowledge of relaxation responses and techniques from their personal practice and they have the ability to adapt it for specific client groups. They often create their own style of RTs and MM for shorter practices. Others prefer to use RTs and MM made by expert authorities, which again they use in the original version and/or after modification.

b. Adapted Versions of MM

Mindfulness-based practice, in particular MBSR was discussed by many of the interviewees. They believe it to be a clinically proven programme and they mostly use it for improving people's health. MBSR is a mindfulness programme adapted from the

authentic mindfulness practice of original Buddhist meditation. Three of the interviewees especially mentioned the 8-week MBSR programme which is the most well-known MM programme. The full version of the MBSR programme and simplified versions of MM were discussed.

Georgia took the MBSR course and now has adapted it in her relaxation programme as a nursing intervention. She designed an 8-week programme manual for patients (breast cancer patients) and she gave it to me for further information. The whole 8-week programme seemed to me very organised in terms of timetable and contexts:

For example, in the first week, we would share how to cope with our stress and so on. Then I do a body scan and try to get them to have an awareness of their own body. When we finish the session, I explain how do they can practise at home and I give them a self-monitoring assignment. This is how I did my first week session. [...] In the second week, I try to go into things more deeply and I try breathing techniques. [...] In the third week, I teach them about mindfulness while eating in order to make them aware of their habits (Georgia-Korea).

In the subsequent weeks she covers walking meditation, hatha yoga, sitting meditation, compassionate meditation and finally forgiving meditation. Georgia highlighted the self-help techniques of MM and self-awareness:

I encourage my patients to practise MM in their house regularly every day for a minimum of 10 minutes. So I made a guided meditation CD [for them]. I think they need to practise regularly by themselves in order to continue the practice without the teacher (Georgia-Korea).

Anna has adapted MM in hospital and for university psychotherapists on a degree course. She currently runs an 8-week MBSR course in university for staff and students.

She believes MM is EBP and growing in popularity:

[...] More of these courses are developing. [...] I think mindfulness is receiving so much coverage at the moment in news and magazines because it is very evidence-based. They're trialling these in research trials to see if they're effective

or not, for those populations, so we're building an evidence base all the time (Anna-UK).

In fact, there is much research into MBSR and practitioners are developing versions of the original 8-week course for specific groups. Anna explained how mindfulness practice is regarded in public settings in the UK:

This is a recommended treatment by the National Institute for Clinical excellence, which approves treatments - medical or otherwise for presentations. So that is why you will often see this delivered to the NHS - mindfulness MBCT (Mindfulness-based Cognitive Therapy) courses. There is a lot of research done around it by psychologists and other practitioners. So it is grounded in science. [...] The NHS is then guided by the decisions of NICE in terms of which medicines they buy - or which psychological treatments they will fund. So because of the extensive amount of evidence around the effectiveness of mindfulness for preventing relapse and depression, NICE have recommended mindfulness courses to be delivered to people to prevent them from developing depression again (Anna-UK).

Not only were academic and public settings mentioned, but private settings too. Isabel said she herself received MM training as one module in the third year of her university psychotherapy degree course. Currently she runs a private counselling service and explained she shared information about MM with others interested:

If you look at 'LinkedIn', you will see lots of people trying to use this - meditation and relaxation especially. Under my group, there are lots - so these are the ones I've joined so - mindfulness and psychotherapy, mindfulness-based intervention [...] And I've chosen books too there are lots of see - about psychotherapy and Relaxation techniques [...] And I've got a book with a CD and then you can do mindfulness practices, meditation with music, and I have been using it for me personally, and then slowly with my clients (Isabel-UK).

She said these two bases (her own training and social networks) make it possible for her to use MM in her work.

Some similarities and differences emerged. Firstly, it was clear that except for the meditation expert group, all the other groups of interviewees more frequently adapt

RTs and MM into shorter and simpler versions to suit their clientele. The meditation group used them differently with beginners and more experienced people and they considered more carefully the client's personal capacity for practice and prior experience.

Secondly, when the interviewees adapt RTs and MM, the range of RTs is similar using types well-known both in the UK and Korea but depending on the purpose and client group, the depth or level of RTs and MM are slightly different. For example, shallower breathing techniques were used with cancer patients for their relaxation. On mindfulness courses, breathing was used in a deeper and more concentrated way in order to explore the inner self or promote self-awareness.

Thirdly, the UK interviewees seemed able to transcend the barriers of religion and culture when they adapt MM and they regard MM as a tool that can produce a relaxation response or special quality of awareness. Their enthusiasm to pursue spiritual consciousness and higher state of awareness seems to transcend religious barriers or ties and they adapt the way of quieting the body and the mind to suit their client.

In this section, different approaches and personal motivations for using RTs and MM, and adapted versions of RTs and MM have been identified. Clearly these adaptations are mostly used in the healthcare context. The range of RTs and MM being used depend primarily on the practitioner's specialism.

5.2 RTs and MM as Healthcare Interventions

In order to enhance clients' health-related quality of life, many interviewees use RTs and MM and various types of RTs and MM were discussed. In this section, I will

explore which RTs and MM are being adopted by each interviewee and how they understand these RTs and MM as mind-body interventions.

5.2.1 Understanding of RTs and MM for Health and Well-being

The interviewees have their own approaches to the use of RTs and MM, which they use to benefit clients' mental and physical health conditions. Jacob said many of his patients are constantly nervous because of illness and they do not realise that they are tense. Consequently they have got used to the thinking that this is their natural condition because they may not have had a relaxation experience very often during their illness. Jacob believes that through the relaxation experience patients can understand that they can live in a more peaceful way, mentally come to terms with their illnesses and physically feel a degree of comfort. Thus it might be a new experience for them and in turn it will provide inner strength in the patient's life too. Jacob said he uses both RTs and MM to complement his main treatments and uses them in accordance with patients' needs:

I am doing sessions with two types of patients twice a week. The first is with myocardial infarction patients and the second with cancer patients. [...] Once a week a one-hour session is available for anyone who wants to participate. Usually 10-15 people gather together to relax. After the session, the patients often asked medical questions about how their illness and relaxation are connected. We also talk to each other for a while (Jacob-Korea).

Jacob described how the relaxation programme may affect the patient's health and why he combines medicine and RTs in his hospital rehabilitation programme:

I suggested to the hospital setting up the relaxation programmes. In Korea, the second leading cause of death is myocardial infarction. Myocardial infarction is a disease caused by clogged heart vessels and nearly half of the patients die and so only half survive. Of these, half of the patients will suffer a heart attack again. So, in order to prevent the recurrence, first the medicine is important, and second, it is important to change their habits. They can easily take medicine but changing their

habits is not easy for them. Smoking, alcohol, high fat intake, obesity are all risks to the patient. This is often associated with stress. [...] When the patients are subjected to stress they become nervous and blood vessel shrinkage is likely to occur. Then, blood pressure goes up naturally and is a burden on the heart. As a result, the patient's condition deteriorates further. But if they are relaxed, there is less strain on the heart and blood pressure store is also returned to normal (Jacob-Korea).

Jacob highlights the circular link between changing habits and stress management. If patients cannot manage their stress then the result is often bad habits (and vice-versa) so through relaxation and meditation sessions, it is possible to manage the stress of patients so as to change their behaviour.

Similarly, Georgia also uses RTs and MM to help clients cope with stress. She believes that through relaxation programmes, patients can better manage their feelings and develop the ability to deal with or avoid negative feelings about the way they are and to be less affected by stress:

I am using mindfulness meditation programme because I think it is a good treatment for stress, especially coping with emotional stress. I think 'mindfulness meditation' is one of important mechanisms to help people easily accept themselves through understanding themselves and without hating themselves. If they are not resistant to themselves and what they are doing etc., the stress will disappear soon (Georgia-Korea).

Olivia said the ability to deal with or avoid negative feelings may affect the rate of patients' health deterioration and she uses RTs in combination with music therapy for patients with Parkinson's disease in order to help them reach a positive state of mind. The benefits of slowing-down techniques were discussed by several interviewees. For example, John said slow deep breathing is helpful for some clients because it potentially slows the system down and calms the mind and body.

The health benefits of using RTs and MM discussed can be summarised. Firstly, patients can experience a truly relaxed state through the relaxation session and a fresh or new experience of comfort. Therefore during hospitalisation, they can learn the way of uplifting themselves and restore the body to return to natural state of balance. Secondly, patients with negative views about their illness can be offered a positive vision (such as hope) through the relaxation experience and it may help them manage their feelings or provide emotional care. Thirdly, receiving inner stillness can reduce anxieties and fears of illness and being overwhelmed by negative thoughts which can make disease worse. Fourthly, after the end of the relaxation programme, patients who try to practise relaxation skills by themselves and consider the self-help intervention can independently take control and provide relief for themselves. Fifthly, the use of RTs or MM can increase conscious awareness and awaken the wandering mind and thus can avoid doubt, fear and unhappiness. In addition, it was also mentioned that for some clients such as cancer and hospice patients, RTs can possibly be beneficial by inducing semi-conscious sleep. Many of these patients find it difficult to sleep because of their pain, so just ten minutes sleep during the relaxation session may provide pain relief for a short time. They may even find the way to go back to sleep again when pain interrupts their sleep. In the next section, the main types of RTs and MM used by interviewees and how they are used for health and well-being will be discussed in detail.

5.3 Use of RTs and Meditation in Health Contexts

5.3.1 Breathing Techniques

Across the professional groups, breathing techniques are most widely used and they are used in two ways. One is the common approach to breathing techniques, namely

abdominal breathing, diaphragm-breathing exercises, breath-holding techniques and the alternate nostril breathing technique. The other way is to use breathing techniques as a mindfulness-based approach, namely the breathing mindfulness exercise and the breathing space exercise.

Jacob uses either guided breathing techniques or abdominal breathing each session for 5 to 10 minutes after realising that most of his patients can breathe calmly after practising breathing exercises. He describes his typical method:

At first, I begin it by getting patients to take a few deep breaths to relax and hold their mind in the present moment (with breathing in and breathing out). Second, “Breathe normally through your nose and pay attention to your breathing.” then “Try to focus on one spot (I tell them to focus on the navel because it works for me) in order not to lose track of your breathing.” And my verbal guidance continues from the beginning to the end of the session so that patients do not lose their way. Then in the next step, “Follow your breath - all the way through - focus on your navel”, “Just focus your attention onto the rising and falling of your belly” and then “Keep observing your rising and falling and let your breathing be comfortable” (Jacob-Korea).

Particularly, in the practice of breathing techniques, he emphasised *posture* and his prime concern was patients’ capacity to do techniques. (He himself tends to work with patients who are having intravenous drips). Conventionally, meditation is practised with four postures: walking, standing, sitting and lying down. He personally prefers sitting in an upright posture but for patients, he suggests that lying is generally more comfortable:

I like to start a breathing session with clients in this posture [lying posture], but if somebody has a problem in their waist or has back pain, the patient can’t adopt this position so I have to find the other posture for them such as lean to wall in sitting posture (Jacob-Korea).

In his experience, a ‘completely supine posture’ is the most comfortable posture for patients and he described in detail his breathing techniques approach:

I've tried many postures for many years, like sitting on the floor, sitting in a chair, lying down and so on, but lying down is the most successful. What the patient does is put their head on the floor or on a pillow on the floor and their legs splayed apart with a gap between their knees the same as the distance between the shoulders. The arms are outspread and there should be a 20cm gap between the hands and the body. The palms should face upwards. They should allow their whole body to sink into the floor. [...] In medical terms this [supine posture] is called 'standard anatomical posture'. This is the best relaxation posture. So I teach this posture to patients first of all. Then I explain, "In this posture let all of your body relax" (Jacob-Korea).

Olivia uses breathing techniques both in active and passive ways and she uses breathing techniques in conjunction with music. For example, she tries to match the rhythm of music with breathing techniques for patients with Parkinson's disease, for whom motor control is impaired:

Sometimes when you use music which has got a regular rhythm that just helps [patients with] Parkinson's be able to organise their movements better. So I bring that into the breathing, so for instance it's a classic thing where you just breathe in for the count of four, then hold the breath - sort of feeling that expansion and then breathing out very slowly and controlled to [the count of] eight. So they're really emptying the lungs. And really, I think that's helping them to use the diaphragm and therefore it massages the organs and then I get them to drink lots of water and that's a way of cleansing. Through the breathing it definitely lifts them and I think it really does help as well (Olivia-UK).

This is a very deep breathing exercise (and counting four for in-breaths, six for out-breaths would be more common). The ratio of four to eight may effectively empty the lungs, but over a longer period could give the patient problems. Some people especially beginners, may experience problems when doing a deep level of breathing exercises over a long time, because inexperienced patients may not know how to make themselves comfortable. Some actually become more tense initially and their feelings of suffering intensify. Beginners cannot always cope and so this can create a state of active tension (rather than relaxation). My assumption is that Olivia uses this technique

for relatively short periods during a music therapy session. Olivia said patients with Parkinson's disease tend to sit a lot and they may not exercise very much and often get depressed. She finds that breathing techniques makes these patients feel more hopeful and raise their energy levels.

John discussed other types of patient with emotional difficulties and how breathing techniques, even relatively shallow ones, affect their emotional control:

When you get into a state of panic, for instance when you've just had a very bad diagnosis and there's a lot of fear, or equally with people who have suffered trauma, and in a hyper-aware state all the time, breathing skills return to a calm state. And if they're extremely anxious, you might even get them to do it as open breathing and relieve anxiety. And if you do that for two minutes, it brings the brainwave state right down - closer to a normal state. With you or me, if we're not stressed, we'd probably take this into a very deep meditation, but for people who are super-anxious, it can bring them much closer to a normal state (John-UK).

As regards breathing techniques used in combination, Olivia uses several breathing techniques with movements such as 'Tai-Chi movements and breath' and 'gesture and breath' and here, she combines music too:

I have done some Tai-Chi and meditation. And so sometimes I will get them to move with the breath, using Tai-Chi movements - with the [in- and outbreath]. And with music like - something like Erik Satie or Arvo Pärt or something like that - that kind of music (Olivia-UK).

Similarly, Rosie combines breathing techniques with music therapy activities in order to induce respiratory stability:

I am working in a Hospice and Palliative [Care] hospital and most of my patients suffer from respiration difficulties. Their breathing is not regular and there are a lot of problems connected with this. In the case of lung cancer patients and in-patients who with wear a respirator, they cannot breathe spontaneously and I found that some patients can breathe steadily according to the rhythm of music or breathing guidance (Rosie-Korea).

In this way, combining breathing techniques with singing or listening to music may enable clients to breathe slowly and comfortably and this can affect therapy itself and help the patients to relax.

At the moment in Korea there is a positive attitude towards the incorporation of RTs and RM among healthcare practitioners and these are often used in many clinical settings as well as *community music therapy* (See Glossary). Lily also incorporates RTs and RM into her music therapy sessions. For example, with healthy clients, usually the session time is one hour and she devotes 10 to 15 minutes for relaxation methods and 40 minutes for music therapy techniques. With hospice patients or patients unable to physically move, the maximum session time is 20 minutes and 5 minutes is allocated for relaxation and the rest of the time is music therapy. Session time therefore depends on the client and with it the amount of time devoted to RTs in a music therapy session.

Georgia mentioned the calming effects of breathing skills, saying that by modifying breathing patterns, some clients can reduce overall emotional pressure and stress:

I try breathing techniques for my patients. I ask them to “Focus on your breathing and observe your breathing. How do these breaths go in and out through your body? [...] Feel your breath.” Then they can focus on the present moment and breathing in and out. After 2 to 3 minutes then they can see how their breathing affects their emotions, such as feeling of sadness, anger and fear of illness (Georgia-Korea).

Various other patterns of breathing techniques were mentioned such as abdominal breathing, diaphragm-breathing exercises and breath-holding techniques. John is especially interested in the alternate nostril-breathing technique which is originally a yogic breathing technique:

I introduce a process which is very focused on breathing. So making sure people are breathing deeply into the abdomen, holding the breath, releasing the breath slowly. So really slowing down the breathing. And then sometimes I also become a bit more specific with the breathing. So I can do the alternate nostril breathing. So breathing up to essentially the centre of the head (pituitary gland again) with one nostril and out and in again (John-UK).

Discussing his work with mental health and palliative care patients, Edward gave examples of breathing techniques:

I use relaxation techniques with the breath, particularly teaching people how to lengthen the out-breath. And how to, after their out-breath, to allow that little pause that happens to be there, and to notice that before breathing in again. It's very easy, but that's - those concepts are at the heart of a lot of the techniques that I use (Edward-UK).

He said that this technique might benefit a patient who is short of breath and in a state of panic. In an email he explained further:

Sit or lie in a comfy position, spine straight but at ease, shoulders relaxed, breathe in - hold for a second, breathe out, making the out-breath slightly longer than the in-breath. Pause after the out-breath for a few seconds until the body naturally wants to breathe in again. Repeat. The pauses are the most important part (Edward-UK).

In the music therapy group, some combine breathing techniques in GIM programmes, for example during the induction stages:

I have developed modifications of the standard GIM and relaxation techniques to make them easier to understand and less scary for anyone who has not done any relaxation work before. The first task is tuning into the patient and listening really carefully to what they need. Then during the session, I use a calming breathing technique, mandala, visualisation etc. (Edward-UK).

In GIM, sometimes my sessions start with a reminder to focus on the breath - just following the in-breath and the out-breath. I felt that breathing techniques act as an invitation to move inward (inside you) and also, perhaps, permission to enter one's inner world for a time and leave the concerns of the world aside for a moment (Olivia-UK).

Overall, many interviewees use breathing techniques as a self-help tool, relaxation tool and for clinical benefits. In fact breathing techniques and patterns have been much studied in academic and clinical research. Originally breathing techniques coming from Ānāpānasati practice (mindfulness of inhalation and exhalation) in Ānāpānasati sutta (Breath-Mindfulness Discourse), (Sutta, 2012; Vimalaramsi, 1997). Breath-based techniques are very likely the most widely used in the healthcare service and the interviewees frequently use them too. During the interview process, I was impressed by the participants' way of using breathing work, since therapists who were not specialised in meditation were using the techniques in similar ways to meditation practitioners in many respects. Interviewees also stressed that breathing techniques can slow down the heart rate and reduce the sense of physical pain, as well as making people slow down psychologically. This can benefit among others sufferers of anxiety and depression, and hospice and cancer patients.

5.3.2 Progressive Relaxation Technique (PRT)

PRT is often used by medics and healthcare professionals because of its health benefits and because it is easy to learn. Edmund Jacobson (MD) originally introduced PRT (Gessel, 1989) - he identified tensing and releasing of 16 muscle groups and developed a sequence of tensing and releasing exercises. His muscle-based exercises have been developed as a form of treatment for control tension, hypertension, heart disease, digestive disorders and states of anxiety.

Several interviewees use PRT separately or in combination with music or breathing techniques. The duration and depth of PRT varies depending on the practitioner's purpose and client. Lily uses PRT in conjunction with music therapy and she particularly emphasised the provider's and the trainee practitioner's need for

experience and knowledge before using PRT with clients. Therefore, she introduces the fundamental method of PRT to her music therapy trainees (in university) in order to convey the PRT approach to tension and release and how to release muscle tension in painful conditions:

Progressive relaxation technique is often used in various hospital settings and I think in the field of music therapy too, progressive relaxation technique with suitable music is one of the good ways to make a client feel relaxed. So I often teach it to my music therapy students. progressive relaxation technique is a very easy method to follow but for me, selecting the music is what takes a long time. I guide progressive relaxation technique all the way through verbally (Lily-Korea).

Here, Lily shows her concern about how to match the music with PRT because she has found that when she chooses suitable music for PRT, clients find it much easier to follow her guidance steps: tension - relaxation - tension - relaxation. For example, she selects Kenny G's *Spring Breeze* for the PRT session because the beat is regular and it is easy to match the tension - relaxation steps to it. Lily's consideration of music selection and the optimal music characteristics would be good advice for a practitioner seeking to combine music with RTs.

Lily and John both mentioned the relationship between PRT and self-awareness. Lily emphasised the client's memories of the relaxation response and self-awareness. During her PRT guidance, she first ensures that the client knows 'what is tension' and 'what is it like to be in a state of relaxation' and she tries get the client to understand how things might be different by contrasting these experiences. Then the client will be able to recognise the differences between tension and relaxation and recall the feelings of releasing muscle tension. That self-awareness may give an opportunity and motivation for clients to practise relaxation exercises:

Memories of comfort and relaxation are quite strong so clients remember them and want to find a way to relax. Through their self-awareness of tension and

relaxation, clients can distinguish them and they realise the positive experience of being in a state of relaxation (Lily-Korea).

John uses the generally used Jacobson's method of PRT, but modified with breath work because this combination of breathing techniques and muscle tension-release is one that he finds to be effective:

The process of progressive relaxation technique - this is about inviting the client to first of all kind of scan their body, become aware of their body [...] And usually with a client one to one I start with the feet and then move up and invite them to become aware of the feelings and sensations in their feet and then throughout all the muscles in their body as they tighten the muscles. So they kind of maybe lift it, tighten it, then hold it tight, then relax, and then breathe out. So there's a breathing process involved here too. So it's a combination of breathing techniques and progressive relaxation technique and then we work steadily up through the body - tightening, releasing all the muscles in that way. And then following that with just a simple process of allowing an awareness to happen - again starting with the feet up to the head - of how it feels in the body after there's been that process (John-UK).

PRT is akin to body awareness practice and the body scan is combined with muscle RTs. Therefore, John uses PRT for muscle relaxation as well as to give clients the motivation to continue to have experiences of relaxation through a process of self-awareness. Through self-awareness of relaxation and tension, the client may go on to use PRT as well as RTs by themselves at home.

In the main PRT shows positive effects for relaxation exercises, but there are occasionally risks. Care needs to be taken with patients with particular conditions. PRT can require strenuous muscular effort and the practice, particularly in its deep form, is not suited to everyone. Jacob, who is a specialist in heart failure, advises that in the case of musculoskeletal disease, cardiovascular disease or myocardial infarction, practitioners need to be cautious in their use of PRT. With such patients he uses simple relaxation imagery rather than PRT.

5.3.3 Body Scan

Many studies report that body awareness practice can produce specific benefits such as reducing the negative mind, protection from getting depression and reducing distressing and chronic pain (Jain et al., 2007; Grossman et al., 2004). The three groups of interviewees also perceive body scan to have benefits for a variety of health conditions.

Different forms of body scan were identified. In the meditation group, body scan was used as a component of mindfulness practice for enhancing body awareness in *present-centredness* (See Glossary). It brings concentration and insight-knowledge to help deal with personal issues and stress more productively.

In the medical group, some use body scans to relieve emotional and physical stress because they believe and have found evidence that body awareness practices can release stress and tension in patients. Some use body scans for mindful body awareness practice which originates from *The Four Foundations of Mindfulness* principles (mindfulness of body, feelings, mind/mental, and mind objects/mental formations). In the music therapy group, body scans are used either in PRT or as one of the components of RTs in GIM sessions.

Edward said there are wide ranges of different relaxation components in GIM and body scan is one example. He often uses body scans in relaxation sessions together with PRT. Similarly, Olivia said she modifies the GIM method to create short relaxation exercises and in using body scan she prefers a lying down posture in a comfortable place with a warm blanket on the floor. Olivia combines her body scans with breath work:

Imagine our breath traveling down the body in order: nose-lungs-abdomen-left leg, then all the way to the toes and then back again and out through your nose. Continue to breathe in and out from each part of the body from toe, leg. [...] and observe the sensations of your body and take our witnessing awareness around the body (Olivia-UK).

She mentioned active RTs (such as Tai-Chi) in a body-focused way and for me personally it was interesting how she considers the body as a means to awareness.

Olivia emailed me:

I have borrowed some of the techniques I have learned in improvisational dance, Alexander Technique, Kinesiology, Tai-Chi, etc, into the sessions because of the positive effects I have experienced myself. Through my own self-observation I realise how easy it is to become tense (holding on to things) even without realising it. Both breathing and movement are so natural and nourishing. We can also become aware of places which may be stuck or where difficulties lie and I believe that traumas can get stuck in the body. Bringing attention, without judgment, can help one to begin to resolve issues. I think this can work well because there is a certain amount of detachment in the relaxed state - so we can notice “oh that place hurts”, we can breathe into that place and begin to disperse the feeling that is there (It seems so hard to put into words). It is also interesting that in active music therapy one often begins by noticing the breathing rate of the client - it can often inform the tempo of the music! (Olivia-UK).

Here, she combines breathing techniques and movement techniques with body awareness and emphasises the importance of clients’ own body-based awareness.

Georgia uses body scans with her breast cancer patients as a form of mindfulness practice:

I often do body scan in mindfulness meditation programmes. For example, I try to get them to have an awareness of their own body. I firstly ask, “Think about the feelings and sensations in your body and release the all stress in your body and mind.” (If patients would like to lie down, I let them do it). [...] “Feel relaxed and try to make all the stressful things go away and then your mind will become peaceful.” (Georgia-Korea).

Many different types of practices were reported to be combined with body awareness practice, including guided imagery, PRT, mindfulness movement, Zen mindfulness

meditation and breathing techniques. Body scan is a focused body awareness activity that brings attention to feeling the sensations of the body from toe to head and focuses in detail on every part of the body. The interviewees were aware of a link between ‘body awareness’ and the ‘relaxation response’ through reflecting on their own and clinical experience. They made the point that the body can be used as a place for awareness and a body-focused way of practice can help to understand our own body responses and such understanding can make easier for us to return the balance of body and mind whenever needed.

5.3.4 Imagery and Visualisation

Several ways to use Imagery and Visualisation were identified by the three groups of interviewees. In the music therapy group, most have learnt basic relaxation skills through GIM training so they use imagery in GIM. In the medical healthcare group, imagery techniques were used in a simple way and in the meditation group, imagery techniques were used in combination with mindfulness practice.

Anna adapts mindfulness practice to imagery techniques such as mountain meditation, which is using images of a mountain in our mind’s eye. It is actually for the purpose of getting in touch with the present moment, which is the core of MM. In her MBSR classes, I felt it was an effective technique for me to relax with the sensation of a solid mind as well as an expansive vision through building the visualisation of the image of the mountain. It was a similar experience to the one which I felt when I doing space meditation (Paricchinnākāsa-kasina: space kasina), one of the traditional Samadhi meditations, which evokes stillness and our connection with space. Anna said this mountain imagery is one of the favourites practices according to her UK client feedback.

I felt that imagery and visualisation techniques may be more developed in the UK than in Korea and more UK participants frequently mentioned it during their interviews compared to the Korean interviewees. In Korea there is less familiarity with visualisation techniques compared to other techniques (although this situation is changing, particularly with the growing interest in GIM).

Olivia explained that she uses imagery techniques as relaxation components in her GIM induction stage (as well as PRT and body-focused practice):

For the GIM clients, I use relaxation techniques to bring them into an altered state of consciousness, so then they can access their own subconscious, semi-conscious, through imagery and experiencing the music. It's called an induction, but really it's using different kinds of body-focused relaxations. It's usually body-focused, but sometimes it will use an image like a ball of light and the ball of light will travel through the body and expand to surround you, or it could be just a feeling of space opening your toes, your ankles, feeling more and more relaxed - that kind of technique. And sometimes it's to do with tension and release - so tensing the body and then just letting it go. And that's how you prepare the client for the music experience - for the GIM experience (Olivia-UK).

Jessica asks clients to imagine or sense the body being filled with air. She also employs visual imagery techniques focusing on basic colour or bubbles for relaxation purposes. And like Jacob, she emphasises a comfortable position for her clients and she often asks them to lie down. When she guides this technique she sometimes plays slow music in the background:

For example, when I start relaxation sessions, firstly I say "Think to yourself how your body feels from head to toe. Feel your body against the ground." Then in the next step, I ask the client to focus on their breathing. "Try to focus on your breathing and imagine 'in my body the breath will fill me. From head to toe, soothing air is entering my whole body. All the way down. [...] head first, then shoulders and then chest.'" Then I ask to imagine to yourself that my body is full of soothing air and feel as much peace as you can." Or when using *Visualisation* or *Guided imagery* I use colour, etc. "Think of any colour which you would like

to think of. Focus on the colours in your peaceful safe place. [...] Or imagine you are inside a large bubble or any place that is safe for you” (Jessica-Korea).

In addition, she may indicate a special place for imagery like by the sea or on a beach.

Referring to a personal safe place, Violet talked about her visualisation practice:

For example, I ask them to imagine they are in a place and the criteria for the place is somewhere that they feel safe so I don't tell them where they have to be. Because what's safe for one person, would not be safe for another. So imagine if I say to them 'imagine you're in your own home - for a woman who's been beaten up by her father, that's not safe, is it? So I say to them somewhere where they feel safe - that's all - and then I get them visualise it, smell it, take them through that experience, but I never direct them to exactly what they're going to experience. And then I ask them to bring into that safe place a person, and again that person is a person who makes them feel safe. But I don't say who that person is. So it could be a friend, it could be their partner, it could be their mother. So the student is always in control (Violet-UK).

In these visualisation techniques, she is sensitive to individual needs and personal traumatic events so her advice is to allow clients to choose their own imagery.

Overall, the three professional groups use imagery exercises in several ways such as mindfulness guided imagery, relaxation skills within GIM and MI and as simple visualisation, and this was clearly related to the practitioners' training background and which techniques are being currently used and popular among their peers. Korean and UK interviewees both seem to share a similar approach to the use of imagery and the choice of object of imagery; some practitioners select specific imagery for clients and others let the client choose the imagery themselves depending on the purpose.

5.3.5 Autogenic Therapy (AT)

Among the interviewees, Jacob is the only person who uses *AT* (See Glossary) as a relaxation technique for cancer patients (among others). Because of his successes he is currently engaged in teaching this technique to medical trainee students. Jacob said

patients can easily release the tension of body stress through AT and through this practice, they can realise how they can generate feelings of warmth and freedom throughout their body. He has modified it into six steps and he described to me the main elements of AT. Summarised it is: (a) The body is heavy, (b) The body is warmed, (c) Slow breathing, (d) Slow heart rate (awareness of the heart beat), (e) Abdomen is warmer, (f) Head and forehead become cool.

He also adapts the technique to focus on just two steps and two sensations because he feels that a simpler way of AT is desirable for physically sensitive patients who are in a stressful situation bodily and emotionally due to their pain:

I provide the guidance to patients like this “let’s feel heavy (heaviness in the musculoskeletal system)” and “let’s feel warmer (warmth in the circulatory system)”. Heaviness and warmth focus on the musculoskeletal system. [...] After finishing the session their body and muscles are resting so the mind can also relax (Jacob-Korea).

He advocates AT because it is possible for patients to carry this out by themselves as a kind of self-help or self-regulated technique. By practising basic techniques of AT, patients can understand the relaxation response and the way of shift from the stressed state to the relaxed state in their own way and they feel more balanced and relaxed. Therefore, patients may understand AT as a self-care resource for treating themselves. Of course, AT can also be modified to meet individual needs of adults as well as children in therapeutic settings, but none of the other interviewees mentioned AT.

5.3.6 Walking Meditation

Walking meditation is often used as an active relaxation technique by several of the participants. Many studies report a number of health benefits associated with walking meditation such as improvement of emotional expression, clearer thinking, reducing

mental and emotional stress as well as special benefits in child and adolescent psychiatry (Hanh, 1985; 2011; Kabat-Zinn, 2009; Sandor, 2005).

Some similarities and differences in use can be seen. The meditation group viewed walking meditation as another meditation approach for cultivating the mind and spiritual realisation. However, with clients, they used it for the more practical purpose of helping people through life, such as reducing mental and emotional stress, and finding inner freedom.

In the other groups, walking meditation was considered as an active form of relaxation exercise for uplifting the body and mind or creating a feeling of energy through exercise. When I attended workshops, my impression was that in the UK practitioners and attendees both seem more comfortable in walking meditation rather than sitting meditation and they seem to get fresh new energy and change their mood by performing walking exercises in stillness.

Edward explained how he modified walking meditation in clinical settings:

Where I was working with a mental health client, and when he was very agitated I would walk with him, and I would try myself to use walking meditation to be quiet while he was talking, in the hope that something of my relative calmness might affect him in a positive way. Sometimes it does, and sometimes it doesn't. He just needs to walk, to talk, because he can't stay in a room. And sometimes it works where, by walking and talking, he's able to express a bit of the agitation he feels and calm down relatively compared to how he was at the beginning. And occasionally I've done a modification on that where I've taught someone - actually in this case the same guy - a technique where he could perhaps count, as he walks, maybe one to ten - and then ten back to one again - so counting in reverse - as a distraction technique from intrusive auditory hallucinations or thoughts of someone who's disturbed in their mind and getting a lot of thoughts. As a distraction technique, I have used a form of meditation where someone will just count as they pace, and then count backwards (Edward-UK).

Edward felt active forms of RTs may help with distress management in mental health settings and facilitate self-expression. He added that for hospice clients too, it can be a way to manage agitation levels. Interestingly, he shows that the calming effect of active techniques may prepare the way to develop a rapport between the practitioners and clients.

Walking meditation is a meditational movement and Adam considers it a method of developing concentration and insight (for meditation experts and trainees). In its original form, walking meditation (caṅkama) is a teaching from the '*Great Discourse on the Foundations of Mindfulness (Mahāsatipaṭṭhāna Sutta)*' as a way of to cultivate three qualities (concentration, insight and wisdom) and usually it is practised walking back and forth (with mindful awareness of the walking posture itself) along a prescribed path (Walshe, 1995). But Adam believes that for non-experts or non-devotees, through movement meditations, people can easily restore balance in body and mind, especially when they feel dull or low in energy, depressed or distracted.

Regardless of their religious affiliation, walking meditation has been adapted by several interviewees for the benefit of their clients. Through taking steps in complete relaxation, a sense of peace at this present moment can be achieved while walking which may help calm overwhelming emotions and thoughts as well as providing refreshment and physical energy. Walking meditation is a practical and effective technique at times of strong emotions or stress, racing or obsessive thoughts, drowsiness or depression. Currently it is used in combination with creative therapies such as art and dance therapy.

Generally, walking meditation is most frequently regarded by interviewees as an active relaxation technique. Interviewees use walking meditation for various purposes and, like other active RTs, believe it can be a beneficial tool for certain client groups.

5.3.7 Loving-Kindness and Compassionate Meditation

Both Loving-kindness and compassionate meditation were mentioned by five of the interviewees and they use these when focusing on developing emotions such as kindness, warmth, compassion and empathy. Interviewees regarded these practices from three main aspects, one is giving emotional support and coping techniques, the second is for psychological interventions, and the third is mindfulness-based meditation interventions.

Adam uses Loving-kindness meditation in a conventional way. Loving-kindness practice (*Mettā bhāvanā*) originates from the meditational subject of the four divine abodes (*Brahma-vihāra*) and systematically it is organised to start with developing the quality of loving acceptance of yourself, and then towards other people. Adam has expert knowledge about the traditional practice of the four divine abodes.

Jacob uses Loving-Kindness practice as one of his RTs in order to open up the patient's mind and feel the loving mind. He said most patients have emotional difficulties and some lose hope and happiness because of their illness. He finds that there are many benefits from regular Loving-kindness practice, such as increased love, gratitude and relief from depressive symptoms. During the interview, he gave me Loving-Kindness scripts that he made for his clients. It was a shortened, adapted version compared to original much longer version, but it seemed more useful and suited to patients in hospital.

John emphasised that there are three important aspects in the relaxation process, first whole body relaxation, second relaxation of the heart through breathing, and third bringing into the heart and activating the quality of compassion and Loving-Kindness. He points out the relationship between relaxation and Loving-Kindness and client's intention:

What we need to do is to bring in this quality of loving-kindness in our hearts. So having done some relaxation, this is a really important part of the relaxation process. And it creates the right basis and foundation for the intent and then the receiving of the music and the sounds is that if we can activate this quality of loving-kindness in our clients and we can do that in various techniques, then they are then going to have a greater sense of self-love and self-worth and self-appreciation, it's more likely that the therapy will be effective (John-UK).

Anna uses Loving-Kindness sessions in her MBSR programme in a university setting as well as practising it by herself too:

What I actually use in my own personal practice would be a combination of mettā practice - you know - a combination of loving kindness practices and mindfulness of the breath and mindfulness of the body (Anna-UK).

Georgia describes her use of Loving-Kindness and Forgiving Meditation in her 8-week MBSR programme:

The end of the session such as in the seventh week, I do compassionate meditation and in the last session of the 8-week programme I focus on forgiving meditation. Forgiving ourselves as well as others is a wonderful experience and I often do it by myself and I like it (Georgia-Korea).

She talked about the personal benefits of Loving-Kindness/Forgiving meditation in her life and because of this she started adapting it in her programme in order to cultivate love and develop compassion.

Overall, many benefits of practising Loving-Kindness meditation were mentioned by interviewees. Among the 40 traditional meditation subjects, Loving-Kindness and

compassion practice in particular have currently been popularised and modified. Much research has shown the role of Loving-Kindness meditation in cultivating self-esteem, self-compassion, recovery from negative emotions and posttraumatic stress disorder (Hofmann et al., 2011; Fredrickson et al., 2008; Kristeller and Johnson, 2005).

In fact, Loving-Kindness practice is often used for experience-enhanced positive emotions and connections with the quality of life. Loving-kindness meditation may also enhance positive interpersonal attitudes and increased helping behaviour because it is organised to cultivate some positive emotional states from ourselves towards others. For example, ‘May I be safe and protected, and free from inner and outer harm’. [...] ‘May he/she/they experience ease of well-being’. Therefore, it can possibly be effective in developing the perception of social connection.

Loving-kindness is also used by UK interviewees for physiological well-being purposes. They came across this technique during spiritual retreats and mindfulness meditation programmes, then began using it therapeutically. My feeling was that the interviewees considered it a form of self-psychotherapy for clients and use it to improve positive emotions in clients as well as themselves. They often use Loving-Kindness meditation with compassionate meditation. It is generally believed that Loving-Kindness practice can naturally cultivate the compassionate mind too.

5.3.8 Mandalas

Two approaches to the use of *mandalas* (See Glossary) were identified. First, the mandala is regarded as a therapeutic tool to explore a client’s own centre of consciousness or express a core self-image of a therapeutic journey during the process of drawing the mandala. Second, it is considered a spiritual practice for consciousness-raising and self-transformation.

Olivia was working on a project for patients with Parkinson's disease with a speech and language therapy team, who were researching into strengthening the patients' voices and sense of well-being over a ten-week period. As part of this project, she designed a different music therapy plan that included mandala drawing:

I got them to do a mandala the beginning of the project - how did they feel about their breath and their voice - this whole section from here to the waist [indicating upper body] and the fact of having to draw a picture of it - and then I used a piece of music while we were doing the drawing - and then at the end of the ten weeks I used the same piece of music. And the difference between the before - and after - drawings was just remarkable. In some cases the whole sense or feel was ghostly or very, very small in one corner of the circle, lots of blank space, or jagged. There was one man who drew like a lung, all in red and yellow, and orange, but it was like one lung. And at the end of the 10 weeks, he drew something that was much more balanced - two lungs, still the same colours, but it was like he'd found the other part of himself. And then another lady did a little spidery drawing in the middle. And suddenly it was like a big rose that filled the whole of the mandala (Olivia-UK).

Olivia explained that drawing the mandala could be seen as an expression of how the lady felt about her voice and breathing after doing music therapy over the ten weeks. She adapts GIM techniques as well as guided visualisation, breathing work, voice work and singing in the ten-week programme. In GIM, mandalas are often used and clients' own experiences are reflected through drawing a mandala.

Olivia talked about a GIM trainer she knows and described another example of how the mandala and breathing skills can work together in a GIM programme:

He would get them just to think about how they think about their breathing space, so there's a circle and he gets them to draw a picture about how it feels in this breathing place. And then - this is before he starts - and then he does breathing techniques (Olivia-UK).

Olivia is particularly interested in breath work with mandalas. Mandalas are often used to facilitate meditation in Eastern religions, such as Buddhist practice in which

breathing techniques are a core element of practice. Even though mandalas and breathing work are related to specific religious practice, she adapts this in her therapeutic practice in a variety of ways, seeing the link between the spiritual practice and health benefits.

Adam said that mandalas - either the contemplation of sacred visual images or the drawing of mandalas - are used for purposes of mental concentration. In fact, mandalas are often used by meditation experts in order to focus the mind for enhanced concentration and insight and as an aid to prayer and meditation. However, Adam believes it possible to use mandalas in the area of art therapy or other creative work and suggests that the mandala is not only for the meditation expert, but it can also be useful in healthcare in combination with other specialist therapies.

Many modern health practitioners have also used the mandala in their work with varying purposes, such as to represent people's inner self, reflect their feelings, making the unconscious conscious or for creating a relaxing and tranquil atmosphere (Marshall, 2003; Fincher, 2000). Several interviewees perceived the value of the mandala as a therapeutic tool and understood the role of the mandala. Mandalas are used in an in-depth way for self-exploration, reflecting on personal experience or for spiritual meditation purposes.

5.3.9 Mindfulness Meditation (MM)

MM is a focal point of this study, since it was so frequently mentioned by interviewees. The three professional groups use MM for various purposes, such as mind-body intervention, nursing intervention, preventive medicine or as a core practice of the Zen meditation. Interviewees described different ways of using MM for people's health and well-being and many adapted versions of MM were discussed ranging from the 3-

minute breathing space meditation on the one hand to a full 8-week MBSR programme on the other.

The medical professional group, in particular, show enthusiasm for clinical preventive medicine (CPM) and use MM as a CPM strategy. They adapt MM for various purposes and the Korean group made it clear that the support of the clinical team and of the hospital organisation are a necessary requirement for the application of MM in hospital settings. Georgia recommended MM not only for patients but also for medical staff and trainees:

Yes, some of my colleagues are also interested in this programme and I would like to encourage them to attend this mindfulness course if they possibly can. I know they are very busy because of their work. For me, I teach mindfulness meditation to my nursing students as one of the modules. I think nursing students are very stressed in their clinical practice as well as having responsibility for patients, so they need to learn some relaxation skills and some spiritual practice for themselves (Georgia-Korea).

Two medical interviewees clearly recognise the positive health benefits of MM for their patients and both have organised an 8-week programme (once a week for 8 weeks for 1½ to 2½ hours per session) and also hold frequent workshops (4-day residential workshops or one full-day workshops) and short programmes of MM for staff, students and patients.

Discussing patients, Georgia said she firstly checks if they are day-patients or hospitalised or recovering, or a mixture of the two. Then, depending on their status and condition, she decides the duration and depth (or intensity) of practice, such as short practices or the 8-week MBSR:

Planning [...] is always a long job for me because I need to make a precise and well-organised plan because they are patients not the healthy general public. Therefore before starting this 8-week programme I had a meeting with a medical

doctor and nurses and they gave me a lot of important advice. [...] Before starting the programme, I want to try to open the patients' mind so I would introduce the MMP [Mindfulness Meditation Practice], then make group rules and agreement etc. Then I started the mindfulness meditation programme in each week's programme (Georgia-Korea).

The meditation group generally use MM and the MBSR programme with clients as well as to educate meditation students and general healthcare practitioners. One interviewee specially focuses on developing the theory of MM for the purpose of extending EBP. He hopes theoretical development and mindfulness research can contribute to practical physical and mental health benefits and is both a trainer and a great advocate and enthusiast for MM.

Among the music therapy group, three interviewees use modified versions of the breathing techniques which are central to mindfulness practice in relaxation music programmes. Some use the breathing techniques in more mindfulness-based therapy and some use them as basic calming techniques in order to support their therapy.

To conclude, a variety of techniques have been adapted such as breathing techniques, body scan, mindful movement, sitting meditation, loving-kindness practice. They include informal types of MM, such as eating meditation, walking meditation and mindful communication and they may also combine guided imagery/visualisation. Depending on the interviewee's specialism, MM is used simply as a RT, a stress management strategy, or as part of a rehabilitation programme, or else a personal transformation tool or component of spiritual development programmes. Therefore, various understandings and approaches to using MM between the three groups of practitioners can be identified.

Many interviewees emphasised the 'present moment' in practice and MM is present-based practice in its essence. The basic teaching of MM is that *life is available only*

here and now, the past is already gone and the future is not yet here. That in the Sanskrit language is referred to by *drishta-dharma-sukha-viharata* (現法樂住) in the traditional meditation sutra. It is translated as *blissful abiding in the here and now.* Therefore, through mindfulness of body, of feelings, of mentality, and of mental formations we can live and stay in happiness in the here and now.

Chapter 6: Finding Chapters: RTs, MM and RM Applications and Responses

Chapters 4 and 5 focused on how RTs, MM and RM connect with health and well-being. Many interviewees discussed the use of interventions for stress management, creativity and spirituality and clients' responses were discussed, in particular their acceptance and resistance of interventions.

In order to explore this further, I will focus my discussion in this chapter on:

- Firstly, how do participants apply RTs, MM and RM for purposes of exploring spirituality and what are their attitudes towards spirituality and creativity?
- Secondly, how do interviewees use RTs, MM and RM for stress management and how do they perceive the benefits of RTs, MM and RM for stress management?
- Thirdly, what do practitioners understand by stress/relaxation responses?
- Fourthly, when practitioners use RTs, MM and RM, what are the client responses and how are they expressed emotionally and physically?

6.1 RTs, MM and RM, Creativity and Spirituality

Several interviewees talked about their interest in the use of RTs, MM and RM related to creativity and spirituality, and the links between these and education, counselling, music, medicine, art therapy, meditation and CAM. This section will look at the key aspects of practitioners' understanding of creativity and spirituality in using RTs, MM and RM.

Various uses of RTs, MM and RM for creativity and spirituality at the personal and professional level were identified. Some interviewees have a strong personal desire to explore creativity and spirituality and some believe creativity and spirituality facilitate performance in their professional work. Depending on their expertise and motivation,

different purposes for the uses of RTs, MM and RM for creativity and spirituality were discussed, some of which may overlap:

- To develop the mental maturity of practitioners themselves (Jacob, John)
- For self-development programmes (Olivia)
- In order to explore spiritual medicine in hospitals settings (Jacob, Georgia)
- In order to understand or convey the meaning of spirituality, using music as a background to creative exercises in teaching settings (Violet)
- Using RTs, MM and RM in psychotherapy in order to empower clients and help them *clear away the noise* such as unhelpful ideas (Isabel)
- Using RTs and RM in creative exercises for nursing students in order to allow minds to open up and be creative (Violet, Jacob)

In the case of the medics and health professionals, cultivating trainees' creativity and promoting continuous self-development emerged as important common sub-themes.

Jacob mentioned that for medical students and student nurses, important educational goals at university level are theoretical education and practical training. However, he strongly emphasised the aspects of students' creativity and self-development. For these purposes he has adopted and developed many receptive techniques in preventive medicine:

My greatest interest is in spiritual medicine and these motivations have influenced my career continuously. I decided to apply relaxation programmes into classes for preventive medicine. My students learn various relaxation techniques not only as future clinical preventive medicine providers themselves who have to learn knowledge and practical skills, but also I hope this will affect their quality of life too (Jacob-Korea).

Similarly, Violet talked about the importance of considering the practitioners' own creativity and spirituality:

In a number of sessions we are teaching topics like spirituality. [...] we ask [students] to make something that says something about spirituality - what it means to them. Because what is spiritual to you could be very different to what is

spiritual to me. [...] So the first exercise is what does it mean to them. [...] They make the most amazing things - they make pictures, they make models, they make 3-D shapes - just beautiful things. And while they are doing that, we ask them to do it quietly, because we don't want them chatting away. And so music serves two purposes. It serves the purpose of keeping it calm and quiet, but also because we believe that music taps into the creative side of the brain, that it matches what we're trying to do with our teaching technique (Violet-UK).

Many studies have been conducted regarding music, creativity and spirituality in the field of healthcare and it is clear that interviewees also perceive the benefits of the use of music in their sessions with creative activities. Some of interviewees use music in combination with a variety of creative activities. When using shells, stones, finger animals, clay, or crayons and paper in her creative psychotherapy sessions, Isabel uses music as a background.

Violet said teaching creativity and spirituality are valuable, but teaching and learning creativity and spirituality is not an easy process:

It is very hard to teach spirituality, isn't it? You cannot stand up with a lecture and a PowerPoint presentation and expect people to learn kind of facts about spirituality. So we feel that they have to really engage with it for themselves first. And one way around engaging with quite difficult concepts is spirituality (Violet-UK).

Even though creativity and spirituality are not easy to teach, nevertheless interviewees are willing to explore them through various means in order to explain or impart the meaning and experience of spirituality to their trainees. The experience of spirituality is in itself an education and can enable understanding of things which are difficult to convey through words.

In the music therapy group, even though they did not talk directly about spirituality, nevertheless some of the participants are concerned with spiritual aspects when they work on breathing techniques, meditation and mandalas in music therapy sessions.

Olivia mentioned *altered states of consciousness* and the process of making contact with inner self in the GIM programme, which might be taken to link to spirituality:

For me, in GIM most sessions start with a reminder to focus on the breath without making any changes - just following the in-breath and the out-breath. This acts as an invitation to move inward (inside you) and also, perhaps, permission to enter one's inner world for a time and leave the concerns of the world aside for a moment. [...] For the GIM clients, we use relaxation skills to bring them into an altered state of consciousness, so then they can access their own subconscious and semi-conscious, through imagery and experiencing the music (Olivia-UK).

As discussed, interest in spirituality in the field of healthcare has grown and there are many current practices and studies that relate to music and spirituality. Here Olivia shows how she uses RTs and music to induce altered states of consciousness in order to bring clients into a state of calmness and to explore their inner self.

Isabel often combines MM and RTs (sometimes with RM) for the purpose of empowering the client and developing their strength to take charge of their life. And she talked of helping clients *clear away the noise* such as unhelpful ideas which prevent people from making a decision, thinking logically and being happy:

Empowering you to live your own life without me. I am giving you the responsibility for your life. [...] I respect that you know your own life actually. [...] At some deep, deep level you know what is good for you (Isabel-UK).

So if people become more present by practising meditation, their unhelpful idea/thoughts will gradually disappear and become more calm. This may affect their abilities to empower themselves and self-awareness and can even promote personal spiritual growth. Therefore, RTs and MM can be a tool for development of personal power and self-empowerment. In addition, the connection between the practitioners' own maturity and spirituality was mentioned. The interviewees point out that the

practitioners' own spirituality is beneficial for both themselves as well as the client too.

To conclude, this section has discussed interviewees' understanding of creativity and spirituality when they use RTs, MM and RM. Their common feeling was that creativity and spirituality are difficult concepts to express and teach. However, many interviewees are exploring various sources of creativity and spirituality and they use a receptive approach to music or RTs, MM and RM for creative activities. For example, when music fills the silence of space, it may help to lead to *pure consciousness* and in this state some genuine realisation, noble experience, or profound inner change occurs in a strong way like the special imagery that arises with the flow of music or at some similar numinous moment. Hence music may facilitate personal transformation and help to achieve a pure state of mind, which may be regarded as an essential state for spirituality. Therefore, there is a deep relationship between music and creativity and spirituality, which makes music a useful resource for increasing creativity. In various ways RTs, MM and RM can also be used to achieve inner quietness and to enhance creativity and spirituality.

6.2 RTs, MM and RM as Stress Management

Practitioners frequently incorporate RTs, MM and RM in order to manage stress in their work:

I often incorporate relaxation skills and music into my music therapy. [...] For example, for stress reduction session for workers I can incorporate their use. [...] I can devote 10 to 15 minutes for relaxation methods then I continue music activities (Lily-Korea).

Stress management was the one of the strong themes that was identified in the analysis and it can be divided four sub-themes:

- Stress management for patients and clients
- Stress management for healthcare practitioners and trainees
- Demand for stress management
- Active and receptive methods

6.2.1 Use of RTs, MM and RM for Stress Management with Patients and Clients

Many interviewees felt there is a deep relationship between stress and health and they used RTs, MM and RM for stress management in different healthcare contexts:

I feel there's a really strong link between stress and mental and physical well-being. And therefore, by promoting relaxation, you are promoting physical, emotional and spiritual well-being (John-UK).

The health challenges that were mentioned as being caused by stress included depression, digestive system problems and various tensions in the muscles; many interviewees commented on how RTs, MM and RM may affect our body and mind:

There are a lot of difficulties that people experience that are caused by stress. What I find is that these relaxation techniques and music - it has this gentle opening experience that affects not only our brain, but our heart, in particular, and allows for the heart of our clients to be more open and more accepting of their stressors and it can directly affect our body functions (John-UK).

In particular, John mentioned that personal emotional traumas or physical accidents may cause stress and many physical, emotional, and psychological conditions can be a cause of stress too. Practitioners who use RTs, MM and RM as interventions for stress management often have to deal with symptoms of stress from unanticipated personal conditions.

In the medical professionals group, their major focus was the relationship between stress and mental and physical well-being, and how to develop stress coping strategies.

Jacob particularly focused on the patient's experience of stress and how it affects the patient's recovery from or ability to cope with illness:

Psychologically, patients unwittingly experience a lot of stress because of their fear of illness. This has an even greater effect on their quality of life too. In addition, it is unhelpful as regards the disease treatment process. The anxiety of the patient definitely doesn't assist the treatment. Patients who experience 'sessions of relaxation' with relaxation techniques and music suddenly know a 'feeling of comfort' and they will feel relaxed and it may take them away from their illness and suffering. For some patients who experience this, it is the first time to feel relaxed in their life. By attending those sessions on a regular basis, through the 'relaxation experience' the patient's way to respond to day-to-day situations will change. In addition, many more patients will be able to have a relaxed mind about their illness. In other words, these small 30 or 40-minute experiences of relaxation can be meaningful to patients who just rely on medicine and surgery (Jacob-Korea).

Georgia said during her care for breast cancer patients she realised that they have many stresses due to fear and depression (having lost part of their body), so she invites breast cancer patients into either relaxation programmes or mindfulness meditation sessions which she runs in hospital. Similarly, Jacob felt that patients are often nervous and create unnecessary worry for themselves; he uses both RTs and MM as a support to his main treatments and rehabilitation programmes in order to reduce their stress.

In this way, through the relaxation experience, patients may realise that they can live in a more peaceful way and they may feel more comfortable with their illness. Thus it might provide a new learning experience in coping with stress and in turn it will provide inner strength in the patient's life too.

6.2.2 Healthcare Practitioners' and Trainees' Use of RTs, MM and RM for Stress Management

Stress is not only an issue for the participants' clients, but healthcare practitioners also

suffer from their own stressors, such as conflict with clients or family, burnout through overwork and tiredness when treating clients, which affects their professional work:

I have met many medical doctors, medical students, nurses all of whom suffer from their own problems and the thought stays in my head “why they are all looking so stressed?” (Jacob-Korea).

Studies have examined how to use RTs for staff stress management and various relaxation programmes have been suggested for managing stress for healthcare staff (McCarthy, 1992).

I had expected that interviewees would mainly talk about the client’s stress or health issues, but both in the UK and Korea, many interviewees were concerned about the healthcare trainers’ stress management and how to guide or teach stress management to medical and nursing students. Four interviewees teach stress management as one of the modules on their courses. Violet emphasised the emotional care of trainee nurses:

Sometimes nursing students get really anxious about their exams, about their assessments. They’re so busy, so that 10 minutes just to shut out their minds. [...] I know that they benefit in terms of just giving them 10 minutes to relax, I think, more than anything, and to keep their minds off all their worries (Violet-UK).

She said that if she teaches her student midwives, then she will expect that they will use these techniques in their work too:

What I am doing is giving them some basic tools, since [...] they would work with women in an antenatal class, or with women in labour, and they would teach the women how to use these basic relaxation techniques, so they are putting them into practice. It’s like a midwife has a range of skills that she can use in different situations. [...] There are [...] women who get really stressed out, and they shout and they scream and they hyperventilate. And so, in that situation, the midwives that I have taught, would be able to try and help that woman relax (Violet-UK).

Likewise, Georgia perceived there are many benefits in using RTs, MM and music for stress management among nursing students because when the trainee knows how to manage their stress, they will convey those methods to other people:

I teach a stress coping programme to medical students in order to allow them to develop the capacity to manage stress themselves (Georgia-Korea).

Anna talked about how UK practitioners use MM as a means of stress management:

The practical benefits can be many. For some people, even if they aren't experiencing any current stress in their lives, it just helps them to feel more like they're living life to the full. [...] And more engaged and really feeling the highs and the lows of every day more rather than being just very focused on, you know, problem-solving and task lists and to-do lists and all the rest of it. But for those who are experiencing stress or anxiety or depression, the practical benefits can assist people to learn to notice what their triggers are for increased stress or drops in mood, and therefore to help them make more skilful decisions about how to respond to those moments (Anna-UK).

Overall, RTs, MM and RM can positively affect everyday living for people who are exposed to stress and those calming effects will have benefits when working with people in stressful situations.

6.2.3 Demand for Stress Management

Music therapists are often contacted by various healthcare and professional organisations and asked to provide services. Following on from these referrals, practitioners often use RTs and music for stress management. Lily said she was recently asked to conduct a music therapy programme by the City Hall in order for employees to reduce stress and find a way to cope with stress and anxiety. She used a combination of approaches: for example, RTs with receptive and active music therapy. One attendee of Lily's sessions said:

It has been a busy day all day, and [...] it is sometimes very stressful. However during the session, I did not need to do anything - I just had to follow your guidance and do nothing. [...] it makes me feel easy and relaxed. I was able to rest today.

Hence, not only because of practitioners' beliefs and motivations, but in response to external requests for stress management programmes as well as feedback received, practitioners use a variety of interventions.

In fact, many larger organisations such as technology companies like Samsung and LG are becoming more concerned about employees' well-being and job-related stress and consequently companies offer in-situ stress management or self-development sessions with therapists or meditation experts. Demand to find a way of coping with stress, anxiety and depression through well-being workshops is growing and people increasingly look at mind-body interventions as a way to manage stress.

6.2.4 Active and Receptive Methods for Stress Management

In terms of reducing stress, some interviewees mentioned that using active and receptive methods together in the same session can often achieve therapy goals better in terms of stress management as well as enriching the client experience. For example, John uses both recorded music as well as live music as relaxation music because both receptive and active approaches have their own benefits.

Some interviewees said for healthy people as well as for sick people, receptive methods such as listening to music, breathing techniques or PRT can reduce physical tension directly as well as reducing mental stress. However, others argued that active techniques such as drumming and the use of percussion can relieve psychological stress, but physically may sometimes produce muscle tension, for example in older people in the hospital setting. Practitioners need to carefully consider the client's

physical condition and ages. (The link between the use of active and receptive methods and cultural factors will be discussed in Chapter 8).

To conclude, this section has discussed how the interviewees use RTs, MM and RM for clients who are undergoing stress, as well as professionals themselves who are stressed out or overburdened with work. The interviewees considered that there are strong causal links between stress and physical and psychological well-being, such as what stress does to our bodies and how our body is affected by stress or relaxation. And they talked about the physiology behind stressful events and stressors.

Practitioners are exploring interventions which use music or RTs, MM as ways for people to switch off busy minds and slow the mind down, and reduce stress, anxieties and fears. The participants' perceptions regarding stress, personal stress management strategies and specific methods for professional use are slightly different. However, it is generally felt that RTs, MM and RM are important interventions that contribute to stress management.

6.3 Practitioners' Understanding of Relaxation and Relaxation Responses (RRs)

There is some discussion among healthcare practitioners as to what is meant by relaxation and the RR. In my study, RTs, MM and RM are regarded as mind-body interventions and relaxation can be defined as a state of deep rest, or an anxiety- and tension-free state. Therefore, mind and body both play key roles in RRs. Different RRs may occur depending on people's physiological and psychological conditions.

The RR may be seen as the opposite reaction to a stress response, which itself is fight or flight response (Jacobs, 2001; Benson and Klipper, 1992). Similarly, many

interviewees considered the RR opposite to the stress response. They try to induce the RR through music activities, RTs or a combination of RTs, MM and RM.

Interviewees' perspectives on what is meant by relaxation included:

- Stress relief and returning the mind and body to pre-stress levels (Isabel, Violet)
- Physical tension reduction (Lily, Isabel)
- Freedom from anxiety and other negative emotions (John, Anna, Jacob)
- Mental freedom (John, Adam, Anna)
- Physical comfort (Olivia, Violet)
- Ability to sleep (for hospice and cancer patients), (Jacob, John)
- Mental alertness and physical and mental relaxation (Anna, Adam)
- Slower heart rate and the feeling of relaxing the body (Olivia, Jacob)
- Relief from hard work and doing nothing (Lily)

Lily feels different client groups experience different RRs. She contrasted reactions of young people at school and elderly people in hospital. Even with clients with similar ages and health conditions responses may vary. For example, the active technique of drumming can relieve psychological stress, but she noticed that physically it can also produce more muscle tension:

Most people attending the session say that after drumming “my stress is relieved.” Other people say their minds have calmed down, but they also often say their muscles are sore the following day (Lily-Korea).

And in many cases breathing techniques or PRT can reduce physical tension directly as well as reducing mental stress, but for some patients such as hospice patients, RTs can produce unexpected physical tensions.

The RR itself can be different in sick and healthy people. Hospice patients or lung cancer patients may have different respiratory abilities compared to normal healthy people, for example. Sometimes breathing techniques, even gentle ones, that promote relaxation in one group will increase stress in another. Receptive and active approaches

to RTs, MM and RM can cause different reactions according to people's physical conditions and energy levels. The type and perhaps the quality of response which can be achieved will depend on a patient's condition and the approach taken.

Isabel said one of her main reasons for using RTs, MM and RM is for relaxation purposes and she uses it when clients feel nervous and stressed. She said stress is a kind of mind and body response and she can sense when the client is actually stressed:

I think stress is visible both verbally and physically. When a client is very stressed, their speech tends to be faster and breathy. The body is either held tightly or they are very active, like they can't sit still for very long, or look uncomfortable in themselves (Isabel-UK).

Olivia talked about her understanding of the meaning of relaxation:

To me relaxation encompasses reduced body tension, slower heart rate and increased sense of well-being (Olivia-UK).

Rosie and Lily feel that according to the time of day, RRs may vary. For example, at the end of a day, their clients, (office workers and expatriate workers) are physically and mentally too tired and busy, who considered 'doing nothing' to be more relaxing than 'doing something' so they preferred receptive methods such as listening to the music rather than more physical activity.

Violet gives her nursing students a model of how to use RTs in order to help them understand RRs:

Probably one of the most simple things I do is to try and get them to understand what they do with their body - how their body affects how stressed or relaxed they feel. For example, I get them to sit in their chair, and do this [action of tensing up] and then just ask them to drop their shoulders and relax and think about it. And then I get them to explore how that makes them feel - and the difference between doing this [action] and relaxing. And the whole idea is about getting them to understand that the body can send messages to the brain. [...] And that's something they can do with pregnant women as well, so if women in labour are

really tense, which they do when they're in pain, they can just encourage them (Violet-UK).

The relationship between the body response and brain can be related to mind-body medicine because mental work is an aspect of brain function and at the same time the mind is connected to the thinking process of brain. Such links between the mind, body and relaxation are still a subject of research.

There are many widely-known special meditation programmes (such as MBSR) and special-purpose RM designed to produce RRs in current use. However, practitioners' approaches to the use of RTs, MM and RM may differ depending on their own perception of relaxation.

Lily talked about her understanding of the concept of relaxation and she pictured it in two dimensions (in the form of a grid):

There is a vertical dimension and a horizontal one. I think relaxation can be explained using the vertical dimension (physical relaxation and mental relaxation). On the horizontal axis, it can be divided into shallow relaxation and deep relaxation. [...] Every relaxation technique has its own unique character. It is not a question of wrong or right techniques. But the practitioner needs to consider these different dimensions of relaxation - physical and mental, shallow and deep. If we think that an activity leads to both physical and mental stress relief, then any music therapy activity can be used. For example [...], sometimes we sing together in harmony. People can feel that they are supporting each other through the harmony. In this way people can experience relaxation. [...] I don't like to methodologically divide active and passive techniques. Every kind of music therapy activity can reduce physical or psychological stress. But in my experience, receptive techniques are of more direct help psychologically as well as physically (Lily-Korea).

Lily emphasises that the relaxation experience may depend on the client and so it is difficult to generalise: the definition of relaxation can therefore be extended to take into account clients' reactions and their comments. For example, if the client receives

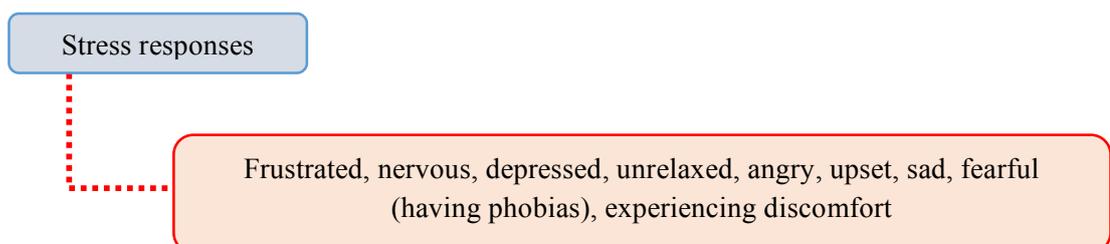
a particular relaxing experience such as comfort or mental relaxation, then she includes this in her categorisation of RTs and RM.

Anna says that a RR is not the same kind of relaxation as sitting absent-mindedly in a comfortable chair, since a RR can be achieved through a mental awakening process. She believes that a RR can relate to physical relaxation as well as mental alertness. However, some practitioners argue that depending on the client group, 'resting' may help some people to relax. For example, patients who have nice, relaxing short sleep during a session can be said to be enjoying a relaxation experience.

In brief, the RR is not easy to define and may depend on whether physical and mental aspects are the focus. Therefore, in order to achieve the RR, clients' own interpretation of what relaxation means to them and what their personal needs as well as conditions are should be considered. Apart from such individual differences and personal situations, even the time of day may mean that relaxation can come to mean something different. These are the considerations of practitioners when they select and use RTs, MM and RM interventions and whether to use receptive or active methods.

6.4 Stress Responses and Relaxation Responses(RRs)

Client responses to the use of RTs, MM and RM can be divided into stress responses and RRs. Clients described their feelings or emotions in various ways:



Relaxation responses

Peaceful, relaxed, happy, safe, confident, dreamy or awake, hopeful, comfortable; experiencing love, kindness, inner strength, a healthy mind, freedom, trust or reassurance

Those stress and relaxation responses may be individual and vary depending on the person but in general, they show the negative associations with stress and positive states of mind resulting from the relaxation experience. And interviewees point out those two opposite responses may directly affect body and mind.

6.5 Responses to RTs, MM and RM

People's reactions to music interventions and their feedback were described as:

Responses to RM

Pleasant, relaxing, beautiful, feeling of lightness, stress reduction, feeling of change in the body sensation

Rosie believes listeners' affective reactions may relate to musical preferences and she related her experience of music therapy practice in senior school:

Reactions to the music are either negative or positive. They will say it is boring or it is really nice or they do not express a reaction. If students have a negative feeling about the music, the whole session will not run smoothly. However, if teenagers choose their own preferred music and feel positive about it, this creates a positive start to the session. Therefore if we are going to a secondary school, before we go we should assemble many genres of music, such as jazz, hip hop [...] and so on, then before starting the session we must ask which the student prefers and play the different genres for the student to choose from (Rosie-Korea).

Young people perceive RRs in a different way compared to adults. For example, some young children do not recognise what relaxation or tension is but they express it through positive and negative reactions:

When I try the relaxation techniques with them, they often say, “My mind feels very nice”, “I feel comfortable.” (Lily-Korea).

Olivia uses a tension and release method for adults for feeling more relaxed, but with autistic spectrum disorder she uses a relatively informal approach to the relaxation session (combining the music with breathing techniques) just so that they feel safe and can de-stress. Therefore, an understanding of relaxation and the degree of the RR may vary depending on the client group, age, gender, educational background, or health condition.

Violet commented on the nursing students’ feedback following the relaxation session:

I suppose it’s their feedback to me that makes me continue to do it, because they love it and they ask me and they say to me: “Will you do one of your relaxation sessions?” and they come back into class and they say, “We tried that technique with a woman in labour and it worked.” and so they give me feedback (Violet-UK).

The attitudes towards acceptance and resistance to the practice of RTs and RM within university settings and hospital settings were mentioned:

In the university setting there are different issues from the hospital setting. Because it’s about education, because it’s about opening your mind, about exploring different things, there’s more of an acceptance that you can play around, you can learn these things, you can open your mind. In the practical setting in the hospital, sometimes it’s considered ‘what do you want to waste your time doing that for?’ It’s not considered important. So I think that people in practice [not in university life/not students] don’t often realise the power of relaxation techniques. [...] So that’s the attitude that you get in the clinical setting sometimes, whereas in the university you’ve got people who are keen to learn, dynamic, excited about practice, wanting to learn everything they can, but in practice they’re stressed out,

they're too busy, they don't have time to do relaxation things with women (Violet-UK).

In general, organisational structure, clinician motivation and personal understanding may influence receptiveness to the use of RTs, MM and RM. Resistance, on the other hand, may be due to physical tiredness and overwork and a lack of opportunity to acquire the knowledge and a lack of understanding or experience of the RR as well as time pressures.

Music and RTs, MM are often used in rehabilitation programmes. Jacob and Georgia explain how they support the use of RTs, MM and RM in their rehabilitation service departments and how they consider the use of RTs, MM and RM in relation to patient's conditions and their hospital organisation system. Jacob talked about the relationship between *recruitment methods* in hospital and patients' acceptance and resistance:

Only in very few cases [is there resistance or reluctance on the part of patients]. I think it's because of the method of recruiting patients. [...] I run sessions with two kinds of patients - those in hospital and those who've been discharged. For patients in hospital I put up posters all around the hospital and I leave registration forms [...] We can accept patients and their families. This means anyone who registers is already interested and so there is no reason for problems. In the case of discharged patients, if somebody has already taken the programme in hospital, we have their contact details and when they leave, the hospital staff contact them [...] and then give out information about all the rehabilitation programmes (physical exercise, yoga, art therapy, and music therapy as well as my relaxation programme) and so there is a chance then for them to join in again. So there again there is no problem recruiting these patients. But of course, during sessions unexpected things may happen and frictions can arise (Jacob-Korea).

He reported typical patient feedback following relaxation sessions:

'It is a fresh new comfortable experience', 'It was a nice feeling', and 'My feeling is comfortable and refreshing'.

Some patients with sleeping problems often fall asleep during meditation and he leaves them to sleep in comfort for a while. Then when they wake up they say they feel better

and he regards this as a good sign of relaxation in the patients. Also when he uses music in conjunction with meditation techniques the patients say:

‘The music was very good’, ‘The music made me really comfortable’.

One cancer patient said that the relaxation session offered him mental strength and he found the session very helpful after experiencing a very hard time during treatment:

‘My mind felt much easier and could unwind’, ‘relaxation techniques in themselves seem to have a mysterious power’.

Jacob said these positive reactions from the patients always give him great faith in the treatment and to continue to run relaxation sessions.

The signs of relaxation were also discussed by other interviewees. Olivia said she can sense that clients look happier when relaxed and their eyes are more open, alert and smiling. Lily said certain kinds of music or music that a client enjoys may facilitate relaxation and sometimes remind a client of happy memories. She sensed this was happening to one client:

The client closed their eyes and listened calmly and this, I would say, is a sign of relaxation (Lily-Korea).

However, if the music is too long, sometimes clients fall asleep, so Lily uses an approach for keeping the client awake drawn from the classic form of the Bonny Method of GIM. For example, while listening to music, she asks “Where are you now?” or “Can you see anything?” Without guidance, the client may wander off and go to sleep.

Medical professionals on the one hand and the music therapists and meditation practitioners on the other appear to have different attitudes towards patients’ sleeping. Medical professionals accept sleeping during the relaxation session and believe sleep

itself is a good sign of relaxation because many patients suffer from pain. They are unable to experience the comfort and quality of sleep, which might also assist their recovery in hospital. Medical professionals tend to use RTs, MM and RM as a supportive intervention during the rehabilitation process. They regard sleep as a method of relaxation for patients, who after a short but good quality sleep wake up feeling better. Therapists and meditation practitioners on the other hand use music or RTs, MM as their main interventions and, particularly in public settings, they run each session with a specific goal during a limited time, so they have to find specific methods of preventing clients from going to sleep. If clients go to sleep during the short session time, it may difficult to run the session.

Rosie and Lily found that the client-practitioner rapport may influence client's acceptance and openness:

Once we have developed a rapport, clients often reveal their inner emotions and tell me their real feeling. Then they seem more accepting and with this rapport volunteer more about their feelings towards the music (Lily-Korea).

They both stress that the client-therapist relationship is an important factor and they sometimes use RTs or talk with clients simply in order to build the rapport.

Isabel said sometimes she asks the client's permission when she uses music and believes this may help prevent any resistance. In her experience some clients prefer to do sessions in quiet and without music:

There's a man. He says it [music]'s irritating him. Now I always ask. "Is it ok with you if I put on a little bit of music?" There's an English word for it -Tentative. That's how we are. That means we just gently try something. If the client says no, OK, so we try something else. We don't push. Always ask and make sure it's ok? If they say no, that's OK. Then they know they are in charge, controlling the decision. [...] The man called Carl Rogers had six basic building blocks for

helping people but he said the main one is actually you know what's best for your life (Isabel-UK).

She tries to practise based on the principles of person-centred counselling and she believes the therapist's respect for clients and their independence and self-direction may influence the client's responses.

Some interviewees use focused practice such as breathing techniques with or without music in order to rest the client's mind. Training the mind to be *one-pointed* (See Glossary) by concentrating on a single subject may develop positive emotions. When people are overwhelmed by stress, the mind wanders and becomes *not single-pointed* - and clients are less able to achieve a state of relaxation or rest during such distracted states of wandering. Through breathing techniques, changes in quality of mind, such as concentration and insight can be facilitated. A fundamental precondition for achieving concentration and insight is a single-pointed mind.

Olivia often felt people with illness or stress can feel negatively about their body, as if they are fighting their body or, in the case of stress, fighting for something vitally important and she related how clients expressed the feeling after engaging in one-pointedness practice:

Bringing the focus back to the breath it is as if they return to the essence of themselves. Clients have reported that they find these exercises at the beginning of the session the most valuable thing. They feel amazed by how positive the effect is! In GIM, most sessions I start with a reminder to focus on the breath without making any changes - just following the in breath and the out breath. This acts as an invitation to move inward (inside you) and also, perhaps, permission to enter one's inner world for a time and leave the concerns of the world aside for a moment (Olivia-UK).

To conclude, various client responses and feedback to RTs, MM and RM have been discussed. The understanding of the RR and the level of relaxation that clients demand or desire may be subjective. For example, differences between healthy people and

patients such as those in Intensive Care Units might be very pronounced due to their physical condition. Therefore, when running a relaxation session client requirements and their physiological and psychological condition need to be taken into account first. However, in general, most clients affirm the calming experience of RTs, MM and RM and generally show their acceptance of the practices with little resistance and report feelings of comfort. Clients frequently express how they feel changed and how their level of trust in the RTs, MM and RM has grown; the relaxation experience has given them the capacity to be emotionally calmer than before.

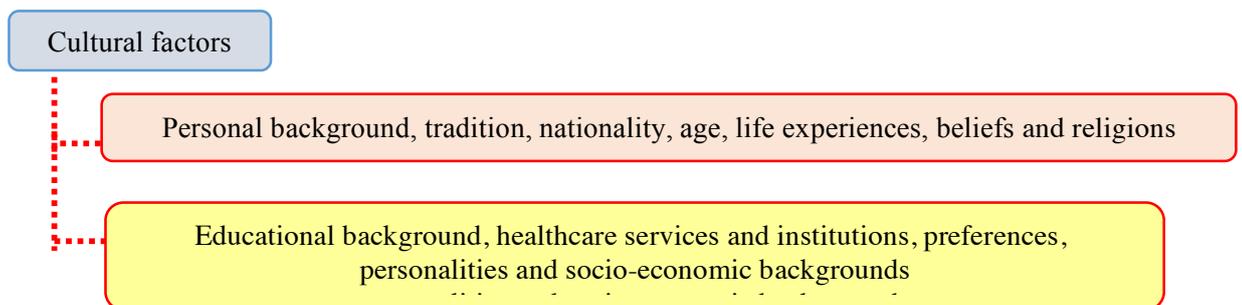
Chapter 7: Finding Chapters: Cultural Context

This chapter considers the cultural context, differences and similarities in understanding and use of RTs, MM and RM between Korea and the UK:

- Firstly, the differences in participants' outlooks and attitudes due to cultural factors in using RTs, MM and RM
- Secondly, the cultural similarities or differences when practitioners use RTs, MM and RM

7.1 Cultural Factors/Understanding and Use of Interventions

The following cultural factors were discussed:



Most interviewees made the point that an understanding of individual differences is essential when considering the use of RTs, MM and RM. They believe that aspects of a client's culture may cause individual differences and therefore understanding cultural factors will also have an effect on the session itself.

7.1.1 Cultural Factors and RM

John discusses how we experience music and feels that how we relate to music is very important. In his view the cultural background relating to sounds and music may start at a very early age:

[..] as we grow up, even inside the mother's womb, as an embryo and as a fetus, our ears develop first as the main sense organ. [...] I think it is - you know, from 20 weeks - we start to hear the sounds (internal sounds) of our mother and then I

think we're probably able to experience and feel the sounds outside - when we're very young, as a baby, whether mother singing to us, whether there's music in the house, whether she's playing any instruments or singing (John-UK).

In relation to this, Rosie, working in a hospice, believes that hearing is the first sense that we develop in the womb and it may be the last to go; when people are close to death, the ear still functions right to the end of life:

Last week someone was dying. A family member called me and asked me to sing her favourite song for her. I took the guitar and joined the family group. I sang and everyone joined in and they all cried. During the session the machine stopped and she died. I hope she was able to hear until her last breath (Rosie-Korea).

She said in the hospice when she arrives in the morning sometimes one ward seems suddenly empty. But the deceased patients had recently joined a session and had sung something together with her and so Rosie hopes they may have forgotten their pain even for that short time (perhaps just a few minutes or so).

Listening to Rosie, I felt that music therapy would have a special significance for such patients and, even though they are dying, they may be able to hear the song when Rosie plays and sings. This may provide for the family a final moment to remember. The focus on involving family in a therapy session is characteristic of Korean thinking. Similar moments are reported by therapists in the UK and families are involved in hospice work, despite differences in culture that will be discussed. It seems that such a meaningful moment will go beyond the culture and John and Rosie show how the music and sound may relate to people's life through from birth to death.

Olivia relates a story:

I had one lady who had very bad myalgic encephalomyelitis (ME) - so much so that she couldn't really go out of the house and had no energy. She was very aware and she was startled by loud noises. I had to go to her - she couldn't travel. She had made her room all orange - orange curtains, orange bedcovers - so there was

kind of like a warm glow in the room. And she wanted to do GIM sessions - so I chose a programme called 'Quiet Music'- there was no sudden surprises or very big climaxes in it - it's all quite gentle. So it might affect my choice of music (Olivia-UK).

Here Olivia considers aspects of a client's background when selecting music. Often she uses classical music in GIM sessions but she considers cultural factors related to classical music too. Once, when she worked with a man from Rwanda, she was very aware of that, since with his African background, his tastes and musical experience would be very different. But he said he was very happy to 'travel' to the classical music, so with this in mind Olivia still used classical music in her session. However, she said that maybe more culturally neutral music could possibly be used:

I think some of us younger practitioners had been working on developing some programmes which are maybe more neutral. And I know there's a GIM practitioner from Hong Kong, for instance, who has made some Chinese music programmes. And sometimes, more contemporary music, like perhaps Einaudi (he's an Italian composer) is more neutral - because there's a sort of world music influence in that (Olivia-UK).

Nowadays the cross-cultural influences on music are in any case stronger and musical tastes are more likely to be shared across the world and this is very possibly what Olivia has in mind when she talks of 'more culturally neutral music'. GIM programmes are developed in many countries, so as Olivia mentions, in GIM programmes many kinds of music may possibly be developed in the future by the new generation of therapists.

Rosie considered how the nationality of a client may affect a session. She sometimes runs sessions for international workers and she has recognised that there are many cross-cultural differences from her other clients, including educational background and language. When she runs any session, her main consideration is individual client's needs and their choice of music but with international workers she feels that there are

specific limitations. For example, she may not be familiar with the music they know or like.

Clearly working with international clients can pose special challenges, including building a rapport with them because of the communication difficulties and cultural differences. In addition, since they are sick people in a foreign country's hospital, they may suffer emotionally due to loneliness, homesickness or a sense of alienation during their hospitalisation. I think, in a hospital session, particularly with international clients, understanding cultural factors is important before starting the session. This is part of the assessment and may be done through talking with the client, but again there may be limitations.

7.1.2 Cultural Factors and Sound Instruments

Several interviewees use sound therapy instruments for RM such as crystal singing bowls, Tibetan singing bowls, Balinese bells, gongs and drums. When I attended John's sound therapy programme, the UK participants seemed to enjoy playing these instruments. Particularly in the drumming session everyone was smiling and also it was a good chance for the participants to laugh with each other and establish a rapport or to bring people closer. John believes:

The cultural influences from the music from other cultures has become stronger here in the UK. And as a result, there is now a greater acceptance and interest in this. [...] I think culturally here I think there's an opening to music from cultures that young people and older people now like. [...] in the context of things like festivals and camps [...]. So now there are more people getting interested in these things like Tibetan bowls and crystal bowls and gongs as well, and also the drumming. And also I think the singing side of it is becoming more important. The drum circles and the community drumming is another way, I see, the sound and music therapy becoming more popular. I think it's all ages - it's young people and older people who are doing this (John-UK).

Singing bowls and gongs are often used in Korean temples. One of the nuns or monks in the temple wakes up early and starts to pray while gently striking the bell as a ritual religious practice. The bell sound in the early morning is peaceful and relaxing. When I visited them, Adam and Jacob both had singing bowls displayed in their offices. Adam said singing bowls and gongs are often used at the beginning and end of the silent meditation session. He clearly feels these bell sounds have a particular kind of power:

I've started getting interested in music in vibroacoustics and sound frequency. One day I met a music expert and we discussed this topic for a while, even though this theory is not very well developed yet in Korea. However in the future I believe it will be very beneficial and a necessary part in the combination of meditation and music (Adam-Korea).

He believes that these pure sounds have strong healing power and many Korean people are familiar with the sound of singing bowls and bells in the temple:

I think a broad range of frequencies exist within music and these naturally occur when we are listening to music or playing a musical instrument. [...] Early every morning we play the big meditation bell which we call Bumjoun (梵鐘) and we have various types of smaller bells too. This means a lot for me as a meditation tool. People know when the bell is ringing we need to be quiet and prepare to meditate to the beautiful bell sound (Adam-Korea).

Personally, Bumjoun and the sound of the singing bell was a starting-point for my own interest in music therapy, because it is a healing sound and gives me both serenity and rest. I feel that it can purify the body and mind (the experience may be of mental refreshment or new energy). I discussed this with John, who said the bell's beautiful sound frequency and energy may penetrate mind and body and uplift the spirit too.

However, when I attended John's sound therapy programme, I wondered why a particular bell sound is calming but other bell sounds not. During one summer programme at around that time I suffered from tinnitus for several months. Some high

frequency bell sounds hurt my ears and I mentioned that to him. He gave me an American drum rather than the crystal singing bowl and my ears felt better and I felt calmer and more balanced.

Rosie mentioned that it is necessary to check a patient's hearing and sensitivity to sound/music before starting the session:

One time I didn't do this rigorously enough and the patient was very uncomfortable. I had brought some little drums, but this patient couldn't stand the sound and the patient wanted to stop the session. I also brought a softer ocean drum, which was better. [...] It happens in some cases so we have to be sure to check everything through carefully, before we put together a session. Often there are unexpected things that happen [...] and we always need back-up plans (Rosie-Korea).

Greater understanding of the frequencies of music and sound in future might therefore be of benefit to those working with client groups such as older people in hospital or those with ear problems (tinnitus or hearing impairment).

7.1.3 Cultural Background and Responses to Interventions

Adam sees a link between an understanding of cultural background and the development of therapies. He believes that combining RTs, MM and RM will provide a new tool for practitioners and in order to develop such interventions, a recognition and understanding of diverse cultural factors may be needed:

Korea's traditional meditation has been associated with music, poetry, physical therapy and various kinds of art. Therefore with an understanding of Korea's unique background of traditional ideas, I hope that a more practical application of combined meditation and musical elements can be utilised and developed (Adam-Korea).

Understanding of tradition and history and a sense of national feeling and character are important in order to match these elements with clients who may share these characteristics and sentiments.

Lily talked about the relationship between cultural factors and clients' responses to receptive interventions. She believes that receptive techniques will become well-developed in future if they are well matched with typical Korean emotions:

I think - this is strongly related to Korea's traditional way of thinking (traditionally handed down from generation to generation), Korean traditional virtues and Confucianism and Korean Society. Many old people have taught our generation 'Do not express your feelings openly or to others', 'it is a blessing to endure', 'meekness' and 'modesty'. It is quite certain that receptive methods can make a client feel good and comfortable and clients mostly respond positively to them, but it always depends on the 'kinds of clients' and 'the depth of relaxation' etc. (Lily-Korea).

Koreans consider above are the important human virtues. So people naturally follow and transfer those ideas. In Korea, the majority of adults grew up with 'Confucianism' as cultural background. People still have the unconscious heritage of these teachings because most of our school teachers are aged between 30 and 65. The majority of people (though perhaps not the younger generation) still think that these virtues are lessons from the ancestors. These traditional virtues and Korean emotions may help to explain why those receptive methods have spread and developed quickly over a short time in Korea. And this explains why receptive methods are a preferred treatment for many people and a suitable approach given the typical sentiments of many Koreans. It is important not to overgeneralise and cultures in any case change over time. Nevertheless, the heritage is handed down from generation to generation. Korean families have typically lived together with the elder generation and there are great ties between generations and so those sentiments tend to survive.

Lily said she often uses RTs in music therapy sessions, whether active or receptive or both. In her experience, older people prefer receptive approaches while younger people like both active and receptive methods:

In my sessions, many adults prefer the receptive methods to methods involving active expression. They feel much more comfortable about the passive way. For example, during the session when I said “Let’s play the drums!” or “Let’s sing!” or “Could you express your difficult feelings playing the drum?”, then most clients do not follow well. Some react very passively like a good student trying to follow the teacher’s command and some play the drum without any emotion and in a very careful way. Of course, depending on the people’s nature, our relationship or rapport, or how things go during the session, passive reactions can possibly turn into active ones during the session. However, still, older people continue to take a passive stance (Lily-Korea).

Perhaps, as Lily suggests, these reactions to the receptive or active approaches may differ in Western background. I feel that not only the traditional way of thinking, but also the cultural way of life may influence the use of RTs, MM and RM.

When I attended John’s workshops in the UK, after finishing the daytime programme of sound therapy, he invited a meditation expert for a guided meditation session at an evening programme. During the guided meditation session, one musician played an instrument for about 20 minutes, so it was a combination of music and meditation. The music was very peaceful, but in Korea we would hear this kind of music when preparing for a funeral. So to be honest, during the meditation I felt sad and I remembered feelings I had had during funerals. (I actually wanted to leave at one time because it made me too emotional). At that time apart from me all the participants were British, so I do not suppose they felt like me and our experience of the same music in the same session would have differed.

Music can evoke emotion whether smooth and sustaining or intense and transforming emotion and the field of music and emotion has been reported by many researchers

(Deliège et al., 2011; Juslin and Sloboda, 2001). Cultural background as well as individual histories clearly influence how we react to music.

7.1.4 Religious Influence

Sometimes cultural barriers to RTs and MM (though not to RM) were mentioned. Sometimes in the UK but more often in Korea people perceive RTs and MM to be related to religious practice and a client with a strong resistance to any particular religion or with a strong religious affiliation, might be resistant to RTs or MM. Olivia said when she runs a relaxation session, in order to avoid sensitivity of those with a religious background, she uses more neutral words and avoids religious vocabulary:

When I ran the ME group for four [this year] - there was one lady who was incredibly anxious about what kind of techniques I would use, because she was very very Christian. And anything that wasn't - kind of - in the Bible - was sort of not allowed. So if I mentioned anything like Chakra or yoga or Tai-Chi, or anything like that, she wouldn't be able to do it, because God would be cross with her. [...] So if I'm working with a group I don't know what their beliefs are - or something like that - then instead of using the word 'Chakras' I just say "Okay, we're going to tune into the base of our spine." And I keep it very much in the body (Olivia-UK).

By contrast, many interviewees considered that music and sound are comparatively safe and bring less resistance in terms of cultural barriers than RTs and MM which are more clearly related to religious beliefs. Therefore, it may be advantageous to use RM because there may not necessarily be emotional effects or preferences to be considered with respect to culture. Sometimes, however, it may be enough to explain that RTs or MM techniques are not attached to any particular religion or spiritual belief.

Notwithstanding any such issues, MM continues to grow in popularity both in the UK and Korea. Anna and Nina mentioned that in the UK there are many courses, modules and a growing number of postgraduate MM courses in psychology departments and

on psychotherapy courses. This is similar to Korea, where the relationship between meditation and psychotherapy has been explored by many healthcare practitioners. In the UK, MM is used more for general healthcare purposes. There is general acceptance of this, because many people are more secularised and do not adhere to organised religion, while in Korea more people have a religious affiliation. MM in Korea is widely seen as a particular religious practice for achieving insight through a deep state of meditation although it has been explored and developed for promoting mental health too. MM has nevertheless spread and grown in both Korean and UK healthcare contexts in somewhat different ways in part due to such cultural factors.

Anna explained the acceptance of MM in the UK:

In the West, there's not been a culture of meditation over here. And this is making meditation more culturally acceptable - more normal. People are seeing this as a normal thing to do - you know, most people do this. And it helps you to be better at being yourself more - it helps you to be better at your job, it helps you to be a better person. So it's becoming a more accepted way of caring for yourself (Anna-UK).

In the UK, Buddhist meditation (and MM) is much less common than in Korea. However, Anna felt that MM in the UK is certainly spreading very quickly at the moment because of media coverage:

Certainly there's no end of demand for these courses and you're seeing them more and more in lots of contexts - either in the NHS, in private courses that people run, in universities, in counselling services, sometimes in schools now, they're developing mindfulness programmes for schools in the UK [...]. It's often a part of training courses for counsellors or psychotherapists or medical doctors now. It's also being used in the military, for example. It's being used to help people prepare to go into war and it's helping people recover from the traumatic effects of being in warzones, when they return - both in the UK and in the US (Anna-UK).

Anna believes that interest in meditation is both a response to stresses and a reflection of a new way of thinking about self-care:

In the West, because we don't have a strong cultural tradition of meditation, we have, I think, neglected this and as a result, [...] are experiencing a lot of burn-out and are struggling to remain resilient in the face of constant stresses and increasing demands of work-places (Anna-UK).

Clients and practitioners in the UK tend to use and view MM as self-development or as a spiritual practice in a more general sense rather than a specifically Buddhist practice. By contrast, in Korea meditation has been traditionally handed down as a Buddhism religious practice and gradually developed. Therefore, meditation has been practised mainly as a Buddhist practice and at a deep level, but nowadays meditation has also been developed in Korea both as a spiritual practice and in combination with personal development programmes.

In both countries, participants believe in the importance of having regular supervision and contact with experienced trainers in MM. Anna said she runs the mindfulness course with a variety of client group and also meets her mindfulness supervisor over Skype to get some support if she is concerned about a client, or if an issue has come up. Besides this, she gets advice from national guidelines for mindfulness teachers in the UK such as the 'Good-practice Guidelines (GPG)' for mindfulness teachers in the UK (UK Network for Mindfulness-Based Teacher Training Organisations, 2015).

In Korea, there are many monks, nuns and ordinary people too who practise MM. Compared to UK, therefore, there would seem to be more chance to meet experts and experience deeper forms of meditation practice. In the UK, there are increasing numbers of experts too, some British, some non-British, and many of the experts are non-Buddhist. Therefore, it seems more likely that MM and a diversity of practice may

be developed in the UK with multi-cultural elements and irrespective of religious associations.

To conclude, cultural factors affect the use of RTs, MM and RM in various ways. When practitioners use interventions, understanding people's cultural backgrounds may lead to better quality of practice as well as help to achieve states of health and well-being. Besides cultural background, individual subjective factors may also affect clients' responses, their receptiveness and feelings of safety or vulnerability.

7.2 Similarities and Differences

Similarities and differences were identified in the UK and Korea between the three practitioner groups which will be considered in the following two sections.

7.2.1 Similarities and Differences between the UK and Korea

a. Similarities between the Korean and the UK practitioners

Firstly, most participants have personal and professional interests in the use of RTs or MM or music in their working place, they are knowledgeable about RTs or MM or music and have an enthusiasm for using RTs, MM or RM for health, healing and stress management.

Secondly, most participants have a similar outlook regarding the benefits and value of the use of music and RTs, MM in healthcare context and these practical benefits seen in their work gives motivation and inspires them to continue to use RTs, MM and RM.

Thirdly, in all three groups their first priority was client-centredness, focusing on how to cater for the individual and how to adapt to the individual when using RTs, MM and RM.

Fourthly, participants are keen to explore RTs, MM and RM sources, sometimes integrated with other elements of therapy and new skills in order to expand the practical resources that they can bring to the service of clients. Also if the circumstance is appropriate, they generally share a positive attitude towards collaboration work with others in their use of RTs, MM and RM (See Chapter 8). One of the reasons is that clients and patient groups vary and they all have different health conditions (See Chapter 4). Because of these differences and individual preferences and the range and combinations of therapeutic practices available, practitioners feel the need to expand the variety of techniques involving RTs, MM and RM in order to support their practice.

Fifthly, I was under the impression that most interviewees, whether UK or Korean, considered music a universal resource and not culturally bound. By this I mean that most interviewees referred less to cultural factors or to matters of religion in discussing RM compared to our discussions about RTs and meditation. Of course, music is cultural, although there seems to be cross-cultural and even global appreciation of certain types of music. But the point is that, cultural differences were less often mentioned in the context of RM than in discussions of RTs and MM during the interviews.

Indeed certain kinds of music and many kinds of sound are shared and travel across media between the East and West. One interviewee even said that 'sound' may transcend cultural barriers. Therefore, they did not suggest that there was a particular debate regarding different cultural resonances about music for health. Interviewees placed more focus on how to select and use music in relation to a client's personal background - their physical or psychological condition, socio-economic and educational background and their individual tastes and circumstances.

Lastly, I personally felt the greatest similarity between practitioners in the three groups was that they are not critical or judgmental people and no judgmental or negative comments were made about one another or colleagues or other people's way of working. All except two interviewees practise some kind of meditation such as mindfulness practice and their non-judgmental attitude may be related to this. Non-judgmentalism may also be regarded as a general characteristic of a person-centred approach and so to typify the attitude of professions such as music therapy.

As mentioned, cultivating and practising non-judgmental thinking and observing oneself doing this in the present moment is one of the main tenets of mindfulness meditation. The participants tend to apply their own philosophies in their work and this was evidence during the interview itself.

b. Differences in practice and outlook among practitioners

Individual differences in practice and outlook were also observed. Firstly, regarding the general uptake and the frequency of use of interventions, there appear to be differences between Korea and the UK, as well as differences in approaches among groups of practitioners from each country. My impression from the interviews is that the use of RTs, meditation and RM (particularly for the receptive approaches) in the Korean healthcare service is more common in comparison with the UK. One Korean interviewee said, "In Korea, many therapists and practitioners frequently use RTs and RM together or separately depending on their therapeutic purposes, settings, institutions and external requests". By contrast, a UK interviewee said, "receptive techniques and achieving deep relaxation through therapy is still a relatively limited area in the UK":

I think that the value of relaxation techniques has become much more widely recognised in the UK in the last 20 years. I think it is really appreciated and I think it is being integrated into quite a lot of different types of therapies. It's integrated into training and qualifications and work generally to do with stress management and so I think it is becoming more prominent. I think it's also becoming much more commonly used in hospitals as well and so I think we are seeing more of it happening here (Anna-UK).

A separate consideration here is that gathering evidence for large-scale studies within the UK is likely to be a challenge. More generally, however, the history and development of RTs, MM and RM in UK and Korea is different. The different understanding and people's mind-sets of RTs and MM will be taken up in Chapter 8.

As mentioned, in Korea more people are exploring both receptive approaches and RTs, MM and RM for their sessions. Not only music therapists, but also more healthcare practitioners are integrating these into their work, and this suggests that more and more practitioners are likely to use RTs, MM and RM in their future work. In fact, most of the interviewees in the UK and Korea are engaged in education and teaching either in school or university settings. Even though the level of popularity of receptive techniques may be different between two countries, the interviewees are all aware of the benefits of RTs, MM and RM and they often explain these to various groups of students and trainees. There would be good reason to suppose, therefore, that the use of RTs, MM and RM will be a growing trend in both UK and Korea.

John actually mentioned the bright future prospects regarding the adoption of RTs, MM and RM:

I think most people who come on the sound therapy training are mostly interested in the sounds and the music - and are less interested in the relaxation. [...] but by the end of workshop, they can see that relaxation techniques have real value. And they do incorporate it into what they do (John-UK).

Secondly, there were several different opinions regarding EBP. It was generally agreed that research and evidence are important factors for raising the profile of practice and substantiating its benefits to service providers, potential clients and others. Nevertheless practitioners also take account of their personal preferences and their own rationales, often depending on the client group and setting.

One interviewee said “most feel the importance of keeping abreast of the latest thinking (including reading journals).” Another said, “EBP is seen as important but it is not the driver of all the practitioners. It is not quite the same as in medicine where drug trials are essential before licensing a drug.” Therefore, practitioners found different types of justifications for their use of RTs, MM and RM, including EBP, personal beliefs and intuitions, introspection based on individual experiences, as well as knowledge acquired through professional work and the case histories of their clients.

However, a general consensus regarding EBP was identified. Particularly in clinical settings (e.g., hospitals, hospices), practitioners prefer to use RTs, MM and music based on EBP, whereas in community settings or university settings they not only refer to the documented evidence but are willing to use RTs, MM and RM experimentally or use the evidence of their own experiences and they try out new things in order to explore which tools will work or not.

7.2.2 Similarities and Differences between the Three Groups of Participants

A number of similarities and differences were revealed between the three practitioner groups.

Within the music therapy group both UK and Korean practitioners mentioned that initial music therapy training is generally more focused on active rather than receptive approaches. Therefore, if the practitioner has little motivation or personal experience

of receptive approaches they may work predominantly using active approaches. However, if a practitioner does have interest or undergoes special training, such as GIM training or an MI course, they may also use music in a receptive way too. Practitioners' personal backgrounds, curiosity, enthusiasm and experience therefore largely determine whether music is used in a receptive way.

In relation to RTs and RM within GIM music therapy methods, most music therapy practitioners agreed that through GIM training, practitioners are exposed to different sorts of RTs (e.g., visualisation, muscular techniques, imagery) in combination with music. Such courses provide an opportunity for a practitioner to learn how to select and adapt RTs together with music, or make tailor-made programmes, develop basic techniques further or adjust them according to clients' levels of stress, anxiety, preferences, interests and energy levels. However, one of the difficulties is the length of time training takes (three years minimum to train fully in the GIM method). Nevertheless, even after only completing level one GIM training, a practitioner can gain skills and insights into receptive techniques and there will then be many opportunities for the use of RTs and RM.

Compared to other two groups, the music therapy group particularly emphasised the relationship between having a good rapport with clients and the success of interventions. They were therefore concerned with how to develop and maintain rapport between practitioners and clients.

Turning to medical practitioners in both Korea and the UK, firstly they focused on practicalities and these were their greatest concern in using RTs, MM and RM. In hospital, the use of RTs, MM and RM is generally to support a patient's treatment and for rehabilitation. Considerations such as education of clients and explaining theory

therefore take a back seat to practical techniques with clear health benefits as their outcomes.

With this in mind, several cautions and constraints in the use of interventions were commonly mentioned with respect to hospital organisation, the need for EBP and careful preparations before embarking on therapeutic treatments (e.g., checking the clients' condition).

A variety of RTs and meditation types were used across the groups, and participants modify these in their own way. Except for meditation experts, all the other groups prefer to use RTs in a simpler (or simplified) way rather than trying to achieve deep levels of meditation. In this way they create useful therapeutic tools in combination with their own specialisms. Levels of practice and the abilities of practitioners affect the way they adopt RTs into their work and this is connected to practitioners' personal backgrounds, and what they have learnt and experienced. Those using MM have first-hand experience and are trained or qualified. Their level of training affects the way they understand and approach RTs and MM.

In using music, there are clear differences in attitude and approach between the three groups. The music therapy group use music as a primary method of treatment and the way they plan and prepare focuses to some degree on musical qualities. By contrast, the other two groups tend to use music as a background to their main work or to support their own specialisms. However, they all agree that the use of music increases the quality of their work and when people are more relaxed through music, they are also more open to the activity or programme.

7.2.3 Differing Familiarity with the Use of Interventions and Differences in Attitudes towards Family Care

Here two major themes which are noticeably different due to cultural factors will be discussed:

a. Use of RTs and MM

In the UK and Korea there is a difference between the levels of understanding of and familiarity with the use of the meditation within a healthcare organisation. Edward talked about the how cultural background, national culture and peoples' way of thinking affect his professional work:

In terms of my work here, one of the biggest obstacles is the culture of the organisation, which is very practical and sometimes very doing-orientated [...] and people are not used to relaxation, or a group relaxing, so you get a lot of disturbances [...] - you get people walking through the room, telephones going, people walking through several times, sometimes the same person. So it can be quite difficult, even when you tell people and even when you try and make that room quiet, that can be an obstacle. [...] Occasionally I've had people who - their intentions are very good, they want to make cups of tea to help people, [...] - but they start making the tea in the middle of the relaxation (Edward-UK).

Edward goes on to describe his own ways of addressing such problems. If a disruption occurs, he tries different things. During a guided meditation session, if circumstances are not conducive to quiet meditation, he might use techniques from hypnotherapy and say to the group:

Every sound you hear is going to take you deeper into relaxation. So if someone walks through the room and you hear a door opening, or you hear a telephone ring, it's just adding to your relaxation, it will take you deeper and deeper into relaxation (Edward-UK).

As such, he re-frames the situation from being a disturbance and even if a session is disturbed, he tries to find a way to continue the session in a natural way. At the same

time he believes that through familiarity and education, the people or organisation might learn to adapt to the requirements:

I try and tell people that we're doing relaxation and that it would be helpful if they didn't come into the room right now. [...] by inviting them to join us in a relaxation, sometimes they understand a bit more what it's about, and sometimes they don't. So there are different ways to work. Occasionally I ask nurses who want to join in to sit near the door, so if anyone comes in, the nurse says "Go away" (Edward-UK).

My own experience mirrors that of Edward. During certain meditation retreats that I have attended in the UK, people have felt free to do meditation together with their babies, they feel free to chat, walk in and out during the practice of meditation, which would not have been the case in Korea. For me personally, the atmosphere is rather disruptive in terms of my ability to concentrate and follow the guidance. On the other hand, I enjoy the atmosphere of freedom. But at the end of the day (because of my personal background and expectations) I would prefer an atmosphere of quiet. Similarly Edward's hypnosis solution to the disruption would not be normal for Koreans. On the one hand we are familiar with the demands of meditation and accustomed to filtering out external noise, on the other the conditions needed for meditation are well understood and disruptions to a session would be infrequent. The necessity to educate both clientele and organisations is much less.

Jacob too surmises there may be a difference between the UK and Korea:

In Korea we have a long tradition of meditation and a high level of interest. People visit Korea in order to learn. [...] I also imagine there [in the UK] meditation doesn't have the same associations with religion and people do not make the connection. So British people will be more open-minded and not be prejudiced to begin with because of religious beliefs. So the application of meditation techniques within healthcare will be much more straightforward (Jacob-Korea).

RTs, MM are therefore perceived differently among different cultures and professions and understanding of meditation and people's mind-sets seem different in the UK and Korea. Another illustration of this is that in the UK I feel that there is a lack of facilities for meditation and organisational support is relatively small. There are not, generally speaking, public places for quiet meditation in the UK and perhaps because of this, meditation tends more often to be regarded as a group activity. In Korea, there are many temples with quiet meditation halls where people meditate individually or in a group and the culture of meditation is therefore established. Therefore people naturally understand what they have to do during meditation or relaxation and the level of help from other people is much greater. The need to educate people or prepare for meditation sessions is less, and all this will affect the progress of a therapy session itself in different ways in Korea and the UK.

In both the UK and Korea there are many meditation societies in the community (such as in universities). In the UK, in my experience, there is more group discussion during a meditation meeting or class. People talk about meditation, personal feelings about meditation, different experiences during meditation and their own lives too. It seems to me that in the UK generally meditation session is a mixture of formal and informal (compared with the more formal nature of a Korean class). Many people have a curiosity about meditation and are at the exploring stage. Some think it is a way to meet like-minded people with similar interests in a relaxed setting (possibly with tea and biscuits provided). It is a mixture of rather short meditation in a quiet place with a more noisy or lively social event.

When Edward uses meditation in a session, this kind of attitude may affect what he does. It is not a question of right or wrong, since we all approach meditation from a different cultural background. However, Edward hopes that attitudes may change in

future. Nonetheless the greater curiosity towards meditation and relaxed approach has its benefits and the group approach and the open discussion may also be valuable in terms of healing as well as the benefit of a social network.

b. Family care in hospital

As shown in Chapter 4, family care for patients was emphasised by the Korean interviewees. Family care and family ties were not included in my research interview topics, but some of the interviewees talked about how RTs and RM can be used in the emotional care of a patient's family.

The Korean interviewees grew up, like all Koreans of their generation, influenced by Confucianism. Traditional Confucian principles of family organisation still retain an important value in Korea. The core of Confucianism is humanistic and it emphasises respectful care of parents, which in Korea is called '효 (孝, Houe)' and taking care of parents is one of the important moral responsibilities and human virtues. Taking care of parents continues even after they die. For example, after the parents die, Korean people normally prepare food and perform ceremonies for them for at least once a year. But in the new generation those who believe in Christianity sometimes do not do this. However most Korean people (even many Christians) consider family care and ancestor worship a duty due to ideas connected with Confucianism. It is the same in a hospital situation and this has an effect on hospital organisation.

Most Koreans grow up with the idea that not taking care of parents when they are old and ill is inhuman. Korean people have strong emotions about taking care of their elderly parents and many Korean people think 'taking good care of' means staying near them. However, if I contrast what I know of Korea and what I have found in the

UK, I feel that in the UK 'taking care of' does not necessarily mean staying near elderly parents and many elderly parents and their children feel more comfortable living separately. Mobility and independence (throughout life), by contrast, are factors that are more highly valued in the UK. Therefore, what it means to take good care of patients, particularly old people, in Korea is somewhat different therefore from the UK.

Feelings of attachment within the family may be similar for Koreans and the British, but the line that is drawn between the individual and the family concerns may be different. In the healthcare service the concept of caring for family is therefore somewhat different too and this is evident, for example, in terms of the provision that is made for family members. In hospital, in particular, in wards and hospitals for the elderly, families are always there together with patients regardless of whether they are hospitalised long-term or just for one day and so many family members are involved in caring for aged parents. In most Korean hospitals, special moveable beds for the family are stored under the patient's bed so that it will be easy to sleep together in a hospital ward with a sick relative and separate facilities such as toilets and shower rooms for families are provided.

This Korean attitude towards the family can have a bearing on music therapy in the hospital setting too. In hospital, therapists often see patients together with their families in their sessions. Therefore, some therapists are interested in planning sessions that involve family members.

In Korea music therapy has a short history and its ideas originated in the West. Indeed a Western music therapy approach is still generally applied. My opinion is that, in the future, Korean music therapy will develop - and develop separately to some extent -

and that developments will reflect traditional Korean culture and that music therapy involving family care will be a part of this. There is clear evidence that recently many Korean music therapists have trained for hospice care (on the 16-week Hospice standardisation programme) and are interested in gaining the necessary qualification (National Cancer Center, 2016), (See Chapter 4.4.3). Music therapy involving family members will give a space at the end of a patient's life for relatives to be together and for lasting, precious and happy memories. In this way family care in hospices and hospitals is valued.

Korean interviewees may have felt freer to go into deeper conversation with me and often interviews with Koreans became more open-ended. Through that process some valuable data were produced even though it was not included in my interview questions. The patient's family care is one such example. The UK practitioners tried to focus more on the main interview questions, because my interview was semi-structured and family care was not included in the interview questions. One distinct feeling during the process of interviewing UK practitioners was that they seemed careful about talking more freely and were understanding of cultural and linguistic barriers, being aware of the problems that might be experienced by a second language English interviewer and so they focused more directly on the main points. In the Korean interviews, we had a common language and culture so rapport was developed very easily and they felt freer to go deeper when talking.

Another possible reason was time. The Korean interviewees did not seem to mind talking at length and in some cases I was able to spend much longer with them. For some, and perhaps all of the UK interviewees, I felt some pressure of time during the interview. Although interviewees were generous with their time, in general we were business-like and kept to the time allocated. There is a more general cultural difference

in this aspect of time-keeping between Korea and the UK. The Koreans I interviewed were also interested in what I was doing and in my studies in the UK. This may also have been a factor which caused them to open up.

Due to the above reasons, in discussing family care, I talked with Korean practitioners only and I did not have a chance to talk about this with UK practitioners. I cannot comment on how these particular UK practitioners think about family care and the use of RTs, MM and RM. However, there are similar moments reported by therapists in the UK and there is a link in literature between role of music therapy and family centred care (Oldfield and Flower, 2008; Shoemark, 2008; Abad and Edwards, 2004; Clair, 2002).

It may be that the approach to family care is different in healthcare service in the East and West but whatever the case family care can reduce the stress of family life during hospitalisation, especially in hospices, intensive care hospitals and children's hospitals. In Korea, especially in a children's hospital, in a music session, parents almost always attend therapy sessions and sit together with and next to their children (sometimes, for example, to make sure IV drips remain intact). And in my experience, music therapy reduces the parents' stress as well as supporting the children too and therefore sometimes, during holiday or Christmas sessions, family-centred care is also included the therapy session.

There are differences between Korea and the UK in terms of people's sense of autonomy and independence and concepts and parameters of self and family. In the UK, individuality and independence are stressed by comparison with Korea. Young people in Britain grow into independence more rapidly and more markedly than Korean young people, whereas Korean culture is more collectivist and this has a

bearing on the way both elderly parents and young people and their families are treated in hospital. I feel that these traditional ways of thinking lead to different models of healthcare organisation, which can impact on the use of RTs, MM and RM in healthcare context in the UK and Korea.

To conclude, this chapter has explored cultural similarities and differences which were identified from the UK and Korea interviewees. The three groups of practitioners have similar enthusiasm about sharing their knowledge of RTs, MM and RM (even though they have different specialisms). Some differences in their approaches to RTs, MM and RM in relation to established and accepted practice, traditional culture and the practitioner's outlook have been identified. More importantly, however, the three groups of interviewees shared common values as to the use of these interventions (benefitting the client as well as the practitioners themselves) in their respective healthcare services.

Chapter 8: Discussion and Recommendations

It is clear that participants have both theoretical knowledge and substantial practical, professional and experiential knowledge. Their experience informs them and their personal recommendations were based on understanding backed by experience too. Here I will explore and reflect on several topics related to cross-cultural perspectives and practical issues which were emphasised by interviewees as well as address topics raised in the literature review. Recommendations will also be made at the end of the chapter.

In the literature review (Chapter 2), topics discussed included collaboration work (Robinson, 2015; Darsie, 2009; Leung, 2008; Ruud, 1998), client-centredness (Bazzano, 2011; Robb et al., 1995; Rogers, 1995; Wheeler, 1981), and active and receptive approaches related to the types of music (Choi, 2006; Grocke and Wigram, 2006; Wolfe et al., 2002). Through the data analysis, client-centredness was identified as an important topic by almost all interviewees (Georgia, Lily, Jacob, John, Olivia, Georgia, Violet, and Isabel), and several interviewees mentioned collaboration work (Georgia, Violet, Jacob, Adam, and John), and responses to active and receptive approaches too (Lily, Edward, John and Olivia).

Some interviewees particularly emphasised the role of music or meditation in relation to education and schooling (Adam), the promotion of learning and improving attention levels and concentration skills in school settings (Jessica, Olivia). This was addressed in the literature review (Kim, 2011; Hong and Yeo, 2010; Ha, 2002; Lee, 1997). The concepts of creativity and spirituality were discussed in the literature review (Bazzano, 2011; Włodarczyk, 2007; Valente and Marotta, 2005; Longa et al., 2001; Borling,

1981) and were mentioned in interviews (Jacob, John, Olivia, Georgia, Violet, and Isabel).

With respect to the above topics, there are sometime clear, and sometimes subtle differences between the UK and Korea. This has not previously been explored. Therefore in my literature review chapter, I have presented a general understanding of RTs, MM and RM and their way of use in both East and West as a common starting-point. My findings chapters (4, 5, 6 and 7) give insights into the different cultural assumptions that underpin these practices and I have explored healthcare practitioners' different rationales and ways of adapting RTs, MM and RM.

This discussion chapter deals with particular topics previously mentioned but not developed, such as why the use of RTs, MM and music appear more emphasised in school settings in the Korea rather than UK practitioners and how the different cultural models of care in Korea and the UK might relate to the education systems, historical and religious background and other relevant factors. In addition, I will consider the degree of emphasis on the practical versus theoretical learning, and the atmosphere during practice sessions that I have encountered during the period of my study.

These factors have brought about a different model of the healthcare service, as well as the use of RTs, MM and RM between UK and Korea. Further discussion of this is required and through this, it will be possible to extend our understanding of the practitioners' rationales for their interventions. In brief, this chapter will contribute to developing understanding of how the use of interventions are related to the differing cultural and healthcare contexts in the UK and Korea.

I will focus my discussion on the following questions, mentioning on any cross-cultural points of comparison that may arise:

- Firstly, what factors bring about differences and similarities in the healthcare services of the UK and Korea?
- Secondly, what differences in approach to RTs, MM and RM can be seen?
- Thirdly, how do participants perceive collaboration work with other colleagues when they are exploiting RTs, MM and RM?
- Fourthly, what is the importance and place of client-centredness and sensitivity to individual clients' needs?
- Fifthly, how can we differentiate active and receptive techniques and what cultural factors affect their use?
- Sixthly, how can music resources be a meditation subject for mindfulness meditation?
- Seventhly, what are the cultural differences in term of spiritual practices, and what can foster creativity and spirituality?

8.1 Cultural Differences and Similarities between the UK and Korea

In Chapter 7 I considered similarities and differences in outlooks and attitudes in relation to cultural factors between the UK and Korea. During the study, I came to realise that a number of important cultural factors bear on differences and similarities found in the healthcare services and use of interventions in the UK and Korea. These relate to:

- Historical background associated with the respective educational traditions
- Learning and teaching differences associated with client-centredness and relationship between practitioner and client
- Different approaches to theory and practice
- Similarities in approach
- Cultural differences associated with religious influences
- Differences in atmosphere during meditational practice

8.1.1 Learning and Teaching Differences between the UK and Korea

The BBC (2013) reported that “the education systems in Hong Kong, Finland, and South Korea are often lauded as among the best in the world, scoring highly in

international league tables". The strong points of Korean education would appear to be the culture of diligence, respect for teachers, the co-work and strong relationships between teachers and parents which encourage students and support the teacher, together with the most up-to-date technology available often made possible through active parental support. What is often missing by comparison with the UK, however, is an atmosphere of freedom, making learning a fun experience, focus on the development of each individual with respect to their value as a human being, respect for learner autonomy and students' own choice. Because of the emphasis on achieving good results in Korea, there is relatively less attention given to physical fitness and enjoyment, activity and creativity at school. As a result, Korean students quite frequently suffer stress-related problems at school.

Besides this, there are significant differences in terms of educational priorities, approaches, and teacher and student expectations in the UK and Korea. This has a bearing on what is understood by a client-centred and practitioner-centred approach in these two cultures. Such cultural differences can be seen in the UK and Korean healthcare services and their respective development. A client-centred approach relies on involving a client in discussion, taking part in and making decisions. However, clients' willingness or readiness to do so cannot always be taken for granted.

Such cultural differences between aspects of the two countries' healthcare service (including the use of RTs, MM and RM) can be seen against a wider historical background. With regard to client-centredness and individual sensitivity, in Korea the notion of client-centred care is in evidence in therapeutic environments, just as in the West, because client-centredness is a core principle in humanistic therapies. However, in the general education system, even though teachers know the value of learner-centred approaches, in reality teacher-centred approaches are the norm and this

cultural climate extends to the healthcare service and therapeutic environment too. A learner-centred approach is a non-directive approach which means it does not deliberately handle people according to a pre-defined purpose. In the UK, learner-centred approaches are more prevalent by comparison and therefore learner attitudes or expectations vis-a-vis the teacher have a different starting-point. Such roles of teacher and learner extend beyond school into society at large. Therefore, in the healthcare service client expectations of practitioners and practitioners' own expectations are also different in the UK and Korea.

This cultural climate is clearly related to Korean history and its education system. In Korea, people over 50 years and older have generally been affected by the Korean War (South versus North Korea: 1945 - 1953) and the subsequent economic recovery. From the early 1960s to the late 1990s, South Korea had one of the world's fastest growing economies. The 30-year miracle was achieved by this same generation now 50 years old or more. This generation sacrificed and worked extremely hard for the economic and educational opportunities of the next generation because they considered this is the best way to pull themselves up out of their economic misery. In order to achieve this over a short period, a highly intensive way of study came into being and Koreans believe the Korean education system and approach is fundamental to continuing economic success and political strength in the face of threat from North Korea.

A typical Korean school lesson is teacher-centred in that the teacher prepares materials thoroughly and takes the lead throughout. Teachers are highly respected as the transporters of core knowledge and information and their role is to direct and impart. The students follow instructions and cram and teacher and student together both commit to doing their best every day. Students' everyday experience resembles a period of concentration similar to an exam period in the UK and students learn to

absorb information quickly. Students are expected to study what they have learned each day until late into the night. This general pattern does not end with school. The roles and patterns of work that are established at school continue to some degree into university and the workplace.

The Korean competitive educational environment, ceaseless study and teacher-centeredness favour an independent study culture over a culture of group discussion. By contrast, in the UK students' communicative skills are strengthened through the educational atmosphere. Teachers are happier to wait and listen to each student's opinion rather than dominating classroom interaction (doing most of the talking, controlling topics and allocating turns). In class, the relationship between teacher and student in the UK feels to me more like one of friendship.

The UK's learner-centred classroom is characteristically more open. Students feel free to venture their own opinions without worrying or being unduly circumspect and the teacher respects each contribution made. Perhaps if Korea had not been faced with economic collapse or the threat of war from North Korea, the education system that emerged might have been more similar to that in the UK. However, it must be recognised that the education systems of the Far East share much in common and there are clearly other factors involved apart from the historical ones that I have discussed.

The educational system and culture that it creates affect other aspects of life and organisation including healthcare services, therapeutic environments and client and practitioner relationships. There are certain expectations of Korean professionals as well as expectations by practitioners of their clients which help account for some of the cultural differences found between the UK and Korea. This may account for a level of confusion among Western healthcare practitioners who come to Korea. The nation's

history and its educational systems are therefore reflected in a specific difference in culture between UK and Korea which has a pervasive and significant influence, even on outlooks in life, healthcare organisations, and extends to approaches to and understanding of RTs, MM and RM.

For example, in a therapeutic situation, for some age groups, a person-centred approach in this sense may be unfamiliar and it is not uncommon for older people in Korea to fail to adequately respond to or engage with a professional in the manner desired. Unfamiliarity can result in discomfort and lack of trust. In the same way, students and clients in the UK might feel discomfort if they are consistently told what to do, lectured to or excluded from discussion. As a result, practitioners in Korea may treat clients sympathetically and individually, but not necessarily expect them to develop the same level of autonomy as might be the norm among person-centred practitioners in the UK. At the same time, older Koreans may respond well to gentleness, tenderness and physical help in a way that UK clients might find intrusive, over-motherly or demeaning.

We can see that in the UK and Korea learning and teaching and healthcare services have developed in different ways. It must be stressed, however, that these differences represent tendencies rather than absolute truths. UK and Korean culture is not homogenous and socio-economic and educational factors, and in particular the age of clients, need to be taken into account. Moreover, cultures change and Korea is fast absorbing elements of Western culture. We must see such differences within their cultural and historical context.

An essentialist view of cultures is that they are seen as fixed and immutable, but we need to embrace a social constructionist view that sees culture as something which

changes over time. Nowadays, through cross-cultural communication and international networks the young generations' attitudes are rapidly changing. This can bring about a level of conflict between the generations in Korea. At the same time there is a new generation of teachers and professionals and in future, change will occur both in the education system and healthcare service and health organisation. We may expect that the advantages and disadvantages of Western and Eastern approaches will be critically considered and that a new culture will emerge.

8.2 Differences in Approach and Adaptations of RTs, MM between UK and Korea

Cultural differences and similarities can be seen in uses and adaptations of RTs /MM and RM between the UK and Korean practitioners. Music therapy is Western in its origins and the way it is used in Korea broadly follows Western practice. In this sense values and approaches are shared in many ways. But nevertheless cultural differences can be identified, such as the respective preferences in the UK and Korea for active and receptive techniques. On the other hand, meditation and mindfulness practice are Eastern in their origins and more cultural differences can be seen, which may be connected with the differing traditions.

Therefore in this section, I will focus more on meditation and mindfulness practice and deal with the following points in some depth. Firstly, there is a difference in terms of the level of concern with theory and practice. Secondly, I will discuss the core shared approach to MM practice in the UK and Korea. Thirdly, I will consider differences in atmosphere when using RTs and MM across the two countries. Finally, can anything be learnt by practitioners in the UK and Korea from one another's approaches?

8.2.1 Practical versus Theoretical Approaches

In Korea and the UK a different emphasis seems to be given to theory; more specifically, differences in engagement with concepts and theories in practice were identified between the two countries. UK practitioners' approaches tend to take pragmatism or empiricism as their starting-point. In terms of the philosophical position, theirs seems a more inductive approach of working from experience not only based on published research findings, but personal insights. This is seen most clearly in actual programme sessions involving RTs, MM where experience precedes discussion, which in turn precedes rudiments of theory, which tended to be presented as an optional hand-out for anyone interested. A typical UK session may contain periods of time given over to discussion of experience among participants, with feedback to a leader often followed by further discussion. At the same time practitioners are primarily interested in giving clients a practical health benefit rather than offering lengthy preliminary explanations.

In the UK it is expected that participants will learn from one another and not only (or even primarily) from the session leader. In a group session people feel free to venture opinions and give their personal impressions and they listen attentively to one another. In this way the session leader can gain knowledge about problems that are thrown up and can deal with genuine issues.

When I attended community meditation programmes in the UK, I was expecting theoretical teaching from practitioner (as in Korea). However, in most sessions, a practice session was followed by extensive group discussion and sharing of meditation experiences. Following more structured MM sessions, practitioners tended to hand out

an evidence-based research paper which participants could take away to read if they wished.

In Korea, the process would be different. When using RTs, MM, typically a session will begin with some kind of explanation by the session leader. Koreans expect to receive knowledge and a rationale before starting a practical exercise and this mirrors educational practice across all teaching. The general Korean approach seems more deductive. Not only in academic courses, but also in community settings, conveying and understanding the theories of practice are naturally considered more of equal importance to the practical benefits. Rather than lengthy discussion, learning the techniques or theory from the practitioner followed by individual practice is the expected norm. Theory would not be presented in any way as an optional extra.

This is not to imply that theory is ignored in the UK. In the UK, the theory behind the practice is presented in university settings of course, just as in Korea. But in general healthcare and community settings, a practical approach to RTs and MM seems more preferred and engagement with theory is less evident than in Korea. People learn the benefits of meditation and RTs first-hand through their own practice and experience and people are self-motivated to practise meditation. Therefore even though the number of meditation practitioners is relatively small compared to Korea, British people who decide to practise meditation have a very clear motivation. Some of those people will read and learn about meditation by themselves too.

In Korea, before practice, clients and interested parties learn more clearly about the steps for practice from expert teaching staff including monks and nuns; organisations support them in various ways. Those who attend engage in intensive practice individually or together in groups following learning materials and following well-

organised and systematic programmes, with facilities for eating, resting, napping and sleeping, childcare, transport services and the like.

When monks and nuns work together with lay practitioners such collaboration is believed to increase quality of practice and systematic learning. Lay practitioners receive advice and recommendations directly from the monk and nun and the rapport and relationship between lay people and meditation experts helps to widen the social network. In this way Korean people and practitioners may achieve a deeper level of meditation through teaching from enlightened monks and nuns. The procedure helps ensure fast progress along with theoretical understanding.

One of the reasons why Western meditation practitioners come to Korea is in order to learn meditation theory and learn insights regarding practice from monks and nuns. As mentioned, one such person is Kabat-Zinn, who learnt mindfulness meditation from the Korean Zen master Seung Sahn.

In the UK, however, the process of learning and practice of meditation are different from the Eastern way. Diligence and creativity on the part of motivated learners ensures progress and the development of individual ways of meditation. For example, in meditation residential retreats, I found many British people practising meditation early in the morning at 5:30 and practising for one or two hours independently without a teacher or leader's support. Besides traditional methods of meditation, they practise in different positions and individual styles and it seems they try to explore and find their own way of meditation. In this way people in the UK seem to achieve a deep level of practice while being creative.

The difference in approach with regard to meditation would seem to relate to religious influences and background. In Korea, meditation is established and has been

developed through Buddhism but in the UK, people seem to regard meditation as a spiritual practice rather than a specifically Buddhist practice. Since they are relatively free from religious attachment or doctrine they feel less bound to follow a particular style and this makes practice more individual and creative. I sense that religion itself is not a primary motivation for interest in meditation. Instead curiosity, self-discovery and possible affinities with a culture or tradition other than one's own may be the spur for interest. And all these may be linked to a sense of freedom (to participate openly and without being controlled) and to sharing. In the UK then, it is possible in this way for new ideas or new ways of experiencing to come about.

8.2.2 Similarities in Approaches

Putting aside these differences, it is important to point out the basic similarities in practice. Firstly, UK and Korean practitioners both regard MM as a spiritual practice. It is used as a tool to produce a special quality or higher state of awareness and for the pursuit of spiritual consciousness. For UK and Korea interviewees their personal common ultimate goal in their use of MM is self-transformation, achieving inner freedom, and seeking the true self. However, in general healthcare settings, MM is used not only for the spiritual purposes, but in both countries practitioners adapt MM for its general health benefits too, such as stress management, relaxing the mind, overcoming negative states of mind and energising and refreshing mind and body.

Secondly, in both the UK and Korea, MM practice sessions are conducted in a systematic, focused and intensive way (often for two hours per session) and over a period (frequently eight weeks). Sensitivity to the client's needs and wishes was also stressed. Since individuals progress at different rates, practitioners carefully consider the client's prior experience and personal capacity for practice.

Thirdly, in both the UK and Korea, MM is adapted from Zen principles, which are the elimination of dualities, a non-judgmental outlook, discovering the true self and letting-go of the ego, transcending religious boundaries and religious attachment. Zen is moment-by-moment insight practice and it is experienced by understanding and self-knowledge and does not depend on concepts, words or logic. It is a creative practice, experiential in approach. It is arguable therefore that the Zen way of mindfulness practice is suited to the UK because of its practical and creative aspects and the multiple faith influences within the UK.

8.2.3 Cultural Differences regarding Attitudes towards the Integration of Meditational Practices in Music Therapy and Healthcare Services

There has been an increasing acceptance of the place and value of meditational practices within healthcare both within the UK and Korea. In Korea the health benefits of meditation have been widely recognised over centuries and its place within organised healthcare has gradually developed; in the UK the trend has been more recent. However, within the healthcare systems of both countries we can identify a certain inbuilt resistance to meditational practices, but for different reasons.

Buddhism in Korea dates back to the 4th century AD and became the recognised national religion. Many people associate meditational practice with Buddhist practice. For this reason, people often associated use of meditational practice with teaching of Buddhism. In music therapy sessions with clients from more conservative church organisations, the use of meditational practice in a session can be met with resistance. It is particularly difficult then to develop a rapport with the client at an early stage. This occurs more often among the older generation who tend to be less open-minded. In the UK, I imagine those issues are much less likely to occur than in Korea and

Christians or people from other faiths would be less likely to associate breathing techniques and meditation with any particular religious practice.

UK practitioners would therefore not need to be overcautious about including meditational or breathing techniques for fear of religious upset. In their own minds meditational practice is seen in terms of its health benefits, as a self-development tool or for spiritual practice, but not necessarily bound up with religion. It was interesting to me that even during an 8-week MM course in the UK, Buddhism as such was not even mentioned at all. However, since meditation is less widely popular still in the UK, it is possibly associated with certain kinds of people. Although the NHS now recognises MM and it is becoming more mainstream and even encouraged, in the public mind it is far from being mainstream and may be considered something of a luxury or a fringe interest in the UK (even amongst therapists). Consequently the reasons for acceptance and for resistance to meditational practice within healthcare may be different between the two countries.

In future this situation is likely to change. Within the UK MM is becoming much more familiar and recognised; in Korea opposition to it among the younger generation of Christians is less. Some Christian churches have even introduced meditation classes. There is an increasing focus on health benefits rather than its place in religion. The value of holistic treatment and mind-body interventions, and as such of MM, are increasingly being recognised in both countries.

8.2.4 Differences in Atmosphere during Meditational Practice

In meditational practice in Korea, regardless of whether it is during therapy or not, people participate in silence, and are careful to sit and move quietly too. Sometimes the atmosphere is one of complete silence, emulating the monks in a Korean temple.

Generally people prefer to meditate in silence and do not want to be disturbed. People learn this habit from an early age and it is reinforced by signs calling for quiet or silence. There is a sense of concentrated energy in Korean meditational settings that I do not experience in quite the same way in the UK and this is due in large part to the atmosphere of silence.

What I know of meditation practice (apart from MM practice) in the UK differs from the traditional Buddhist practice atmosphere and sometimes it seems like a more informal event or even a social event with a mixture of silent practice. The wide-ranging group discussion, feedback and sharing of experiences that typically follows gives an impression that people might not be able to cope with long periods of silence. People behave more as they normally would, they often feel free to come and go and low levels of noise do not seem to bother people. The atmosphere is welcoming and free and so it is not off-putting for newcomers, young people and beginners. This is an interesting cultural contrast for me and I find the culture of British meditation practice fresh and new.

Secondly, the role of leaders and participants is different in the UK and Korea and those different roles in themselves create a different atmosphere for practice. In the UK the atmosphere seems more to be created by participants themselves through their group discussions and feedback. In Korea participants are generally quiet during practice and although participants also contribute to the atmosphere, it is controlled more by the guidance and personality of the leader. This reflects educational practice in the two countries.

Thirdly, organisational support affects the atmosphere during meditation in the UK and Korea in different ways. In Korea, because of the historical background, there is

much more opportunity to practise and learn meditation in a variety of places and the associated organisations and social networks are well established. The organisational support for participants to practise meditation in depth has been discussed. In the UK, organisational support and networks are clearly less developed than in Korea in this respect. For example, in community classes several women brought along their babies or children, and sometimes children were free to run around. There is a positive aspect to this, I feel, in that in this free atmosphere children may encounter meditation in a more welcoming environment and not feel afraid or bored.

Fourthly, the natural question in a Korean person's mind will be "What is the rationale behind this practice and what exactly is expected of me? What qualifications, training and experience does the practitioner have?" And it seems that the question in a British client's mind is more likely to be "What is the direct benefit to me of this? Let's get on with it so that I can experience the benefits." Rather than thinking about the practitioner's abilities or qualifications, the question is "Will I be able to do it?" This of course is a broad generalisation. Such questions nevertheless clearly reflect more general cultural differences related to learner-centred and teacher-centred approaches, the relative importance of theory and practice and the atmosphere and roles that naturally grow out of these considerations.

8.2.5 Can anything be learnt by Practitioners in the UK and Korea from one another's Approaches?

As is clear, I have come to see the different values of the approaches in the UK and Korea. Firstly, in the UK, engagement in discussion, sharing ideas and understanding one another by means of discussion are beneficial in terms of both the learning and the atmosphere in which this takes place. The mood is one of sharing and equality that can

subdue competition or hierarchy within the group. Moreover conclusions and decisions are not arrived at in a hurry. Real experience, including mistakes, are shared, which can be of benefit both to participants and practitioners. I was impressed by the UK approach to practice in many ways. The feeling of friendship and relationships between clients and practitioners and among the group, the respect for other opinions, and the openness can contribute to an atmosphere that is both relaxed and creative. This humanistic approach could be insightful for Korean practitioners (some of whom are more results-focused) and is vital in developing a truly creative kind of spiritual practice.

As mentioned, each country has its own teaching and learning style, which may relate to the more practical versus theoretical approaches within the educational traditions respectively of the UK and Korea. As for music therapy approaches such as GIM, there is greater similarity in approach between UK and Korea regardless of the education tradition. However, in the case of MM and RTs sessions, UK practitioners tend to offer less in the way of guidance or explanation (even though they may well have the knowledge to do so) and prefer to take a step back, compared to Korea. Instead they prefer give participants a chance for exploration. The advantage of this approach has been discussed, but my feeling is that the lack of explanation and detailed guidance from a leader may actually result in people making mistakes and *wandering* during practice, which for some at least may result in a failure to experience the real value of meditation. For some, initial experiences of this sort can be off-putting. I could see that people in the sessions I attended were at different stages and some may have even been beginners. The lack of guidance therefore was a possible issue or else represented a missed opportunity. For example, techniques such as breathing techniques, sitting meditation, lying-down meditation and walking meditation do require a certain

amount of explanation and guidance, equally for beginners and those wanting to progress. For those more accustomed to deductive learning styles, the pace of learning may at times feel slow and inefficient. In addition, simplified methods were the norm. By avoiding more systematic and painstaking original methods something may be lost.

The reasons why guidance and explanation may be avoided in the UK by comparison with Korea may be due to the different approach taken, as I have outlined. On the other hand, it may have something to do with the level of expertise or confidence of practitioners in giving instructions or advice. It may also be due to (presumed or real) expectations or capabilities of participants. However, expectations and capabilities themselves can be developed. My personal feeling is that practitioners in the UK could do something more to help participants understand better.

I feel that MM has become established in the UK and is currently growing fast. Many people engage in the practice for self-development and self-transformation and not simply for the stress relief or relaxation purposes. In-depth teaching, detailed guidance, and greater support from organisations or networks will offer more people this chance of self-transformation and to pursue their purpose of practice.

As a Korean, what impressed me most was the UK practitioners' free and creative use of mind-body interventions for practical healthcare purposes. This motivates me to think more creatively in my own practice. In addition, I have learnt in a new way the meaning and value of learner-centredness and clients' participation through discussion in the own learning. On the other hand, I am informed by theoretical knowledge gained from of Korea's long history of meditation techniques, its own traditional resources, as well as the value of expert insights and guidance for those who are seeking to learn.

It is often such explanations and insights which enable the learner to make sense of their own experiences.

To conclude, we have seen how practitioner-client relationships and atmospheres are affected by such factors that are built in to the culture. We have also seen differences in a nation's preferences for learning styles. At the same time basic similarities exist in terms of ultimate goals, seriousness of attitudes and basic underlying principles, notwithstanding the religious climate. Expanding cultural awareness between East and West contributes to our understanding of approaches to healthcare issues and healthcare models. It facilitates future cross-cultural dialogue.

There are distinctive strengths in the way in which practitioners from Korea and the UK view RTs, MM and RM and use them in healthcare practice. The question therefore is how to combine what can be learnt from their respective strengths within an existing framework. At the same time, it must be recognised that cultures can and do change and today this change is rapid. The healthcare environment is no exception and practice from around the world can inform such change.

8.3 Collaboration Work

There have been many clinical trials of techniques relating to *music and health* and *meditation and health* and many healthcare practitioners have tried to combine music or RTs with their own specialist therapies (Scheufele, 2000; Thaut and Davis, 1993; Fried, 1990). Music for relaxation and meditation and the two combined are among the complementary therapies that are commonly used in clinical situations.

Such trends may be affected by concepts of transdisciplinarity and teamwork in health research and services. '*Transdisciplinarity*' is a term sometimes used in the context of teamwork in health research and services and is defined as:

collaboration in which exchanging information, altering discipline-specific approaches, sharing resources and integrating disciplines achieves a common scientific goal (Rosenfield, 1992).

Collaborative practice and the purposes, workings and benefits of *multidisciplinary* (See Glossary) teams have been investigated in recent years and combined approaches are a growing trend (Fennell et al., 2010; Zwarenstein et al., 2009; Watson, 2007; Connor et al., 2002). Transdisciplinarity perspectives of practice between music therapy or meditation in health are similarly an interesting and growing research direction (Choi and Pak, 2008). Collaborative work and transdisciplinarity in research have also been developed and many studies have been conducted in order to understand issues from a macroscopic perspective rather than focusing on narrower specialist area perspectives (Carr and Wigram, 2009; Magee, 2005).

If the desire for collaboration is genuine and strong the resulting joined-up approach between sympathetic and like-minded colleagues is not only beneficial to practitioners expanding their professional toolkits, but psychologically positive for clients at the receiving end.

At a practical level, many practitioners feel the desire to expand their therapeutic tools and to consider a mix of possibilities in order both to serve their clientele as well as for their own personal development. The value of collaborative working, sharing ideas and specialisms, and learning more therapeutic techniques from each other is recognised. Music therapy is sometimes used in combination with art therapy, creative therapy, play therapy, RTs and meditation therapy (Edwards, 2016). Similarly many healthcare practitioners have employed and modified RTs and meditation techniques and they are exploring how to use these skills in combination with other tools, such as music, art and dance.

Similar understanding of the value of integration and collaborative work was found among the UK and Korean practitioners. Teamwork is a common feature in all this. For example, in hospital settings, Jacob and Georgia (both medical practitioners) mentioned that in order to achieve a better result, cooperating together and work as a team is necessary. They meet other therapists and exchange information. In this way many therapists gain more experience of co-working in a clinical setting and the chance to learn new techniques and ways of addressing clinical issues. Doing so can help to solve the frequent communication issues and allow for opportunities to engage in successful communication. Indeed, most interviewees are interested in therapeutic techniques outside of their own specialist areas, which they have learnt about in workshops. Through pursuing these interests, they develop both their motivation and scope for collaborative work.

However, in practice there may be different types of conflicts and limitations depending on the collaborative environment, collaborating parties and belief systems. Practitioners have different backgrounds (in terms of study and clinical experience) and so specialist terminology is used. Sometimes communication problems may occur when experts from different fields work together and while preparing programmes:

I was running the relaxation programme together with other practitioners which means we are all from different fields (medical, therapy and yoga and so on). I suddenly realised that [...] even though we are all Korean I felt that I was discussing with foreigners talking a different language. Experts in each field use slightly different terminology and sometimes it is difficult to understand what they are saying. I think each expert should act as the bridge (Jacob-Korea).

When colleagues from one discipline work together, they develop a habit of using a particular kind of terminology and therefore differences between the expert groups' terminology may lead to misunderstandings of each other. The interviewees

recommended that to become familiar with one another's terminology, the experts should help each other and acknowledge each other's professional perspective.

Secondly, in collaborative work, one interviewee mentioned the perceptions of superiority among some collaborators, particularly where doctors are involved. There may be issues of power too. Usually the clinician has the most powerful voice in hospital. This potential source of friction is also likely to occur when two or more specialists are working together.

Jacob said his hospital administration arranges relaxation programmes comprising collaborative work between meditation experts, yoga teachers and therapists. Jacob believes that '*Two heads are better than one*' and that in order to work more productively and develop relaxation programmes traditional concepts of hierarchy among medical teams must be challenged. However, some of his medical colleagues, he believes, have a feeling of superiority and, in particular, are unprepared to work together with complementary therapy practitioners. Even among healthcare practitioners, feelings of superiority between experts in different fields may interfere with the bond between them and practitioners may lose the chance to really communicate with each other.

Perceptions of superiority may arise due to the cultural characteristics of Korean society and particularly competition leading to feelings of elitism in higher education. Such superiority and competitiveness also extends to individuals and departments in university and again to professional life. Therefore, competitiveness between specialists (and particularly clinicians and therapists) in Korean society may be more pronounced than in the UK. In this way the collaboration environment and style may also be affected. A collaborative environment requires practitioners to be

understanding of and focused on the purpose of collaboration and the increased benefits that a client can derive from the team input, placing the client at the centre of the process.

Other challenges can occur when practitioners engage in collaborative work or transdisciplinary projects. For example, their subject knowledge, research methods (theoretical knowledge and practical applications) are different from one another. Practitioners may feel out of their own comfort zone, lacking confidence, sometimes leading to disengagement or a sense of emotional isolation when experts from one or other field work together (Grand et al., 2011; O’Kelly and Koffman, 2007; Hills et al., 2000). However, the process of sharing information or experiences in itself often permits the development of new insights and may help other therapists solve the problems they come up against too.

I will refer to some of my personal experiences of collaborative music therapy work while working in the psychiatric unit of a Korean Army Hospital. Some of the soldiers were resistant to music and not interested in musical activities. At the same time the soldiers were experiencing symptoms which included excessive anxiety, low self-esteem, anger, irritability, obsessive thoughts or voices, together with the side-effects of medication.

There were many other therapists there so it was really a good chance to share their therapy experiences and to find out about the other therapy courses. Sometimes I passed on some relaxing music to the art therapist, which she could then play in art therapy sessions and we exchanged ideas with one another. We openly shared our therapy materials and were very happy to share information by email too. Below is an

account of my personal experience of music therapy teamwork in Korea written at the time:

[...] one of the soldier clients did not talk to me for six months and I nearly gave up on him. He always threw the drumsticks at me and shouted (I understood this to be because he came to my session not voluntarily but under military orders). [...] I tried many types of music therapy techniques such as drumming, songwriting, rhythm activities, it was really difficult to continue and every moment felt challenging for me personally. I discussed my difficulty with the art therapist and one day she suggested using art in conjunction with music during the therapy session. She showed me how to use drawing in a simple way. I had just finished level one GIM training (in which I learnt to use 'mandala drawing' in music therapy) in which I was advised to be cautious of GIM techniques with psychosis and neurosis patients because of the possible side effects. So I talked things through with the supervisor. What I did was play relaxing and soft music and I gave out some large drawing paper and asked the soldiers to draw anything that they wanted to draw. The one who threw the drumsticks started to draw a picture of his family and afterwards he started to cry and he finally opened up and told me his story. It was finally a way to meet him, using music and art. [...] When he told me this story I could see his fear and anger in his eyes and the next soldier suddenly started telling his story too. [...] Up until this point I had never had a meaningful conversation with them, but with the art therapist's help I was able to start communicating with the patients. After this the next music therapy session encountered less resistance and they attended the music therapy sessions voluntarily. Some started to enjoy the music therapy session too. [...] This experience opened my mind to the possibilities of working in combination with other therapies.

For the soldier, art and mandala drawing (in combination with RM) were the trigger to the start of meaningful communication and it is unlikely that music therapy alone could have had the same effect.

I have chosen a particular area of collaboration work using meditation, RTs and relaxation music as my personal professional therapy work. I felt that if practitioners have ability to work with an integrated team and if practitioners have the opportunity to adopt and adapt methods from different professional training experiences, it may be of benefit to various client groups or individuals. However, as mentioned, in actual

clinical practice involving collaboration, there will be many difficulties that arise, such as uncertainty regarding responsibilities or an element of role ambiguity or lack of clarity as regards aims within the team. Nevertheless, I firmly believe that collaboration work will be helpful for practitioners themselves too, because they extend their boundaries and benefit from sharing.

To conclude, we need to be open to collaborative multidisciplinary approaches which present us with different and unique professional training experiences and focus more directly on helping a client and maximising the effectiveness of treatments. These multidisciplinary approaches and mixes of approach can be valuable in special ways. This can create new intellectual spaces between each area of research as well as practice.

8.4 Client-Centredness and Individual Sensitivity

In using RTs, MM and RM, a person-centred approach (PCA), (Rogers, 1979) is regarded as one of the common themes of practice and person-centred approaches have been the focus of many studies in music therapy and meditation (Bazzano, 2011; Wheeler, 1981). Rogers (1995, p.115) states “individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided”.

In my study, interviewees stressed the importance of client-centredness and sensitivity to individual clients’ needs thus reflecting this chief concern. Firstly, interviewees emphasised that client-centredness can result in positive therapeutic outcomes. Therefore, they tend to use RTs, MM and RM that match with individual clients’ background, psychological conditions, educational background and socio-economic

status, physical mobility, physical handicaps and limitations (including the ear and hearing problems previously discussed) and energy or fatigue levels. These were described as the crucial factors in understanding individuality and informing the practitioner's therapeutic goals, and methods, the achievable outcomes and the practicalities. Secondly, understanding the client's own inner resources and mind-set, determining what they really want and their personal motivations for attending the session can be helpful and may also throw light on clients' resistance or unexpected responses during the session. Therefore, interviewees perceived the value of assessment procedures and assessing personal characteristics as outlined above before embarking on interventions.

Individual sensitivity was highlighted frequently. The intervention itself may affect a client emotionally or in other ways, sometimes unexpected. For example, in using RM, aspects of the music, such as the mood or lyric, may invoke different reactions depending on the individual and the circumstances. For example, in Rosie's experience, in some cases when playing music with lyrics, certain clients may focus on lyrics rather than the music, which can have unexpected or undesired results. Knowledge of the client and their subjective experience can help a practitioner determine the appropriateness of musical resources.

When using RTs, some clients respond differently because of the manner of guidance. For example, in guided breathing methods, some older clients, particularly in a group context, may show resistance to following direct instructions regarding breathing: they feel uncomfortable, or they may feel it intrusive and sometimes do not want to join in. However, if RM is used in combination, breathing techniques are likely to be more effective and create the feeling that the activity is voluntary and not forced. If the RTs can be combined with the client's favourite music, the response may be even better.

RTs, MM and RM may provoke different reactions depending on the physical condition of clients and there are risk factors involved in these relaxation approaches. As mentioned in Chapter 7, caution is needed in applying such techniques with hospice patients or cancer patients because they may have different respiratory abilities and individual sensibilities. Georgia's advice is that the healthcare practitioner first check the state of patients thoroughly. Particularly in intensive care settings, an external practitioner's lack of information about patients' medical history may bring unintended results, as illustrated by Georgia's story of working with a yoga expert. Georgia said once when she was working with a breast cancer patient she ran a session together with an external yoga expert who the organisation had invited. Georgia already knew the breast cancer patients' condition in detail, but the yoga expert did not have a detailed medical history for each person. One breast cancer patient had had an operation on her left hand side and arm and the yoga expert tried to get her to move her left arm. Georgia went over to the yoga practitioner and explained the situation. But it was too late because the patient was already feeling depressed through the realisation that she was unable to make the movements. Georgia said practitioners coming in from outside often make these kinds of mistakes.

A particular problem here is that certain groups of practitioners (such as yoga practitioners) do not always follow the same kinds of guidelines as, say, music therapists do. This may be due to inadequacies in initial training courses in some alternative therapies. This problem tends to occur in one-off sessions when an external practitioner arrives just in time to do their sessions. Awareness that different individual sensibilities are properly taken into account is needed to avoid such risks. Georgia's advice is that the practitioner meet the hospital staff before they actually come into

contact with the patient and receive a full update on the patient's condition whether it is a one-to-one session or group session.

The subject of motivation was raised, especially the desire and willingness to take part in sessions including meditation activities. When using RTs and meditation, if clients have personal interest in taking part or are already motivated through previous experience, this in itself may facilitate the process of relaxation and relaxation responses. This reflection was made by both Jacob and John. In John's experience, the more motivated clients are, the more they achieve. And even for clients with no prior motivation or those who think "I don't know exactly what this programme is, but if I join up maybe it will help me cope", this positive attitude also makes a difference to the quality of the programme.

Jacob believes that frequent sessions can increase motivation and in order to increase people's motivation he believes it better to do relaxation sessions more frequently in hospital. In his view, a programme of 15 sessions or an 8-week programme of relaxation programme would be ideal for developing motivation (compared to one-off sessions that sometimes take place in Korean hospitals).

This is borne out by my own experience too. In Korea, some client groups attend sessions not voluntarily but compulsorily as part of an organisation's scheduled programme, school regime or rehabilitation programme. In such cases, most clients lack motivation when they attend sessions. However over time, through the regular sessions, client motivation gradually changes and sometimes clients adopt a more positive attitude towards the RTs, MM as well as RM, and this is often backed up through client feedback.

There is a similar link between the motivation of healthcare and admin staff (who help out with or organise sessions) and quality of the sessions. Jacob said that in order to increase staff motivation and to promote relaxation programmes in hospital settings as well as to train staff, he ran an 8-week programme or 4-whole-day residential courses. Despite the difficulties of recruitment, once staff have a better understanding of what is going on and what can be achieved through the relaxation programme, they can contribute more to aspects of the programme including help during the sessions, session preparation and assisting with publicity. Therefore, motivation of everyone involved - clients, healthcare practitioners, and admin staff can influence success.

Understanding the client's purpose for joining in can help with planning a graded structure of levels in a relaxation programme. If the client is lacking in motivation at the outset, sessions containing easier techniques and more detailed guidance may be desirable. They are less likely to gain from a full relaxation programme and it may prove difficult to follow a pre-set programme. On the other hand, if someone is motivated and already has experience of meditation, for example, it may be desirable to introduce them to advanced techniques and the elementary techniques will not be appropriate. And if a client attends a relaxation session to seek spiritual uplifting or else simply seeks to lessen their physical pain, practitioners must be careful to make this a specific goal in the relaxation programme. So practitioners need to offer individuals specific client-oriented programmes that will satisfy clients' purposes.

To conclude, Rogers (1957, p.98) writes that the client needs to be cared for "as a separate person, with permission to have his own feelings, his own experiences". Person-centred perspectives on practice are a common theme in health services in East and West (Hui et al., 2006; Avants and Margolin, 2004). In my study also, person-centredness emerged as a key value among the 12 interviewees and a basic core

principle of all three groups within their respective practices involving RTs, MM and RM.

8.5 Active and Receptive RTs, MM and RM

In this study, different ways of using active and receptive RTs, MM and RM have been outlined (See Appendix 13) and it has been seen that interviewees use a number of types of RTs, MM and RM in order to help clients achieve relaxation and develop self-care techniques. For the purposes of this study, in order to avoid a superficial and broad analysis of too many practices, I have focused on the specific range of active and receptive RTs, MM and RM discussed or used by the 12 interviewees.

Interviewees made it clear that they had different purposes in using active and receptive techniques using RTs, MM and RM. For mind-body relaxation and stress relief purposes, receptive techniques are mostly used. With active techniques, a client is given the opportunity to express themselves, which can both make clients relaxed and also bring the child or the adult into a relationship or increase the sense of self (through self-expression).

Acceptance and resistance to receptive techniques was also discussed, reflecting a cultural difference between in the UK and Korea. As previously mentioned, receptive approaches are well matched with typical Korean emotions and especially over 50 years, receptive methods are preferred to active approaches. This clearly corresponds to respect for authority and passivity in education and upbringing. Older people in the UK seem happier to engage in group activities and more at home with active approaches and discussion. For me personally, the amount of group discussion and activities during the class and courses was one of the cultural surprises during my stay in the UK. By the same token, in Korean schools 5 minutes meditation in the morning

before starting the class in junior or senior school was not untypical in the past. For cultural reasons it would be more difficult to imagine this happening in a UK school. Such cultural differences may extend to and be reflected in healthcare and therapeutic practices, even now that in Korea and the UK there has been a measure of cultural change.

The difference in responses to active and receptive methods were discussed by UK and Korean interviewees. Edward mentioned that in the UK people may feel scared to (suddenly) ‘slow down and to quieten down’ during a session or other situation. Korean people are typically less resistant to receptive methods and would not be scared to slow down (even in a group situation). There is familiarity with receptive types of practice. So Edward found that a mixture of active music therapy techniques or of active meditational techniques, like walking meditation, together with receptive techniques can be make people more at ease and relax.

Another cultural factor discussed was the relationship between the responses to music and socioeconomic status of the client. In receptive approaches, particularly those with a focus on listening to music, understanding of client’s preferences for music is important. This relates to Rosie’s comment on how the client’s socio-economic status affects her sessions (See Chapter 4.2.2). Musical preferences may relate to educational background and socio-economic status and openness to various genres of music is also related to the degree of exposure to Western culture. During the Korean War (1945 - 1953) and for some time after, relatively few could afford an education; familiarity with Western music came about later with the rapid economic developments. Few people of this generation had contacts with Westerners or with Western music and culture. This is common knowledge among Korean music therapists and the point is often made that the musical tastes of the elderly need to be taken into account.

In both the UK and Korea, exposure to and liking of classical music may depend on socio-economic status and educational background. However, in Korea the protracted war and near economic collapse during the 1950s through to the 1970s served to polarise the experiences of that generation and subsequent generations. External cultural influences were a rarity at that time and it was a period of little change, culturally speaking.

Lastly, during the process of interviewing and literature review, certain questions arose in my mind regarding the notion of *active* and *receptive* and the way of categorising active and receptive RTs, MM and RM. Receptive and active methods have been defined and categorised in various ways, as mentioned above. Generally RM would tend to be categorised as a receptive method. Perhaps it would be taken for granted that walking meditation or drumming is an active form of RT or RM and people will think walking or beating a drum is active whereas sitting still or listening and being quiet is passive and receptive.

Lily and Adam define RTs, MM and RM more broadly, however. Their view is similar in that taking into account the therapeutic purpose, the categories of active and receptive RTs, MM and RM should not be restricted or fixed. They both feel it is difficult to come up with a clear definition of active and receptive RTs, MM and RM and they say they still consider this question. Their own comments on this reflected my own thoughts.

I would argue that active and receptive RTs, MM and RM might also be distinguished according to how deeply the mind and body goes into a state of relaxation. Depending on the degree of relaxation and level of engagement of the relaxation response, the meaning of receptive and active can be defined in a different way. Regardless of

whether the approach itself is considered active or receptive, if the state of relaxation is deep, this can be regarded as an *active state of relaxation*.

In this way, even while listening to music, people can *actively* engage in exploring the self-image and spiritual aspects of themselves and through such musical experience they may reach a deep level of inner reflection and relaxation. Similarly sitting meditation may appear to be a passive pursuit but it can actually actively engage participants in profound mindfulness, calmness and a process of self-reflection. Therefore, what may be regarded as receptive practices can actively facilitate the transformation of the mental state and be thought of as a form of mental exercise.

However, if during the walking meditation, people are preoccupied by their own concerns or remain in a state of unease, fear or worry and generate negative emotions in this case, people are engaged only passively in doing meditation. The mind remains in a shallow state, even though body is actively moving, and so the state of relaxation or serenity achieved may also be less deep and there is less active engagement.

In terms of categorising active and receptive practices therefore, the degree of active or passive engagement that takes place during the intervention might itself be considered a parameter. Also depending on the practitioner's own interpretation or outlook, active and receptive RTs, MM and RM can be defined in different ways. Whether we call a technique active or receptive, therefore, might depend either on the activity itself (such as playing music or listening to music) or the mental state which accompanies that activity (the intensity or depth of practice or relaxation experienced). Thus the categorisation of specific practices into active or receptive, may not be a fixed one since the same activities can be performed both actively and receptively. This leaves open to doubt the validity of the distinction between active and receptive.

8.6 Music for Mindfulness in a Present-Moment-Focused Way

In this study, a variety of meditation subjects and RTs related to the uses of music have been discussed. In modern research the relationship between music and meditation is constantly being investigated (Jo, 2014; Lin et al., 2008; Wolsko et al., 2004; Chang et al., 2003). In terms of music, the current study focuses on RM sometimes in combination with RTs. In the *Visuddhimagga* (清淨道論), which is the classic manual of meditation doctrine, forty meditation subjects are described (Bhadantachariya, 1971) and many meditation resources derive from this traditional text and have been developed by meditation experts, but music is not one. I would argue, however, that music itself can be a meditation subject for mindfulness meditation. This theme has emerged from interviews and the literature review, but I will add comments relating to my personal experiences and study in the UK.

Eastern and Western theories of meditation practice have been developed differently (Weick and Putnam, 2006). The background of Korean meditation is based on Buddhist belief, but complex multiple faith influences, curiosity and interests have both triggered and informed meditational practice in the West. Although the traditional Eastern way of meditation can provide the basic and fundamental teaching, it may be possible to add or develop new meditation subjects in order to provide a greater range of opportunities for the wider population of both East and West and not only for the traditional meditation expert. I personally believe that music can be a useful resource for meditation although it may be different from the traditional way of meditation and its ultimate purpose may even be different. By the same token, the use of meditational practice/mindfulness meditation within music therapy can possibly be beneficial too.

In music therapy, music is often used in order to improve attention span for client groups who need to focus and to increase their levels of concentration. Research has shown, for example, how music affects schoolchildren's task performance (Hallam et al., 2002) and can increase concentration spans of those with ADHD (Thaut and Hoemberg, 2014; Chong and Kim, 2010; McFerran, 2009; Rickson, 2006; Jackson, 2003).

Several interviewees mentioned the link between music (and music combined with RTs) and concentration levels, attention and calming. Some use music combined with breathing techniques or visualisation for general calming purposes. People are often busy or else restless and easily distracted by their environment. So, for the purpose of reducing 'racing thoughts', practitioners use breathing techniques to make people relax through concentration.

If you lengthen the in-breath, you energise the body, then lengthen the out-breath to relax (Edward-UK)

Olivia said she often works with children who are quite 'scattered, isolated and overactive' and in order to create a point of focus and concentration she uses active or receptive music therapy. Olivia feels that music has the effect of quietening people down and having people come into focus. She says "It's like a sort of magic blanket that settles" and in group work with children, she often uses music as a focusing device.

She believes that certain music and sound tools change the frequency of the brainwave and the brain will synchronise itself with the music. She calls this *entrainment* (See Chapter 4). Some music can produce a healing frequency for relaxation (7 or 8 Hertz) and using such music, the body is more able to heal itself and mind and body can go

into a state of rest. As discussed in Chapter 4, the music therapy interviewees also describe music as providing some kind of a structure, like a container. For this reason also certain types of music can help people to regulate feelings and calming, so if clients are agitated and scattered, music can help them to express it in a more structured way. Then through this process, gradually a client can become more relaxed and bring down that sort of over-excitement. So there are a number of ways in which the interviewees explain the link between certain types of music and the focusing and calming processes.

Not only in music therapy, but in psychology, it is often reported that some musical tones, instruments and low frequency sound can affect and slow down brainwaves (Thompson, 2009; Peretz and Zatorre, 2005). Also in the study of meditation, aspects of music combined with meditation practice have been explored, including the effects of quiet background music during meditation, and how music can help people to learn meditation (Tang et al., 2007; Sarath, 2003; Zanzig, 1996). Therefore in a variety of study areas, the special powers of music have been recognised.

As regards my own experiences, I attended a 7- day residential meditation retreat in the UK. One time a practitioner used meditation tapes with music in the background and I thought it was a good way to introduce meditation to beginners and, perhaps in a different way, for experienced people too. I felt relaxed and at that time I strongly felt that music has a special power both to soothe and at the same time capture and inspire the mind and induce a relaxed state quickly. The power of music can facilitate meditation and I was able to do mindful meditation with music. Now when I combine music with meditation it works for me and personally I have started to use music-with-mindfulness as one of my own ways of mindfulness practice.

Mindfulness meditation is about trying to increase contact with the present moment but it may be contested that music in the background may introduce a certain mood or atmosphere from the past. This is clearly the case and music can quickly teleport our minds to the past if music carries particular memories. It may also transport us to the future or to imaginary places. Music has this immediate potency to transport the mind. At the same time, music also has power to take our minds into the present moment and enable people to focus on the present. Therefore, suitably chosen music can possibly be used as a subject of mindfulness practice and it can help us concentrate more on the here and now.

As discussed in Chapter 2, certain characteristics in music facilitate a state of relaxation. Music which has a strong beat, is too loud, too fast or slow, or with particular timbres may lead to increased nervousness, discomfort or restlessness, however. Therefore, musical genre, musical styles (e.g., sedative or stimulative music) and musical characteristics should be selected taking into account client preference, situation and personal level of physiological and psychological stability.

The link between *music and mindfulness* has recently been explored (Innes et al., 2017; Rodríguez-Carvajal and de la Cruz., 2014; Grocke and Van Dort, 2013; Diaz, 2013; Vidyarthi et al., 2012; Robarts, 2009; Baer, 2003; Magill, 2001). At the Guildhall School of Music and Drama in London a mindfulness course (both the MBSR and MBCT) has been set up for music students and this is an example of how MM is currently being adopted by musicians and the performing arts. These are indications that the combination of music and MM is being developed and resources for RTs, MM and RM will be more widely available.

Meditation is traditionally sometimes considered an individual practice to be performed alone and it may also be practised in groups according to certain rules, but in the Western world meditation is equally likely to be undertaken in group settings and more informal ways of practice are also a growing trend. The role of music is an example of this change. Music can provide a safe structure and can appeal to people and create relationships between people. For some people, observation of one's inner experiences and present moment awareness, which are one of the purposes of meditation, can bring resistance. Even though life itself takes place in the present moment and even though people may be motivated to practice meditation, still meditation in the present moment and exploring the inner self can be difficult, particularly for beginners, young people or for extroverts. Music can help overcome those difficulties and facilitate the development of mindfulness practice.

Several interviewees in the meditation expert group also suggested the use of music for meditation purposes. Adam said he had considered for a long time how to develop meditation skills in combination with other treatments such as music and music therapy because these two subject areas can provide a lot of support for each other in practice. In Korea, meditation departments at university have a long history and are well developed. Adam believes that a theoretical framework for 'combining music and meditation' is important to develop and that EBP is a requirement. Currently, the combination of these two subjects are run in popular modules (at undergraduate, masters and PhD levels) in *Zen Meditation and Meditation music* and *Zen Meditation and music therapy* in Dongguk University in Korea (Dongguk University Zen Studies, 2016).

In the UK meditation departments per se are not currently found in university settings as in Korea. Therefore, the route into meditation for practitioners is somewhat

different. In the UK, mindfulness meditation courses have nevertheless recently become popular at masters degree level (e.g., Bangor, Exeter, Oxford), (FindAMasters, 2016). However, a formalised way of combining music with mindfulness is yet to be explored.

Anna said that in the UK there are many meditation tapes with music in the background for meditation or RTs that are commonly used. However, the use of music in mindfulness meditation is different according to her. When music is combined with mindfulness meditation, it is about trying to increase contact with the present moment not to inculcate a certain mood or atmosphere. Therefore, mindfulness while listening to pieces of music or else the sounds around may be regarded as a specific mindfulness practice. The idea is to listen deeply to the music and sound with mindfulness and mindfulness practice are the main purpose when music and sound combined.

In therapeutic environments (e.g., art therapy, or psychotherapy, as well as music therapy), integrating mindfulness practice may have different purposes from Anna's. Mindfulness may be used to support the therapy itself or to maximise health benefits.

One similarity that can be seen between mindfulness and music is the concept of *flow states*. Kaufman and Gregoire (2015) define flow as “the mental state of being completely present and fully absorbed in a task. When in a flow state, the creator and his or her world become one - outside distractions recede from consciousness and one's mind is fully open and attuned to the act of creating”. *Flow states* can variously be regarded as ‘peak experience’ (Privette, 1983, p.1361), ‘genuine satisfaction during a state of consciousness’, ‘The best moments usually occur if a person's body or mind is stretched to its limits in a voluntary effort to accomplish something difficult and worthwhile’ (Csikszentmihalyi, 1990, p.3), ‘fully absorbing experiences and optimal

experience' (Csikszentmihalyi, 1990, p.5) or 'aesthetic emotion' (Marković, 2012, p.1). Through both mindfulness and music interventions, mind and body can enter the *flow states*, which are creative states associated with feeling of happiness and mindful-awareness.

These feelings and consciousness awareness can be explained in terms of five components (오온, 五蘊, Panca khanda). In Buddhism and mindfulness practice, 'self' or 'personality' is comprised of the five components which are: a) Physical forms or material qualities (색온, 色蘊, Rupa), b) Feelings or sensations (수온, 受蘊, Vedana), c) Ideas or perceptions (상온, 想蘊, Sanna), d) Karmic action, disposition, or tendencies (행온, 行蘊, Sankhara), e) Consciousness, mind, and mental powers (식온, 識蘊, Vinnana). Each of these five components can become an object of mindfulness meditation (The practical dictionary of Korean-English Buddhist Terms, 2011).

Therefore, our daily life experience and experience of our selves can be understood as a function of the five components. What is more important is those five components are never the same for a single moment, being in a constant state of flux and mutation (五蘊皆空, 諸行無常). For example, our feelings constantly change between pleasant, unpleasant, neutral and our perceptions also constantly change. The five components have no permanence or substance according to Buddhist thought. Concepts of being 'free of the idea of attachment and permanence' are a core philosophy of MM namely non-self, non-attachment, non-judgment and letting-go.

These main principles of MM can be applied in music therapy. Mindfulness approaches (as receptive techniques) have begun to be adapted in music therapy area

with various groups (e.g., Huntington's disease, drug, alcohol dependencies) and in music imagery (Van Dort, 2015; Grocke and Van Dort, 2013).

Grocke and Wigram (2006, p.127) say 'visualisation' can help people to be focused and "focusing or centring is a necessary part of the relaxation process where the therapeutic intention is for the mind to be quiet and still". They consider that our emotions, ideas, sensations, thoughts or images can be mindfully (focused) observed and explored and then the flow of images and thoughts can be let go or let pass rather than trying to reject them. As such mindful visualisation uses music imagery and the concepts of *letting-go* and *mindfulness observation* can be a bridge to combining mindfulness and music therapy.

Eckhardt and Dinsmore (2012) present 'mindful music listening' as useful tool and they say it can be a potential treatment such as depression. Grocke and Van Dort (2013, p.117) state:

Mindful listening enhances the awareness of sound, and transfers to everyday life, in that it enables the listener to appreciate natural sounds in everyday life-becoming more aware in the present moment. In addition, music, listening, and mindfulness can lead to greater self-acceptance and insight.

As such, the contribution of mindfulness for music has been explored revealing effective and useful tools for integrating mindfulness into music therapy. Not only music therapy, but also art therapy combines MM into practice. Art therapy and MM is not a new concept (Franck, 1973) and integration of MM and art therapy has been developed (Garland et al., 2007; Monti et al., 2006). Monti et al. (2006) explore the efficacy of mindfulness-based art therapy (MBAT) for cancer patients. They selected 111 cancer patients divided between a mindfulness intervention group and a control group. The mindfulness group showed a significant decrease in symptoms of distress

and improvements in quality of life. They foresee a future role for mindfulness interventions as options in psychosocial treatment for cancer patients.

To conclude, Kabat-Zinn introduced the effectiveness of MM in clinical settings and set out the psychotherapeutic benefits of MM (emotional regulation, stress reduction and increase the psychological well-being), (Williams, 2008). Mindfulness-based approaches have been adopted in therapy areas both with client groups and healthcare practitioner trainees. As regards my personal experience of mindfulness and music in the UK, I was able during the programme to concentrate and listen to each single instrument, all the different harmonies, the patterns, and the spaces between sounds. As a music therapist, I habitually had to evaluate, make judgments about or comment on music in order to choose music suitable for each client group, but during music-with-mindfulness practice, I was free from having to make any sort of judgment and, because of that, could be completely absorbed in the music. During the mindfulness course, listening to music became a totally different experience and I just listened mindfully to the music and sounds themselves and this gave me an experience of deep relaxation. It was similar to my experience with breathing practice (the main practice of the mindfulness programme).

Therefore if listening to music is used in a present-moment-focused way, it can be a type of meditation in itself. It has particular advantages too and these are related to the almost ‘universal appeal’ of music (Peretz, 2005; Green, 2003) and to the familiar and natural associations we have between music and relaxation and happiness. Music can be used both to accompany various mindful meditation activities and as a subject of mindful meditation in itself. The integration of MM and music is an important topic in my study both in terms of ‘*mindfulness as meditation*’ and ‘*mindfulness in therapy*’.

Not only this, but music lends itself to self-help techniques, providing a structure for activities, a time-frame, a regular rhythm and an atmosphere that is comfortable and secure.

8.7 Creativity and Spirituality

Creativity and spirituality are among the themes that emerged from the interview. Many studies have sought to identify the link between creativity and spirituality and mind-body interventions. The health benefits of a sense of spiritual well-being and ways to achieve this have long been investigated (See Chapter 2.13) and notions often discussed in relation to this include self-awareness, self-exploration, self-regulation, self-reflection, cultivating concentration and insight, altered states of consciousness, pure consciousness, a balanced mind and body, openness, non-judgmental awareness, inner strength, calmness, peacefulness and empathy. Specific programmes have been devised for self-development, spiritual medicine, creative exercises and spiritual development courses; RTs, MM and RM frequently support these programmes.

Three points which emerge from the current study are: firstly, cultural differences in terms of spiritual practices between the two countries; secondly, the connection between spiritual well-being and fostering creativity and spirituality; and thirdly, creativity and spirituality in education.

8.7.1 Similarities and Differences in terms of Spiritual Practices between the Two Countries

The concept of spirituality among Korean practitioners who employ meditation is often related to religious doctrine or beliefs but for the UK interviewees, the development of the spirituality using meditation does not always relate to any religious

orientation or belief. However, in both countries, the use of music for spirituality does not seem related to religious attachment.

Other common characteristics related to spirituality and creativity can be seen among the UK and Korean interviewees. The interviewees seem to have a special interest in spirituality and spiritual practice. For me, spirituality was evident during the interview in the atmosphere both because of their attitudes and also the trappings of the working environments (Tibetan singing bowls, joss-sticks and meditation cushions). I felt a sense of spiritual energy, of calm and tranquillity and pureness emanating from the interviewees. Therefore this prominent aspect of the atmosphere of the interviews has led me to reflect on spirituality, although not everyone spoke specifically about it.

Many interviewees practise meditation or RTs personally and therefore their inclinations are directed towards spirituality. In their professional practice too, they are exploring various sources of creativity and spirituality in using RTs, MM and music. They recognise a deep relationship between these interventions and creativity and spirituality, and possess the ability to adapt interventions for the purposes of developing creativity and spirituality.

8.7.2 Taking Care of Mind and Spirit

Like the interviewees, many healthcare professionals have shown interest in spiritual well-being for practitioners; researchers have also made the point that practitioners' mental and spiritual health should be shown particular consideration. A link between practitioners' creativity and spirituality and practitioners' maturity has also been made (Baker, 2002).

In the healthcare service, generally most health and social care focuses on the client or

patient, while care for the practitioner's mind and body is often unintentionally ignored and the practitioner ends up feeling overwhelmed and stressed because of burnout due to job demands, responsibilities and work environment. Problems of an exhausted mind may spill over into work. In response coping skills for practitioners have been devised. Many of the interviewees have also developed or used stress management tools, for the most part adapting RTs, MM and RM interventions for stress management and emotional care not only for their clients but for themselves too (See Chapter 6.2).

Mental and spiritual care is deeply connected with managing stress levels. When stress is overwhelming, people lose some of their natural stability, mind and body easily become unbalanced and people may experience uncomfortable and unhealthy feelings and negative thoughts. Faced with this situation, cultivating creativity and spirituality becomes more difficult and interest in cultivating creativity and spirituality diminishes. A positive attitude is one of sources that feed the spirit and spirituality can more easily arise when the mind and body are in a state of relaxation. That is why in creative activities, RTs and music are often used. Through their calming effect and being relaxed, people become more positive and open-minded which encourages inner spiritual creativity.

Aponte (2003) discusses the therapists' ability to be sensitive to the clients' spirituality. A therapist-client relationship is intimate and the therapist's mental state may affect the client during the process of treatment. Practitioners who stay *centred and grounded* (rather than staying in chaos, feeling out of control, overwhelmed by fear and anger, or wandering) are relaxed and balanced. During the session, their centred mind can transfer to the client directly; therefore a practitioners' mental state will make a client feel more comfortable, free and at home. Likewise, a practitioner's

creativity insight, openness and spirituality can transfer to the client and foster a mental state of creativity in the client. For this reason too taking care of practitioners' own mental well-being is necessary.

So practitioners' care of their own mind and spirit is arguably as important as their care for the client. There are various self-help techniques available and these need to be introduced to practitioners through systematic teaching programmes. Mental and spiritual care for practitioners can also relate to their particular spiritual interests. Anna, for example, practises Vipassanā meditation in order to understand insight and concentration and her spiritual interest in the development of insight clearly affects her professional work as a mindfulness meditation teacher.

Clients themselves have differing degrees of creativity and spirituality and their spiritual needs also vary. Practitioners who continuously seek to understand and explore their own spirituality may be better able to cater for the client's spiritual needs. Conversely unintentional neglect or misunderstanding of a client's needs for spirituality is more likely if a practitioner is not personally and actively engaged in care for their own spiritual well-being, just as a practitioner who does not know how to make themselves relax may find it difficult to make a client feel relaxed.

Spiritual self-care can nourish the vitality in our lives and may also help people to manage their own suffering. Developing spirituality and creativity has long been an interest of healthcare practitioners; the interviewees believe it gives a special meaning to life, enhancing mind-body strength, and that higher states of consciousness can be achieved in this way.

8.7.3 Creativity and Spirituality in Education

A number of studies have explored creative and spiritual work in education for healthcare practitioners (Kang et al., 2009; Hall and Mitchell, 2007). Several interviewees pointed to the importance of education for the development of creativity and spirituality. How creative thinking comes about and how students can feel its presence were among the main considerations and various receptive and active approaches using RTs, MM and RM were discussed for creative and spiritual work in education.

Creative spirituality may arise at particular or sudden moments of insight or times of calm reflection. Space between thought may be needed for this and it is often achieved during a reflective moment.

Reflection prevents our brain from becoming *fixed in its way of seeing things*. [...] Creativity emerges when we generate *novelty for the brain*. Reflection is a form of mind-training, one that takes us beyond fixed ways of thinking (Dalai Lama Center for Peace and Education, 2009, p.2).

When our mental state is calm and mindful, we can see reality more clearly and often experience a certain creativity of spirit. Such dynamic and alive reflective mental states can be achieved using either receptive or active techniques and so both approaches can be adapted for creativity activities and spiritual development programmes.

Many techniques have been developed in order to cultivate healthcare trainees' creativity and promote understanding of the concept of spirituality (See Chapter 2.13). Interviewees also commonly perceive the value of the human spirit in terms of health and adapt various RTs, MM and RM into their teaching and healthcare programmes for such purposes.

In teaching settings, some interviewees combine RTs, MM and music in creative and therapeutic activities. They also make the point that the everyday routine of many healthcare trainers is busy and stressful and there are few such opportunities to learn self-discovery and the process of developing creative ideas from the conventional education system.

Music is employed by interviewees in order to access the subconscious and induce an altered state of consciousness, for example through GIM and music psychotherapy programmes. For example, Olivia and Edward believe that a moment of spirituality can arise with the flow of music. This may be a spiritual healing and a personal transformation process. Violet says music taps creativity and spirituality therefore she uses music for creative work for nursing trainees. A deep relationship between music and creativity and spirituality in education is recognised. Therefore music can be a useful resource for increasing self-awareness and sublime states of mind in education.

Anna, Adam, John and Jacob all emphasise *non-judgmental awareness* and this is one of the concepts of spirituality emerging from the interviews. Bringing awareness non-judgmentally to the here-and-now is a key theme in their MM teaching programmes. The endless judgmental thought of everyday life leads to tiredness and stress and thoughts that seem stuck. Restless thought needs to relax and resting can energise life in a refreshing, productive and constructive way. Non-judgmental awareness is like a state of mental rest and feels like cleaning the brain. It can increase the ability to reorganise the mind.

Jacob views MM as an important educational tool for his medical trainees and nurse trainees for enhancing their mental state and gaining creative intelligence. Similarly Anna, Adam and Georgia, teach MM to their trainees for the purposes of emotional

care. Practising meditation is a process of inner quietness and self-awareness and it can help to deal with unhelpful thoughts and mental noise (fluctuations in thought). It enables better control over non-necessary thoughts and therefore the emotions.

To conclude, people may have different senses of well-being and creativity and spirituality. One of the reasons why people educate themselves to be creative and spiritual is that they seek freedom and inner happiness. What we refer to as spirituality is a difficult concept but when we engage with it and feel spiritually for ourselves, it is more likely to be understood. For holistic and emotional care, RTs, MM and RM can be used in various ways in teaching, therapy or counselling, practice. Creativity and spirituality can grow and be supported through the process of relaxation, listening to music, imagery, moment-by-moment awareness, mindfulness, concentration, and insightful experiences. Likewise RTs, MM and RM (both individually and in combination) can be used for specific therapeutic aims, which may in some way relate to the development of creativity and spirituality, for promoting spiritual growth and emotional and spiritual well-being. These aims include cultivating self-awareness, self-exploration, self-regulation strategies, self-development, self-reflection, self-empowerment, cultivating insight and concentration.

8.8 Interviewees' Recommendations

The recommendations that will be discussed here are:

- Firstly, why do interviewees recommend the benefits of self-practice and what value do they ascribe to experiential knowledge in RTs, MM and RM?
- Secondly, what specific recommendations are given regarding the guidance during a session? What values are ascribed to the guidance given to clients?
- Thirdly, what advice regarding financial support is given?

8.8.1 Value of Experiential Knowledge of RTs, MM and RM

The idea that practitioners' experiential knowledge and self-practice can enhance the practitioners' skill are found in different ways in both in the UK and Korea interviewees. Both groups recommended that practitioners need to try techniques out for themselves and attend programmes and workshops (GIM and MI) and experience these live. Experiential learning and self-practice were among the main recommendations by interviewees and they regarded this as a valuable part of the understanding of practice.

In using RTs, MM and RM, understanding states of relaxation, how the body responds to the interventions and how music affects the emotions through personal experience were recommended. As already mentioned, some concepts such as *altered state of consciousness, spirituality, mindfulness* and *insight* can be difficult to grasp and hard to make sense of. However, if practitioners explore and experience RTs, MM and the effect of RM by themselves, this helps the practitioner make sense of those concepts and think in a different way about the interventions.

Secondly, understanding before applying makes a difference when it comes to preparing and running the relaxation session. Experiential knowledge of practice and a practitioner's self-reflection are often mentioned as being related to effectiveness when leading a session and enhancing practitioners' skills (Yeganeh and Kolb, 2009; Lau and McMain, 2005; Bennett-Levy, et al., 2003). This affects participants' own therapeutic work because increased understanding of relaxation skills is associated with better quality sessions and it has benefits for the healthcare practitioners themselves as well as the patient or client.

During a relaxation session clients may sometimes face various types of difficulties and they may ask about these. In their hearts they may have doubts or resistance, so the practitioner must be able to cope with this situation and special consideration and sensitivity may be needed. However, sometimes the practitioner will not easily find answers to the clients' problems from theory or ready-made answers (in books) and sometimes practitioners will gain credence if they pass on what they themselves know from experience. If someone already has experience, then theory or books may be helpful, but without having personal experience, it may be difficult to understand what is written in books as well as how to respond to and treat and clients' problems. The development of mindful awareness and insight can be another aspect of learning through experience and these factors can help to find a solution work together with the client (We may contrast this highly client-centred approach with that of a biomedical practitioner).

Thirdly, practitioners' mind-sets can be changed through deeper practice and experience and reflection on what they are doing. This may be connected to the process of maturing, which affects practice too. And practitioners' improved state of mind, body and spirit will directly affect their ability to benefit the client and their quality of performance. Several interviewees mentioned the practitioners' maturity and personal skills, such as having a healthy mind and the ability to heal themselves and the practice of healing themselves. Lily emphasised that no matter how RTs and RM are used, skill as a therapist and maturity are the first priority and she talked about these in relation to the notions of the wounded healer and counter-transference.

Counter-transference (See Glossary) was explicitly mentioned by three of the practitioners (Lily, John and Rosie). In a therapy context, both *transference* and *counter-transference* have been explored. A client's feelings may be redirected (or

transferred) to a therapist and this known as *transference*. Priestley (1975, p.236) describes transference as “a process by which a patient attempts to relive with her therapist the unfinished business from former important relationships in her life”. Conversely *counter-transference* is the redirection of the therapist’s feelings toward the client. The concept was originally developed by Freud (1910, p. 144): “a feeling or reaction that arises in the [therapist] as a result of the patient’s influence on his unconscious feelings”. Freud viewed counter-transference as a negative phenomenon which may threaten the therapeutic process. Subsequently too, many practitioners have warned against it; however, there are also arguments regarding the benefits of counter-transference, when there is awareness of it (Hayes et al., 2011). Caprioli (2016, pp. 12-13) writes “It has become an essential tool in understanding the experiences of clients and therapists. The current view maintains that a therapist’s exploration of countertransference ‘allows the therapist to pay attention to the client’s behaviors that are affecting the therapist in particular ways and why this is the case’ (Hayes et al., 2011, p. 96). Thus, the definition and utilization of countertransference have grown and it has become an important key concept in understanding therapeutic process”.

Music therapy is a creative and can be construed as a psychodynamic process between the therapist and the client. Counter-transferences have been discussed in music therapy (Bunt and Hoskyns, 2013; Wigram, 2004; Bruscia, 1987; Priestley, 1975). Referring to the work of Priestley (1975) and of Bruscia (1987), Wigram (2004, p.207) describes it “as a process where the therapist comes to the therapy situation with feelings, attitudes, motivations, values, beliefs and behaviour patterns. She [Priestley] identifies two types of reaction: first, the therapist’s unconscious reaction to the client and the client’s transference; second, the therapist’s identification with the client. In the second effect, the therapist identifies with unconscious feelings or internal objects

of the client that give him/her insight into the client's hidden inner life". Wigram (2004, p.207) also refers to Bruscia's categorisation of counter-transference: "Positive: when the therapist can observe his/her personal reactions in therapy and use them to benefit the client. Negative: when the therapist is unaware of his/her reactions to the client, or is unwilling to observe them".

Counter-transference is a created phenomenon between the therapist and the client (Kirkland, 2013); it is much discussed and there is a belief that this potentially influences with a therapy session (Dunn, 2009; Pedersen, 2006; Austin, 2002; Bruscia, 1998). Pedersen (2006) in her abstract summarises how counter-transference can occur in a music therapy situation:

[4] Counter transference experiences include an unconscious change in the musical expression and a change in the musical and therapeutic relationship between the music therapist and the patient, and the work is brought at another level.

[5] A change in the counter transference moment can be experienced as positive or negative, the latter [negative counter transference moments] are identified solely at those moments when the therapist is insensitive to the process of the patient [...].

In the face of counter-transference, mindfulness-based therapy would suggest the therapist develop 'mindful awareness' of the hidden sources which can trigger their feelings and perceptions which are not related the present session itself. It may benefit the practitioner then to focus on the 'here and now' rather than recall past events (such as unresolved conflicts from the therapist's past experiences or relationships) and for the therapist to remain mindfully aware so as not to confuse their own prior experience with the client's experience. During the process of therapy, it is beneficial for the therapist to seek insights while remaining non-judgmental, non-attached and neutral in attitude.

Awareness of counter-transference relates to the inner qualities and maturity of the practitioner and practitioners need to develop this awareness. Through the process of self-reflection or self-evaluation, practitioners' inner quality and maturity can be enhanced and practitioners may gain more sensibilities and insight into how their feelings or actions may directly affect the client during the session. This can be part of systematic reflective development for professional practitioners.

To my mind also, there are connections too between the practitioners' quality and ability on the one hand and self-healing on the other. Developing the ability to heal oneself may therefore be regarded as part of a practitioner's skill set. Self-healing may be achieved using various tools and methods and mind and body interventions may assist self-healing. Meditation, relaxation programmes, music therapy sessions or individual training may directly affect the practitioners' mind-set and maturity as well as the quality of the session. Practitioners need to take the time to understand what is going on during the relaxation process. When they have practiced by themselves they more clearly understand what problems may arise. It is like a rehearsal for a music concert.

During the interview with Edward, he several times pointed out that describing RTs is not easy and that personal experience of RTs and RM is needed first before practitioners use RTs for making clients relaxed:

I can't easily explain [...] in words. Practitioners need to be experienced first-hand. Rather like swimming. You can explain to someone the principle of swimming using 10000 words but until they get into the water, they do not know it directly (Edward-UK).

So practitioners should themselves experience the techniques and know what it is to relax before applying the RTs. The personal value of the practitioners' experiential

knowledge was clearly illustrated and it was recognised both by Korean and UK interviewees.

Hanh (2008) says mindful breathing techniques can transform people's emotions such as fear, despair, anger, and craving. He recommends an ideal comfortable duration for breathing in (inspiration) and breathing out (expiration), even though it may differ for healthy and sick people. For example, in a deep breathing exercise, counting three or four for in-breaths (4-5 seconds), five or six for out-breaths (5-6 seconds) and for a normal breathing exercise counting three for in-breaths (3 seconds), four or five for out-breaths (4-5 seconds) can be comfortable. Hanh (1985) recommends 'mindful breathing' in both deep and normal breathing, so when taking a long or a normal breath, we need to be aware that we are doing so and we are breathing gently.

In the UK, I attended popular meditation classes and meditation retreats in order to understand more about UK practice. One time, I myself gained some insight into why the practitioner's rehearsal is important because of my own uncomfortable experience of the approach to breathing techniques. It was a guided meditation session and I followed the breathing technique guidance but the duration of the in- and out-breaths was faster than my normal breathing speed so I was engaged in hurried breathing rather than calming breathing which resulted in a slight headache. Whether with breathing techniques or other types of RTs, careful preparation is advisable and practitioner's self-practice before the session may prevent unexpected problems arising or help suggest a way to fix the problem. In music therapy training, practitioners' pre-session testing out of practice is always regarded as being important, but in practice this does not always take place.

In Korea many young practitioners use the PRT and run relaxation sessions that are often combined with music. Sometimes, when working together with others, I felt that

the tempo of the music did not fit the PRT and in the relaxation session that the music was slightly too fast. Those mistakes tended to occur if there was a lack of rehearsal or experience of working with a particular client group, or at busy times such as Christmas or when leading several sessions in one day.

Despite time pressures, there are many reasons therefore for first-hand practice and rehearsal before a session. Through self-practice, it is possible to extend a practitioner's RTs and ability to work with varied client groups. Current guide books or texts are generally good to use in a session, but a practitioner's own guidance may also have value not found in existing guide books, that may help build a practitioner's self-confidence, personal rapport with clients and ability to develop more specialised programmes.

To conclude, it is desirable that healthcare practitioners gain learning, sensitivity and maturity through personal experience and understanding of the processes and benefits before applying interventions. In order to learn and gain personal experience at first hand, attending relaxation programmes can be encouraged and joining networking groups and attending training courses run by experienced teachers are therefore beneficial. Also as part of the process of personal practice and understanding the techniques, the advice of interviewees was for practitioners to compile their own list of techniques, such as RTs, MM and RM for use with various clients.

8.8.2 Guidance for Practice

Guidance by practitioners was often mentioned by interviewees in relation to RTs and RM and the importance of guidance was emphasised. The role of guidance may depend on the therapeutic approach. Across the interviews, *guidance* was spoken about in two rather distinct ways. Guidance can refer to all the interaction with clients from

initial greetings through to the goodbyes at the end of the session. Alternatively guidance is regarded as the specific instructions that accompany (and form a part of) GIM, and the therapist's role is not strictly speaking that of a guide, but as an enabler, support or facilitator.

There are different approaches to guided meditation but, under the guidance of a practitioner, the client is taken step-by-step through a meditative experience accompanied either by live or recorded guidance and, depending on the session length and total meditation time, the method and type of guidance may differ. In the case of GIM, Goldberg (1995, p.112) says the "music and therapist are co-therapists" and the role of therapist is "to focus and encourage, as emotions, sensory images, physical sensations, memories and thought emerge" so the client (or traveller) is guided to engage in the here-and-now using music-imagery experiences and the therapist facilitates and supports the creation of those music-imagery experiences for personal growth. So in this Bonny method of GIM the therapist does not strictly guide as such, but supports and helps deepen the unfolding of all of the imagery. In many ways the traveller's psyche does the guiding.

In relaxation programmes, Jacob verbally instructs his patients from the point of entering the session room until they leave - and talks them through everything that happens. This is what guidance means for him. Like Jacob, the medical practitioners, in particular, considered practitioner's guidance to mean a mixture of instructions, counselling and guidance. These practitioners give medical counselling during relaxation sessions because their patients often ask them medical questions. Patients have their own agendas and, for a session to run smoothly, the medical practitioners have to attend to these and answer questions that arise. And sometimes medical practitioners have to introduce the programme and explain why they run the relaxation

sessions in hospital, why relaxation is important and how it relates to illness, the causes and effects and the importance of stress and how they can manage it. They consider these kinds of instructions and counselling part of their guidance.

This discussion (above) regarding the more extended kind of guidance by medical professionals was based on data from the Korean medical professionals. In Korea patients feel that they have limited access to doctors and to medical advice from professionals. For that reason they tend to take advantage of a doctor being present and ask questions that are on their mind. Perhaps this is less likely to happen in the UK and that patients will be more disciplined in their approach to things and less inclined to ask personal questions. Therefore, those differences may lead to different types or styles of guidance in the UK and Korea.

The role of guidance for the client is important for a number of reasons. The quality of guidance can help people to build self-awareness and to encounter a new image of themselves. Without guidance, clients, especially newcomers, will lose track and mentally wander off during the session. Therefore, interviewees advise that whether the guidance is step-by-step or less strict, clients should generally speaking be supported by guidance and well-thought through guidance can help clients explore their inner self, create a self-image at the deepest level as well as enable them to develop self-help strategies.

8.8.3 Financial Support

Financial support is an important issue for practitioners who use RTs, MM and RM in their practice as well as providing opportunities and encouragement for people wanting to extend their professional toolkits. The medical practitioners group said most about funding and financial support and the other groups were rather hesitant to discuss

finances, although it was a specific interview question. They said the issue was complex and they preferred to focus on other concerns. The medical practitioners group, however, were happier to speak about financial concerns as well as the administration and running of sessions or programmes and gave recommendations regarding financial issues.

My comments are therefore somewhat limited, but the medical practitioners in Korea did make some worthwhile points. They said they themselves have regular salaries as a doctors or nurses and that they were able to obtain levels of funding from within the hospital organisation, such as the centre for myocardial infarction diseases, or the hospices and palliative services centre. In their own situations at least financial support for relaxation programmes is stable, relaxation programmes are paid for, they do not need to charge patients and so patients who attend the relaxation programme do not need to consider the costs of treatment. However, the medical practitioners believe that the funding may not continue and doctors and nurses may find it more difficult to run therapy and relaxation programmes in hospital. Currently they frequently invite therapists and practitioners to deliver or co-work on programmes and external practitioners cannot offer their services for free. This is really their major concern and they believe funding is of primary importance with respect to the use of interventions in clinical settings. In community settings and in one-off sessions, practitioners may sometimes work as volunteers, but hospital work requires a greater degree of professionalism and commitment. The medical practitioners are hopeful, therefore, that the government will provide special allocations of funding and support for this kind of programme in future since hospital support cannot be taken for granted.

Steps needed to be taken to attract funding were also recommended. Publicity for existing programmes and development of new rehabilitation programmes in hospital

can increase interest in the use of such programmes and greater awareness among clients and staff. Secondly, there is a need to train practitioners - whether doctors, nurses, therapists or healthcare practitioners - who are interested in delivering relaxation programmes. Certification is needed, since it is difficult to attract funding for courses run by unqualified staff. Music therapy courses or mindfulness meditation courses such as MBSR taught by universities have a standardised syllabus and these are more and more recognised by the government. In the mainstream healthcare service, relaxation programmes are widely used. However, specific RTs which have been adapted independently by some practitioners, such as abdominal breathing, PRT, relaxation imagery, AT, biofeedback and hypnosis are not yet considered mainstream in themselves. More rigorous standards for practice are needed. At the moment, those RTs are introduced as a kind of CAM and have been used in many situations, including hospital settings and clinical settings, but they arouse suspicion, particularly if practitioners are underqualified. In the long run it may be felt to be easier and cheaper to give patient tablets or medical interventions and this is more likely when there is any level of doubt surrounding the therapy or qualifications of the practitioner.

There is therefore a need for practitioners to obtain standardised qualifications as well as wider recognition for the techniques themselves. Moreover, as mentioned in Chapter 4, many healthcare practitioners, supervisors and therapists are looking to EBP in order to raise the profile of their specialism, attract funding and secure employment, as well as enhancing the service they provide. Financial considerations can be a barrier and a common challenge in practice. However, interventions which gain recognition by the government-funded bodies will help attract funding and attitudes to the use of such interventions will change over time, enabling therapeutic practices to develop and spread.

To conclude, in this chapter, I have discussed a number of topics emphasised or recommended by interviewees. In some cases healthcare practitioners in the UK and Korea have different attitudes towards these topics and or else perceive them differently according to the situation. Also in each topic some cultural differences and similarities have been revealed showing how the culture differences affect healthcare environment too. For me the discussion and reflection on these topics has informed my own practice, as will be taken up again in the next chapter. I was given valuable recommendations which I had not taken on board before starting my research process. In the future it may be worthwhile to explore the same topics with the benefit of a wider understanding of the cross-cultural factors and knowledge of the situation with the various healthcare practitioners group and various settings.

Chapter 9: Conclusions

9.1 Conclusions

In this study, I have investigated the theoretical background and evidence base for the use of RTs, MM and RM and how practitioners adapt these interventions for promoting health and well-being. The differences in participants' outlooks and attitudes due to cultural factors and cultural similarities or differences between the UK and Korea have been identified. Lastly, cross-cultural perspectives, practical issues and recommendations regarding the use of interventions have been discussed.

The following objectives have been achieved:

- Gaining insights into practitioners' understanding and uses of RTs, MM and RM (either as an individual or collective experience) in healthcare contexts in the UK and Korea.
- Identifying the key cultural factors which lead to differences in outlooks and attitudes regarding the use of RTs, MM and RM among UK and Korean practitioners.
- Identifying the potential value of RTs, MM and RM as mind-body interventions and new therapeutic tools for mental, physical, emotional and spiritual self-care.
- Recognition of the possibilities of RTs, MM and RM resources for multidisciplinary integrated care in the UK and Korea in order to maximise health benefit outcomes.

9.2 Limitations of the Study

The limitations of study that I will identify were partly expected before starting the study and some were unexpected.

9.2.1 Expected Limitations

The first limitation concerns differences in traditions and cultural backgrounds. Because of different cultural and traditional background, differing attitudes and views

regarding the use of interventions in the UK and Korea were encountered. As a consequence of this and also because of interviewees' own level of familiarity with certain features of professional life, particular responses varied in terms of length and focus. A clear case in point were the discussions surrounding meditation. Traditions are different and Koreans are generally much more comfortable discussing meditational techniques because of widespread familiarity with them. Therefore, there is an imbalance between the UK and Korea in terms of analysis, and comparisons in such cases were difficult to draw.

Secondly, interviewing in a second language brought different issues to light and conducting cross-border fieldwork in the UK and Korea presented certain difficulties that in some way were expected. These issues were to some degree at least anticipated and, as explained, I felt that they also provided my study with certain advantages and allowed me to gain new levels of understanding and provide insights too. However, the 'sense of the unfamiliar of the UK culture' and 'language boundaries' referred to in Chapter 3.8, can present limitations as well as advantages. For example, my level of cultural understanding, the unfamiliar aspects of the UK healthcare environment that puzzled me and having English as my second language would all to some degree affect the interview process. I realised that the cultural gap and language barrier was not very easy to overcome. The important process of building a rapport would be generally much easier with Korean interviewees, who had the same cultural background, than with the UK interviewees.

9.2.2 Unexpected Limitations

Other issues were not anticipated. Firstly, I had not expected that during the interview specific topics would be mentioned by practitioners from only one of the two countries

or else by one group of practitioners that would otherwise have been valuable to analyse more fully. Some of the discussion therefore reflected the thoughts of one group in particular and this may be regarded as a limitation of my study. Of course, if any practitioner was unwilling to talk about a specific question, it was inappropriate to pressure them into talking and so with some topics I had to analyse interview data in a one-sided way. Examples of topics, such as ‘financial support and practice’, ‘guidance and practice’ have already been mentioned and discussed in Chapter 8.

A second unexpected factor may also be regarded as a limitation. Most interviewees have a personal interest in spiritual practice, mind-body interventions and self-help techniques (though the level of interest varied), they generally have had personal training and they themselves have been transformed through their own practices. And many practitioners are interested in meditation and mindfulness-based approaches, in which being non-judgmental is a core principle of practice so their discussion was gently positive and self-reflective rather than critical. This affected the character of the interview as well as the actual data and certain questions seemed to be avoided.

As professional practitioners the interviewees no doubt have their own views and the ability to criticise or make judgments, but this did not come through during my interviews. Rather than insisting on their own opinions they were more inclined to be open to other people’s opinions and new ideas. They quite often returned questions to me if there was any suggestion of being critical (of healthcare provision, for example). If I asked which intervention might be more effective they tended to describe a particular practice or situation (of their own) rather than drawing comparisons. Therefore, certain questions were not answered in the way I had expected them to be and my focus of analysis had to be amended. As mentioned in Chapter 3.2.3, my

approach was a constructionist rather than a realist one and analysis needed to take account of the conversational context and flow.

To conclude this section, the limitations identified, whether expected or unexpected, are mainly due to cultural factors, my own level of cultural understanding, and the personal qualities, in particular the non-judgmental character, of the interviewees. Whilst such factors were more than those anticipated, nevertheless these factors themselves gave me the opportunity to explore differences and expand my understanding. Although the limitations remain, during the process of grappling with cultural differences I personally felt that this provided me with a valuable first-hand learning experience offering insights as a practitioner and a wider understanding of the situation in the UK and Korea.

9.3 Contributions of the Study

My study has researched the RTs, MM and RM interventions that practitioners have adopted, their rationales and approaches, and how these can be affected by differing cultural and healthcare contexts. This qualitative and comparative case study of RTs, MM and RM within the specific context of Korean and UK healthcare is, to my knowledge, one that has not yet been explored.

My study is exploratory and broad in scope, an approach which is common in qualitative research where there is little existing research and where a key contribution made can be developing understanding and the meaning of particular social practices. In relation to cross-cultural points of comparison, there are various topics that can be taken up again and built on by future researchers (See Chapter 9.4.1).

Through this cross-cultural exploration, basic similarities were identified between the two countries in terms of ultimate goals and basic underlying principles. In particular, I found that there are certain similar aspects regarding therapeutic practice, for example, non-judgemental awareness, non-attachment, the letting-go ego, and non-duality. Those underlying principles can be viewed as examples of the incorporation of spiritual practice in healthcare, the combining of Eastern and Western therapeutic philosophy and a focus on self-help (both in the sense of techniques that can be learnt and used independently, and in the broader sense of using one's own personal inner resources for therapeutic benefit).

Korea and the UK represent different cultural models of healthcare service and different approaches to interventions. Despite these different perspectives, beliefs, tendencies and religious influences, practitioners are commonly aware of the importance of knowledge sharing and benefits of integrating Eastern and Western practices in terms of their use of interventions and integrated medicine.

For example, in its use of RTs, MM and RM, 'multidisciplinary integrated care' has become established in music therapy in both UK and Korea. Like other professional practitioners, music therapists build relationships and networks and share across the worldwide community. As such RTs, MM and RM are clear examples of interventions that are currently, and will increasingly be used in combination and will draw on practices in other countries. Therefore, by uncovering the ideas that underline UK and Korean practice my study contributes towards both to the body of research on 'multidisciplinary integrated care' (Fennell et al., 2010; Ruud, 1998) and to cross-cultural healthcare research within this growing research area.

Understanding Eastern and Western culture(s) and their differences and similarities can facilitate the sharing of information between East and West. My discussion of the particular comparisons between the UK and Korea with respect to RTs, MM and music in healthcare will contribute to this understanding. In Korea, practitioners are curious about Western approaches and keen to learn from different approaches to therapy and practice. I will be able to share my experience of practice in the UK and the knowledge I have gained about the UK practitioners back in Korea. The international focus among Korean healthcare practitioners has looked to Western study and practice, in particular America. With respect to RTs, MM and RM, there is a lack of knowledge within Korea about the UK compared to America. I clearly felt, when I attended international healthcare conferences in Korea, not only that UK participants were few in number, but that the UK seldom figured in discussions. Since information exchange between the healthcare practitioners in Korea and the UK has so far been limited I hope my study will serve to expand cross-cultural awareness and understanding among Korea and UK healthcare practitioners of use of their respective therapeutic methods. In this sense my own study is distinctive and opens up a relatively unexplored area of study in Korea.

Not only in academia, cross-cultural awareness and understanding may become more important over time as traditional geographical and social barriers break down. Globalisation can mean the import and export of the cultures (Bhugra and Mastrogianni, 2004). The ‘globalisation of healthcare’ and ‘transcultural health and medicine’ are a growing trend in both East and West and those views influence both practice and research. My study could be a starting point for intercultural communication between UK and Korean practitioners who are interested in RTs, MM

and RM. And my study will help to fill gaps in knowledge about UK healthcare as well as introducing aspects of Korean practice to UK practitioners.

The study therefore contributes to setting the groundwork for cross-cultural understanding of practice and to encouraging further international communication between UK and Korean practitioners. For me personally, this has been partly achieved. I have learned much that is of value from the process of interviewing UK practitioners and reflecting on this, which has expanded my therapeutic knowledge and insights in terms of my own practice. I therefore have some degree of confidence that this aim has been achieved.

In general terms, the strength of the study lies in its depth and detail regarding cultural understanding of 12 purposely selected professional experts within various healthcare environments. It also provides a detailed background to cross-cultural points of comparison for anyone wishing to undertake related research. This extends to differences between UK and Korea in philosophy and approach, practitioners' concerns, case study comparisons, and the growth and popularity of RTs, MM and RM in the respective healthcare services.

The nature of the study must be borne in mind. Since it is an initial case study and not based on previous research, my qualitative research is exploratory and open - not based on pre-formed hypotheses. Through this process of open discussion (albeit within semi-structured interviews) and subsequent self-reflection, insights have been gained into beliefs, values, differences in approach and practice and complex of cultural issues. Such research is founded on the belief that understanding of a phenomenon in relation to its cultural context will grow gradually. Although my study is restricted to particular interests of the users of music, relaxation techniques and meditation in

healthcare, the findings and implications for future cross-cultural studies are broader. Many of the issues dealt with are common or have clear parallels within the healthcare community.

9.4 Future Research Possibilities and Final Reflection

9.4.1 Future Research Possibilities

As described, the UK and Korea have distinctive strengths in their use of mind-body-spirit interventions. In the future, by growth of cross-cultural dialogue, the practitioner can learn from their respective strengths within their existing healthcare frameworks. The two cultures may therefore be able to learn from each other and benefit practitioners and clients in both populations.

The difference in range of RTs, MM and RM resources and the approaches in practice may lead to cross-fertilisation within therapeutic practice and in the future, there are possibilities of modifying RTs, MM and RM in both East and West. This will contribute to potential creation of clinical methods of RTs, MM and RM in the provision of healthcare areas with practitioners who have an interest in mind-body-spirit care. There may also be possibilities for future research as outlined below.

Cross-Cultural Qualitative Research

During the process of my cross cultural case study, firstly, I recognised the importance of the differences in the healthcare organisation in the UK and Korea and, as mentioned, these are intricately connected with historical and cultural factors. A lack of understanding of healthcare organisation can lead to limitations in cross cultural communication among healthcare practitioners in the East and West. Secondly, there are also significant differences between the UK and Korea in the understanding of

spirituality and creativity in health (already alluded to in my study) and I feel that these themes would constitute worthwhile topics of further study. Thirdly, my study has used in-depth semi-structured qualitative interviews focusing on professional perspectives. In future it might be possible to explore through a qualitative study patients' understanding of and responses to such interventions, their perspectives and outlooks, and how cultural factors affect these. Fourthly, long-term cross-cultural qualitative research in healthcare, whether as an observer or as a participant, might be recommended for more in-depth research. Cross-cultural study tracking patients in the residential long-term care (hospice care, rehabilitation unit care, child disability care and adult disability care) is another possible area for exploring cross-cultural comparisons relating to healthcare provision and practices, and human behaviour.

Integrating Theory and Practice

This study describes collaboration work among practitioners from various specialisms who incorporate RTs, RM and RM. Multidisciplinary integrated care offers possible new areas of research including various connections between meditational practices and music in health. Possible themes would include:

- Combining Receptive Methods in Music Therapy with Guided Meditation
- Music and Mindfulness: Integrative Mind-Body-Spirit Interventions
- Guided Imagery and Music (GIM) Combined with Receptive Techniques of Meditation
- Integration of Music and Mindfulness: The Path of Non-Attachment and Non-Duality
- Music and Mindfulness in Multidisciplinary Healthcare
- Integration of Mindfulness Meditation and Receptive Techniques and Music Assisted Relaxation

9.4.2 Final reflection

In modern healthcare, there is an emerging interest in integration of physical, psychological and spiritual practices among practitioners. As mind-body-spirit interventions, RTs, MM and RM are an example of this trend in modern practice.

Korean and British patterns of practice and healthcare and community service have been developed in unique ways. Increasing trends toward globalisation and transcultural healthcare, cultural awareness and cross-cultural communication have been expanded accelerating the broad change in cultural models of healthcare in the East and West. We may anticipate that new models will look beyond national boundaries on the one hand while simultaneously embracing traditional cultures.

This study illustrates how, in their use of RTs, MM and RM, practitioners are trying to find ways to promote and improve health and well-being. In Korea there is a concept ‘安樂’ that is often used within the context of health. ‘安’ means peace and relaxation, ‘樂’ means happiness. Well-being is connected to happiness and happiness cannot be without peace of mind (安心) and through ‘安心’, we become comfortable and relaxed.

Health is therefore intricately bound up with the cultivation of ‘安樂’. Our approaches to healthcare may depend to some degree on such culturally bounded notions. However, beyond East and West, calmness and serenity comes from inner peace and RTs, MM and RM can make it possible to reach levels of tranquillity and have the power to nourish happiness and well-being.

Lastly, I would like to add my personal reflection on the journey of study as foreigner. I have met many healthcare practitioners, including meditation experts, music therapists, sound therapists, and nurses and doctors who are interested in combining

RTs, MM and RM. During my PhD course in the UK, I have seen new ways of adaptation of practice and I was inspired by the practical approaches of practitioners to interventions. I was also inspired by teaching styles, and the methods of communication with one other and the encouraging methods employed. These feelings and experiences were new and contrasted with my experience in Korea. It was this inspiration that helped me continue to finish my PhD study and feed my spiritual growth too.

I have first-hand experience in the UK related to my area of study and practice and which I can use myself as self-help techniques. I can reflect on a new appreciation of mindfulness meditation, music and sound therapy and these considerations make me more mature as a therapist. Undertaking this research study has been an invaluable learning experience in professional life too. I have gained some understanding of the nature of research and nature of the research process and this research study has also provided me with key ideas and guidelines for future developments in my own career as well as possible changes to my own future practice.

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Glossary

Allied Health Professions

The NHS (NHS, 2016) defines *Allied Health Professions (AHPs)* as “a diverse group of practitioners who deliver high quality care to patients by carrying out assessment, diagnosis, treatment and discharge, across a range of settings in the NHS, Local Authorities, independent and voluntary sectors.” Music therapists are included in this category, along with many other kinds of therapists. They work alongside NHS staff, such as doctors and nurses. Their aim is to “further improve services provided by AHPs to achieve better outcomes for patients after illness and injury”.

Altered state of consciousness

An altered state of consciousness is a temporary change in one’s normal mental state and sense perceptions without being considered unconscious. Altered states of consciousness can be created intentionally or by accident or due to illness. People can intentionally try to alter their conscious state through many means such as drugs, meditation, hypnosis and imagery. There are many reasons why people try to attain an altered state of consciousness (including for religious and spiritual reasons, for relaxation and for health purposes).

Autogenic Therapy (AT)

Autogenic Therapy was developed by the German neurologist and psychiatrist Dr Johannes Heinrich Schultz (1920). It has been adapted by many healthcare practitioners for increased self-awareness, self-control and stress management techniques, as well as for emotional and behavioural problems (Sadigh, 2001). In my study, AT is described and used as an RT.

Body Tambura

A musical instrument constructed from lightweight wood and rectangular in shape. It comfortably fits on a person’s lap, or back when lying down, and produces peaceful calming sounds. In my study, the body tambura is an example of an instrument used specifically for receptive music and RM (See below). Research shows its effectiveness and benefits in reducing anxiety, distress and fear and that it affects a client both psychologically and emotionally.

Brainwave music

There are five main frequency brain waves: Alpha, Beta, Theta, Delta, and Gamma. Beta waves (14-40Hz) are the brainwaves of our normal waking consciousness and are the most common brain wave pattern. Alpha (7.5-14Hz) are the light or deep relaxation wave and can be detected during wakeful relaxation with closed eyes. Theta brainwaves (4-7.5Hz) are sleeping waves and these occur in the highest state of meditation. Delta (0.5-4Hz) are deep sleep waves. Gamma waves (above 40Hz) are called “The Insight Wave”. These waves are associated with ‘bursts of insight’ and may be implicated in creating a unity of conscious perception and high-level information processing. Brainwave music means music that can help to activate people’s brain waves into entering a specific state. This can be used for various therapeutic purposes, for example concentration, for meditation, and for studying purposes.

Community Music Therapy

In music therapy, *community music therapy* is gradually growing in popularity in a range of therapeutic and clinical settings. Ruud (2004) defines “community music therapy is a way of doing and thinking about music therapy where the larger cultural, institutional and social context is taken into consideration”. This means that music therapy is extended beyond individual care to benefitting the *community system* (in Ruud’s terms) in which the individual resides or engages. In my study, the music therapist group, like the other healthcare practitioners, are often engaged in community settings in actual practice too and take the wider context into consideration.

Compassion Meditation

See *Lovingkindness meditation* below

Complementary therapies

Many different terms for complementary therapy are known, including alternative therapy, alternative medicine, holistic therapy and traditional medicine. A wide range of treatments exists under the umbrella term of ‘complementary therapy’ and complementary therapies are ones used alongside conventional medical treatments. Alternative therapies are treatments that are used in place of conventional medicines or treatments. There is little scientific or medical evidence for some of these therapies, and they may be unsafe or cause harmful side effects. Other therapies or modalities are based on principles that are not recognised by conventional medicine, but may nevertheless have an established evidence base and have been proven to work for a limited number

of health conditions. The Panel on Definition and Description (1997) provides this definition: “Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed” (Defining and describing complementary and alternative medicine, 1997).

Counter-transference

In my study, several aspects of *counter-transference* have discussed, particularly focusing on the therapy contexts. Various definitions are given; for example, Psychology Glossary (2017) defines “Countertransference is a situation in which a therapist, during the course of therapy, develops positive or negative feelings toward the patient. These feelings may be the therapist’s unconscious feelings that are stirred up during therapy which the therapist directs toward the patient. A therapist might start feeling uneasy about therapy or the patient, unhappy with the way therapy is going, or unhappy with themselves. Just like transference, this is not an uncommon situation in the therapeutic situation. Of course, therapists must not act on any feelings they have”.

Creativity

Creativity means “the use of imagination or original ideas to create something; inventiveness” (Oxford, 2017), or creative ability (Merriam-Webster, 2017). In my study, RTs, MM and RM are regarded as resources for cultivating creativity in education, counselling, music therapy, preventive medicine, art therapy, and meditation practice (Hall and Mitchell, 2007; Daykin et al., 2006). Creativity is viewed both in terms of self-development and as a factor in therapy, for example in the promotion of healing in mind-body interventions.

Emotional Care

During a period of illness, patients generally feel additional stress and experience emotions, such as fear, anger, sorrow, anxiety, frustration, and depression. They need personal emotional care and support. Mosby (2016, p.610) defines emotional support as “the sensitive, understanding approach that helps patients accept and deal with their illnesses; communicate their anxieties and fears; derive comfort from a gentle, sympathetic, caring person; and increase their ability to care for

themselves”. RTs, MM and RM can play a part and in my study, practitioners use RTs, MM and RM within their emotional care.

Entrainment

The concept of *entrainment* is a term used in various fields include physics, biology, and the social sciences as well as music research. In terms of biomusicology, Clayton et al. (2005) say “entrainment describes a process whereby two rhythmic processes interact with each other in such a way that they adjust towards and eventually ‘lock in’ to a common phase and/or periodicity”. Music with a fast and staccato beat can induce faster breathing and heart rates than slower music and the heart rate changes slowly or speeds up in response to tempo. Our bodies have an autonomic mechanism for entrainment and we entrain to rhythms without noticing it. If we are ‘spellbound’ by a musical performance, we will be entrained into the rhythm. Entrainment can be explained in terms of physics because there is less energy used when two objects are entrained with each other. When we are in step with the surrounding energy we expend less energy, when we are not in sync we expend more. In everyday life it is beneficial to find external rhythms that are slow (such as those of nature, quiet surroundings and certain kinds of music) to entrain to. Therefore, music can help to induce the relaxed state and in mindfulness practice; for example, it can be a way to slow down.

Evidence-based Practice (EBP)

Evidence-based Practice (EBP) is the most recommended approach for the 21st century. French (1999, p.74) defines EBP as “the systematic interconnecting of scientifically generated evidence with the tacit knowledge of the expert practitioner to achieve a change in a particular practice for the benefit of a well-defined client/patient group”. In my study, the practitioners’ opinions regarding the EBP of using music were complex. Many stressed that research and evidence is an important factor for raising the profile of their profession and proving its benefits to service providers and potential clients. However, not all used music or sound in accordance with EBP in its strictest sense. Many practitioners offered mixed rationales for their use of music (evidence already written up, personal evidence, personal evidence which will be written up in future, together with personal beliefs, judgments, trial and error, etc.). For example, some referred to EBP but personal experiences were also mentioned. Some recognise that evidence is a good thing but not the main driver of their practice. Other practitioners, however, focus very deliberately on EBP and putting theory before practice. For them, EBP is clearly important and they are personally strict about using RTs, MM and RM sources based on EBP: a theoretical background is always a

key rationale for practice. Some practitioners are constrained by regulations in hospital settings, which require EBP to be clearly stated in any treatment plan for RTs, MM and music therapy. Nevertheless, there are possible gaps between what we learn from research or theory and what we do in real clinical practice.

Guided Imagery and Music (GIM)

Guided Imagery and Music (GIM) is a music-assisted therapy used to explore one's own inner world and help clients to work on significant life issues. Helen Bonny founded GIM and defines the therapy as: "the purposeful use of prepared classical music by a guide or facilitator to evoke sensory and emotional responses in the listener. These responses, in the form of imagery, symbols, feelings, past and present life review, sensations, unfolding metaphors and transformative experiences, become the heart of the session. Through the guide's use of relaxation, verbal intervention and knowledgeable application of the music, the client receives insights which lead to healing and therapeutic resolution. The ingredients for the process include: verbal communication, relaxation, focus/concentration of attention, and a music program." (Bonny, 2001).

Gugak

Gugak is 'national music' in Korea and can be divided two broad genres: folk music and court music. Korea.net (2013) says "[...] While court music includes ritual and aristocratic music like aak (imported from China), dang-ak (a fusion between Chinese and Korean court music) and hyang-ak (purely Korean), the folk music has p'ansori (vocal), sanjo (instrumental music), jeong-ak (instrumental and vocal music), nongak (farmers' music, drumming, dancing, and singing), shinawi (shamanistic music) and salpuri (dance, related to shaman rituals)". These forms of traditional music still have a place in Korean culture and some forms have recently been developed, such as Changjak-gugak or Shin-gugak, as well as newly-composed music based on traditional Korean music and fusion gugak, with Western elements.

Integrated (or integrative) health and Integrated (health)care

Integrated health is a term used to encompass medical care interventions together with CAM (including mind-body therapies) and patient support services. The term suggests that these interventions and services are typically considered or used in combination by a multidisciplinary team. Shaw et al. (2011) state integrated care is "a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to

address fragmentation in patient services, and enable better coordinated and more continuous care.” Related to integrated care are the concepts of collaborative care and continuity of care (which focuses particularly on the patient’s perspective).

Interpersonal sensitivity

Hall and Bernieri (2001) state that “interpersonal sensitivity refers to the accuracy and/or appropriateness of perceptions, judgments, and responses we have with respect to one another.” Reis and Sprecher, eds., (2009) describe interpersonal sensitivity as “both how well one reads other people and how appropriately one responds.” Interpersonal sensitivity and relationships are important in healthcare as well as other types of human relations and have often been a subject of study.

Intervention

There are differences in terminology used by the three groups of practitioners. One example is the use of the word *intervention*, which tends to be used in connection with a particular specialism. The Korean medical professional group typically describe RTs, MM and RM all as *interventions* which may seem to imply a medical usage. However, the music therapy group tend to refer to music as an *intervention* but not RTs; and in the meditation group, RTs and meditational practices are typically called *interventions*, but not music. In my literature review study, many researchers speak of music and meditation both as *interventions*. More generally in Korea the term *intervention* is used with reference to RTs, MM and RM, however, and one interviewee said: “In South Korea many nurses are looking for integrated mind-body interventions such as music therapy or meditation”. Therefore in my study, without seeking to draw a particular distinction, I use *intervention* to refer to RTs, MM and RM in terms of mind-body *interventions* for any clinical purpose or else when a practitioner group specifically used this term during my interview. I also use therapeutic approach to refer to RTs, MM and RM when practitioners use RTs, MM and RM for general therapeutic usage with no specific medical outcome in mind. And if a practitioner uses RTs, MM and RM in their general teaching I simply use RTs, MM and RM, without referring to an intervention or therapeutic approach.

Iso-principle

The *iso-principle* is often discussed in music therapy in relation to mood or physiology state. Davis et al. (2008) defines it as “a technique by which music is matched with the mood of a client, then gradually altered to affect the desired mood state. This technique can also be used to affect

physiological responses such as heart rate and blood pressure”. Music is associated with feeling and certain characteristics of music can affect people’s feeling and physical state. For example, let us assume that a heartbeat is 120 bpm (beats per minute), faster than the healthy resting heart rate (60 to 100 bpm). In this case, the matching point for the music tempo is 120 bpm. By decreasing the music tempo gradually, it may be possible to lower the client’s heart rate to a more desirable heart rate. Similarly, normal respiratory frequency in adults is 12-20 breaths per min and if someone has respiratory difficulties, we may help to regularise breathing using the iso-principle and the therapist’s matching skill. The iso-principle can therefore be used in various ways to help people emotionally and physiologically.

Loving-Kindness and Compassion Meditation

In this study, many benefits of practising *loving-kindness meditation* (Mettā bhāvanā) and *compassion meditation* (Karunā bhāvanā) were mentioned by interviewees and they use these types of meditation either in a conventional way or in a simpler version. Loving-kindness practice originates from the meditational subject of the four divine abodes (Brahma-vihāra). In traditional Buddhist practice, there are 40 meditation subjects (Kammaṭṭhāna, 業處, the place of work) taught by the Buddha and among the 40 subjects, there are four divine abodes, namely loving-kindness (Mettā), compassion (Karunā), gladness (Muditā) and equanimity (Upekkhā), (Bhadantachariya, 1971). These are called four sublime states of mind. Based on this traditional practice, loving-kindness and compassion practice in particular have been popularised and modified. Systematically the practice is organised to begin with cultivating the quality of loving, compassionate acceptance of yourself, and then this develops out to other people and love eventually expands to the whole creation.

Mandala

Mandala means *circle* or *centre* in Sanskrit and derives from the root *manda*, “which means essence, to which the suffix *la*, meaning container, has been added”, hence it can be regarded as a container of essence (Pal and Richardson, 1983, p.44; Harms, 2011). Since ancient times such circular patterns have represented the universe and been used in spiritual healing. Carl Jung adapted mandalas as an ideal tool to bring consciousness into a visible concrete form. And even he himself used it: “I sketched every morning in a notebook a small circular drawing, a mandala, which seemed to correspond to my inner situation at the time. Only gradually did I discover what the mandala really is ... the Self, the wholeness of the personality, which if all goes well is harmonious” (Memories, 1965, pp.195-196). Modern health practitioners have used the mandala

in their work with varying purposes, such as to represent people's inner self, reflect their feelings, making the unconscious conscious or for creating a relaxing and tranquil atmosphere.

Medical community

Medical community is similar in meaning to medical profession and refers to the body of individuals who are qualified to practice medicine and who work to help maintain the health of clients.

Meditate

The word *Meditate* comes from the Latin *meditari*, "to think or reflect upon". A simple definition of *meditate* is 'to spend time in quiet thought for religious purposes or relaxation' (Merriam-Webster, 2016). The word can be used in a number of ways in ordinary speech and the full definition of meditate is: a) to engage in contemplation or reflection; b) to engage in mental exercise (as concentration on one's breathing or repetition of a mantra) for the purpose of reaching a heightened level of spiritual awareness; c) to focus one's thoughts on reflect on or ponder over; and d) to plan or project in the mind (Merriam-Webster, 2016). The second meaning b) is the one which is generally referred to in this study, but a) is applicable to cases in which a general healthcare purpose is to achieve a state of mental calm.

Meditation

Meditation can be regarded as religious practice or profound personal spiritual practice. It can have various meanings and purposes that may differ from individual to individual, therefore for some people it is *the act* of meditation, reflection (Collins English Dictionary, 2016) or contemplation of spiritual matters while others feel it is *the what is experienced* through meditation as well as the act itself. The meaning of meditation can differ depending on religion: for example, meditation in Buddhism and Christianity may differ in meaning. A general definition of meditation, in the way it is used in this study, is: a) the act of remaining in a silent and calm state for a period of time, as part of a religious training, or so that you are more able to deal with the problems of everyday life (Collins English Dictionary, 2016).

Meditation music

Meditation music is a term sometimes used in this study. It is a type of RM and is used for relaxation programmes. It does not necessarily imply that the music is written only for the express

purpose of meditation in this study. However, certain types of meditation music can be specifically composed for the purpose of meditation or research involving meditation.

Mind-body intervention

Mind-body intervention is the name of a U.S. National Center for Complementary and Alternative Medicine (NCCAM) classification that covers a variety of techniques intended by practitioners to use the mind capacity to affect bodily function and symptoms. Many of these techniques are best described as alternative medicine, including meditation practice and prayer, and therapies that use creative outlets such as art, music (music therapy), or dance. Mind-body interventions can be defined as “therapies which use a variety of techniques designed to enhance the mind’s capacity to affect bodily functions and symptoms” (Tomlinson and Kline, 2004, p.234) or “techniques that focus on the interactions among the brain, mind, body, and behavior, and on the ways in which emotional, mental, social, spiritual, and behavioral factors can directly affect health” (Kwekkeboom et al., 2010, p.128). In my study, RTs, MM and music are considered important mind-body interventions for people’s health and well-being in healthcare service.

Mindfulness-Based Stress Reduction (MBSR)

Jon Kabat-Zinn developed the *Mindfulness-Based Stress Reduction (MBSR)* course at the University of Massachusetts Medical Centre. After his successes in the USA, in 2001 Kabat-Zinn presented the MBSR course in an experiential 5-day workshop at Bangor University in the UK with health professionals. In collaboration with Mark Williams of the University of Oxford, he wrote a book and developed and ran courses in Britain. Now a considerable amount of research has been carried out into mindfulness meditation and the effectiveness of this meditation programme has been demonstrated through the accounts of patients’ experiences and their clinical responses to the programme. Hundreds of hospitals around the world have now adopted the MBSR programme and many participants attend mindfulness meditation courses.

Mindfulness meditation (MM)

In my study, *Mindfulness meditation (MM)* means a form of mindfulness practice and adapted versions of active and receptive MM were discussed in Chapter 5. Practitioners use it for stress management, as an emotion regulation strategy (for controlling anxieties and fears), in order to support clients who have experienced episodes of depression, recovering from illness (e.g., cancer), as a self-development tool and for spiritual practice. A range of MM interventions were mentioned by practitioners, such as the 8-week MBSR programme, Zen mindfulness meditation,

breathing techniques, mindfulness movement, body awareness practice, including guided imagery and the progressive relaxation technique (PRT).

Music Assisted Relaxation (MAR)

See *Relaxation music (RM)* below

Multidisciplinary

Multidisciplinary means “of or relating to several subjects or disciplines” or “combining or involving several academic disciplines or professional specializations in an approach to a topic or problem” and *multidiscipline* means “an approach or method which encompasses several disciplines, involving a knowledge of several fields” (Collins English Dictionary, 2016). In my study, the term *multidisciplinary* is often used together with *collaborative* meaning “in the manner of working with others on a joint project” (e.g., collaborative and multidisciplinary approaches).

Naturalistic generalization

Melrose (2009, p.1) defines *naturalistic generalization* as “a process where readers gain insight by reflecting on the details and descriptions presented in case studies. As readers recognize similarities in case study details and find descriptions that resonate with their own experiences, they consider whether their situations are similar enough to warrant generalizations. Naturalistic generalization invites readers to apply ideas from the natural and in-depth depictions presented in case studies to personal contexts”.

Noetic

In this study, the notion of *noetic* and noetic quality related to spiritual experience were mentioned. *Noetic* means “of, relating to, or based on the intellect” and “in the field of philosophy and refers to the action of perceiving or thinking” (Merriam-Webster, 2016). James (1985, pp.366-367) says certain types of religious experience and ‘mystical experience’ can be noetic. For him the four marks of mystical experience are ineffability, noetic quality, transiency and passivity. As regards the noetic quality he says: “Although so similar to states of feeling, mystical states seem to those who experience them to be also states of knowledge. They are states of insight into depths of truth unplumbed by the discursive intellect. They are illuminations, revelations, full of significance and importance, all inarticulate though they remain; and as a rule they carry with them a curious sense of authority for aftertime”.

One-pointed (mind)

In Buddhist terminology, Ekaggatā is translated as “one-pointedness” or “concentration”. Bodhi (2012) says: “This is the unification of the mind on its object.” A ‘one-pointed mind’ can be cultivated by single-pointed concentration practice (samadhi) as well as insight practice (vipassanā) and a fundamental factor of concentration and insight is the single-pointed mind. According to Buddhism, people with ‘one-pointedness’ can be protected by five hindrances (pañca nīvaraṇāni), which are sensory desire (kāmacchanda), ill-will (vyāpāda), sloth-torpor (thīna-middha), restlessness-worry (uddhacca-kukkucca) and doubt (vicikicchā).

Present-centredness

The evidence for present-centred therapy (PCT) as a treatment has been examined using various client groups. In my study, MM and meditation practice are present-centred therapy because their focused way of practice can enhance personal awareness leading to an increase in present-centredness. There are many ways of being present-centred. A representative present-centredness practice is mindfulness meditation. Mindfulness is an ancient Buddhist practice and mindfulness practice is being purposefully mindful in the present moment. The mind trains to refocus on and remain in the present moment becoming intentionally aware of thoughts and actions.

Psychosocial interventions

Psychosocial interventions refer to various ways to support people to overcome difficulties and challenges and maintain good mental health, without the use of medication. Psychosocial interventions can include “behavioral therapy, cognitive therapy, communication skills training, counseling, education/psychoeducation, family therapy, problem-solving therapy, psychotherapy, stress management training, support groups, supportive-expressive group therapy.” (Jacobsen and Jim, 2008).

Pure consciousness and Transcendental consciousness

Alexander et al. (1987, p.92) consider both the state of *pure consciousness and transcendental consciousness* as “Higher States of Consciousness” and they mention what characterises the experience of transcendental consciousness according to Maharishi (1977):

“[...] It is wholeness, aware of itself, devoid of difference, beyond the division of subject and object-transcendental consciousness”

During meditation, those states of mind can be discovered. For example, through Samadhi meditation we can achieve a state of pure consciousness. Maharishi defines pure consciousness as “a silent state of inner wakefulness with no object of thought or perception”. Transcendental consciousness is defined as “state achieved through the practice of transcendental meditation in which the individual’s mind transcends all mental activity to experience the simplest form of awareness”. These notions of pure consciousness and transcendental consciousness have been explored in both East and West and can be understood in different ways through cultural elements but are universally available across cultures. By means of these forms of consciousness people can experience higher consciousness and inner peace.

Relaxation music (RM)

Music for relaxation can be simply defined as composed music that can be used specifically for relaxation and Music Assisted Relaxation (MAR), which can influence emotions and treatment outcomes in a positive way (De Niet et al., 2009). Much literature has explored the genres and characteristics of RM. In my study, RM refers to music to support the client’s physiological, physical, or psychological relaxation. Such music may can elevate, inspire, and calm the mind and it can also help clear or purify our mind and ease us into a relaxed state. Moreover, RM can take us to a place of safety where we can unwind, become uplifted and renewed. Different definitions are ascribed to RM. For example, it is described as a kind of music which can inspire feelings such as those of joy, tenderness, tranquillity, satisfaction, contentment, refreshment, oneness and inspiration (Hwang, 2008). And RM invites us to relax, release, envision, hope, and to find strength, comfort and inspiration, as well as helping us let go of our thoughts and become detached from the tumult of the outside world. Therefore, RM has the ability to produce physical and behavioural responses, thereby speeding up or augmenting the RT’s effect while reaching and regaining the calm of our inner centre. Categories of RM have been widely explored and RM resources have also been catalogued, expanded and researched. RM can include certain types of classical, New Age, pop, film music, α Wave Music, jazz, rock, country, chant, folk, opera, alternative, Latin, fusions, R & B, religious music, Asian-inspired music (e.g., Indian music), Korean folk music, other World music, environmental music, Mantra music, Yoga music, Buddhism music, Celtic flights of fantasy, etc. In my study, no matter what kind of music, if people find it relaxing, it can all be used for RM. Apart from recorded music, a variety of music and sound instruments for RM can be used either in active or receptive approaches. For example, crystal singing bowls, Tibetan bowls, small shakers, tingshas, gongs, bells, percussion and drums,

egg shakers, wood blocks, choir chimes, wind chimes, ocean drums, body tambura, classical guitar and electric guitar have been used in both research and practice to produce relaxation responses.

Relaxation response (RR)

A *relaxation response (RR)* refers to a supportive way to return the mind and body to pre-stress levels. Herbert Benson explains that the relaxation response is the opposite reaction to the stress and the fight or flight response, emphasising that the relaxation response as a non-pharmacologic modality is a useful therapeutic intervention. In order to prove the preventive value of relaxation response, he examined meditative practices such as Zen mindfulness meditation, breathing techniques, and in so doing renamed “meditation” a “relaxation response”. It has been shown that meditative practice promotes better health and people who meditate regularly have lower stress levels, increased well-being and reduced blood pressure levels. And in a relaxation state, people usually exhibit normal blood pressure and oxygen consumption; respiratory rate, heart rate, and muscle tension are decreased (Benson and Klipper, 2000). Many studies refer to the relaxation response, for example Shapiro (2008, p.231) who claims that “this relaxed state has been considered the central mediating mechanism accounting for meditation’s clinical effects whether for managing stress [...] or aiding psychotherapy.” McCaffery and Beebe (1989) maintain that “relaxation is [...] a state of relative freedom from both anxiety and muscle tension, manifested as calmness, peacefulness, and being at ease” (quoted in Kwekkeboom and Gretarsdottir, 2006). However, there is some discussion among healthcare practitioners as to what is meant by relaxation and the relaxation response, because it is a kind of mind-body response and it may lead to different reactions depending on people’s physiological and psychological condition. Therefore, many practitioners describe relaxation and the relaxation response in their own way. In my study, the interviewees discuss the use of various methods of RTs, MM and music in order to achieve the relaxation response and create inner peace.

Relaxation techniques (RTs)

Relaxation techniques (RTs) of various kinds have been widely researched and adopted for specific therapeutic purposes and aims (See Chapter 2). RTs are the kinds of methods, approaches or procedures which induce a calm, relaxed and positive mind as well as reduce stress, pain, anger, fear and other types of negative emotional responses. In my study, when referring to RTs I sometimes include meditational practice and sometimes not, following the interviewees’ own interpretations. The 12 interviewees’ range of RTs include breathing techniques, progressive relaxation technique (PRT), guided-relaxation imagery and visualization, walking meditation,

sitting meditation, lying meditation, loving-kindness meditation, compassionate meditation, forgiving meditation, Zen meditation, mindfulness movement, vipassanā meditation, mandalas, autogenic training (AT), body scan, positive psychology technique, three-minute breathing space, yoga and Tai-Chi.

Sound Therapy/Sound healing

Sound therapy was introduced to the UK in 2000 with the establishment of the British Academy of Sound Therapy (BAST). Compare to music therapy (which has state registration) and music therapists (which have legal protection as registered music therapists), sound therapy does not yet have state registration in the UK, but sound healing has gradually grown in the UK and studies have revealed evidence for the effectiveness of sound healing and sound therapy. Sound therapy is “an approach which combines the power of new technology with an aesthetic response to sound. It can empower interaction and develop communication skills [...]. Benefits arising from sound therapy, such as developing a means of expression, of exploring with sound, of developing communication skills, physical activity and control, are incidental to, but result from an aesthetic response to sound itself” (Ellis, 1995, p.59). Sound therapy (or healing) emphasises the energy frequencies and believes that our body contains its own energy frequencies. So sound frequencies are used to interact with these and stimulating sounds used to rebalance the body’s energy. In sound healing, there are many instruments referred to as healing or calming tools, such as gongs, drums, bells, crystal bowls, Tibetan bowls, tuning forks and the human voice. Compared to music therapy, sound healing still lacks an evidence base in clinical treatment but BAST points to the effect of sound healing for stress-related disorders, tinnitus, mild depression, anxiety and arthritis, for increasing the state of calm and relaxation and promoting health and well-being.

Spirituality

Spirituality means “the quality of being concerned with the human spirit or soul as opposed to material or physical things” (Oxford, 2017); “the quality that involves deep feelings and beliefs of a religious nature, rather than the physical parts of life” (Cambridge, 2017). RTs, MM and music can give opportunity for spiritual experience through self-reflection, self-awareness, self-discovery and self-transformation (Kang et al., 2009; Aldridge, 2003) and can promote continuous self-development, which contributes to a healthy and balanced life. RTs, MM and music have been adapted in various settings and the practitioners in this study apply RTs, MM and RM as self-development tools and valuable resources with a view to promoting spiritual awareness, experience and understanding.

Stuckness

Body *stuckness* means the state of being stuck in a physical sense including feeling physically stuck, feeling powerless or feeling inflexible. What it means to be stuck may vary. For example, if our body feels light and energy flows easily we will not feel stuck, but if the body feels heavy, it may cause body stuckness. Sometimes mental stuckness can directly affect body stuckness. For example, if we are unable to make decisions we may feel mental stuckness and so in our body we feel heavy and energy will not flow. There are various forms of stuckness referred to by practitioners, such as emotional stuckness, psychological and physical stuckness.

Subject heading

According to Reitz (2004, p.169) a *subject heading* is “The most specific word or phrase that describes the subject, or one of the subjects, of a work, selected from a list of preferred terms (controlled vocabulary) and assigned as an added entry in the bibliographic record to serve as an access point in the library catalogue. A subject heading may be subdivided by the addition of subheadings (example: Libraries--History--20th century). The use of cross-references to indicate semantic relations between subject headings is called syndetic structure.”

Tingsha

“One of a pair of small cymbals bound by a strap or chain, used in prayer and rituals by Tibetan Buddhist practitioners” (Wordow, 2015). Tingshas are small cymbals originally used by Tibetan Buddhist practitioners for their prayer and rituals, but currently in sound therapy tingshas are often used for relaxation and to produce healing sounds.

True self

True self can also be described as “the transcendental ego as contrasted with the illusory or temporal ego of sentient beings” (The practical dictionary of Korean-English Buddhist Terms, 2011). Akhtar (2009, p.128) characterises true self feeling as “a sense of all out personal aliveness, more than simple animal aliveness because it includes an awareness of being or feeling real”. The idea of *true self* and *false self* has long been explored and it is often discussed alongside authenticity and inauthenticity. Bruscia (1996, p.105) says “authenticity is being who I am. It is an at-oneness between consciousness, intention, experience and action”. And authenticity is “an individual’s capacity to be genuine and honest with themselves and others” (Aldridge and Fachner, 2011, p. 36). The true self is the existence of oneness between the inner genuine self and the outer

world and it follows that truth to oneself can be felt by genuine and authentic experience. At the same time true self-nature (真我) can be discovered by getting rid of self-centeredness (Suzuki, 2010). And true self-nature, which is a sublime state of consciousness can be achieved through intentional effort and one of the recognised mental efforts is meditation.

Wounded healer

The term *wounded healer* was first used by Jung (1951) but it is still frequently discussed in terms of the therapist-client relationship. It remains a practitioner's dilemma. One reason is that therapists are healers while simultaneously experiencing the same pains or difficulties in life as the client. The role of a practitioner is to support clients but sometimes practitioners feel helplessness or vulnerability in their own life too and themselves need support. In some cases, their personal issues may be unconsciously revealed during a session and their power to heal will diminish accordingly. Resources for healing are needed in order to raise their skill, quality of insight and sensitivity as effective therapists. Jung contrasts the therapist's wholeness with 'clean hands' perfection (p.15) which again contributes to the therapist's power to heal others (Wheeler, 2007). In a more positive sense, people are open to change and an understanding of the notion of wounded healer can make them sensitive to the risks and receptive to healing practices for therapists such as psychotherapeutic practice.