Music Therapy in Concept and Training: A Cross Cultural Perspective

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Introduction

This article will focus on music therapy education, training and clinical practice in Japan and the U.S. It will touch upon the development and growth of the field of music therapy in Japan and the U.S., as well as cultural considerations. This article is intended as an introduction and overview to the field of music therapy. A primary focus will be placed on a concept and philosophy for music therapy. This article is not intended as a scholastic research report.

It has been my good fortune to have been invited to Japan many times since January of 1983. It has been a privilege to know and have close contact with fine therapists and medical doctors from Sapporo to Kochi. I am far from an authoritative expert on Japan's medical or rehabilitative systems. However, I would like to share some of my professional and personal perspectives based on dozens of trips to Japan, and many seminars, clinics, and supervision sessions as well as my work with Japanese clinical and medical specialists.

After almost twenty years of music therapy, my experiences in Japan could easily fill a book. We will explore music therapy as space and time allows, given that this will be one of several articles in the Niigata Journal of Health and Welfare (NJHW) Vol.1-2, published by the Niigata Society of Health and Welfare (NSHW).

1. Music Therapy in Concept

The word "music" encompasses hundreds, even thousands of years of tradition and evolution in many diverse cultures. "Music" is not an easily defined entity or art form. "Therapy" is also a word that has many interpretations, some of which depend on the context and client /individual in need of therapy. "Therapy" comes from a Greek word, "therapia" meaning "to help". The interpretation and practical application of these two words depend greatly upon culture, society and historical period.

When combined the two words music and therapy as in "music therapy", the possibilities for interpretations and applications are further multiplied. It is important to clarify a concept and definition for music therapy. What is music therapy? What is not music therapy?

The American Music Therapy Association (AMTA) defines music therapy as a "well established allied health profession similar to occupational therapy and physical therapy. It consists of using music therapeutically to address physical, psychological, cognitive and/or social functioning. Because music therapy is a powerful and non-threatening medium, unique outcomes are possible. In music therapy, each individual is provided support and encouragement in the acquisition of new skills and abilities. Because music touches each person in so many different ways, participation in music therapy offers opportunities for learning creativity and expression that

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may be significantly different from more traditional educational/therapeutic approaches".

Historically, many cultures and civilizations have used music at the most important times in the life of the community (society) and the individual members of that community. Music was traditionally used to celebrate, to accompany and ease hard labor, to unify, to excite, to soothe, to pray and to grieve. Ancient and even current cultures use music to acknowledge and thank nature, explore their own inner rhythms and melodies and the sounds and cycles of the world around them.

Music touches our spirit and gives a sense of self in relationship to others. Music brings us together and allows us to be a part of unified and harmonious whole. Music expresses beauty and may give us a sense of peace or centeredness. It expresses who we are and allows others to know us better. Music integrates and develops skills and capacities.

Societal and religious traditions since ancient times have valued music as a force that could uniquely affect individuals psychologically and physiologically. It has been regarded and utilized as a form of individual and group therapy for hundreds/thousands of years. Healers, shamans, wise men, religious and political leaders have all employed music because they recognized its unique potential to excite and elevate, express solemnity, ease stress, heal or help to alleviate illness, give honor and commemorate important events and unify and arouse soldiers before war.

Great thinkers and writers from Plato to Einstein, from Confucius to Freud wrote about the power and the subtlety of music. They recognized it as a force and beauty that could simultaneously, emotionally, cognitively and physiologically touch an individual or large groups on many levels. They recognized music as a discipline that could develop human potential. And they honored music as a mythical and mystical way of expressing the unexplainable, the world around them, and the cycle of birth and death.

From ancient times, music was revered as something holy and spiritual. It can express what words cannot. It is an art form and language beyond words. Music therapists are trained to be sensitive to sound and silence and to all the nuances of melody, rhythm, and harmony and all their dynamics of change. They are also trained to use music creatively, imaginatively and spontaneously to stimulate and make contact with their clients.

Unfortunately, in most modern societies people use music indiscriminately and incessantly in stores, restaurants, shopping malls, elevators, and office waiting rooms. So many of our environments are polluted with sound (music and otherwise). There is an expression in English that "silence is golden". Silence allows us to digest and reflect. Silence and pause are meaningful parts of music therapy. All great composers knew the meaning of silence (in musical terms generally considered a rest), used it and honored it.

2. Music and Therapy

As therapists we learn to investigate our client's disability or pathology. We make a diagnosis and treatment plan upon our findings ideally in conjunction with the reports and consultations of other specialists in related clinical and medical fields. Yet the basic question is what approach or approaches will we pursue to enhance the development and recovery of our clients?

Music is unique among all the arts. It can express and explore energy, emotion and experience. It elicits our cognitive functions, concentration and memory. As a field of therapy it can support medical recovery, developmental growth for those with disabilities, quality of life for the elderly and release feelings and promote self-awareness and confidence in psychiatric care and psychotherapy.

Music therapists are an integral part of a treat-

ment team that might include a medical doctor, psychiatrist, psychologist, social worker, a nurse, speech, physical, or occupational therapist, special educator, or direct care staff. Music therapists also may coordinate clinical goals and objectives and support the treatment process of speech, physical or occupational therapy, for example. Because of the tremendous range of music therapy it is important to have a concept that is relatively simple to understand and meaningful to students, professionals and family members.

3. Contact (Clinical Contact: A Concept for Therapy)

"Contact" is not a word or concept that is usually focused on as the essence of music therapy. However, contact embodies therapy in action. "Contact" is the beginning of awareness and relationship. Contact is interaction. It can open channels for communication and attention. It can motivate movement, thought, action and self-expression.

In regard to the clinical concept of "contact" I sometimes think of the wonderful Spielberg movie "ET", which is a heart-warming film. ET and the little boy Elliot touch each other's index fingers at the end of the movie and poignantly say "ET, go home" with a tear in their eye. By "contact" I also mean to touch and know our clients emotionally, to feel them and allow them to feel us through the music. In this way we may develop a relationship of self- expression, familiarity and trust.

Consider a bridge as a metaphor for therapeutic process and interaction. A bridge must make secure "contact" with both sides. The function of the bridge is to support the transport of vehicles, trains and people. The bridge is a way of crossing over and bridging the gap.

Therapists make communicative, physical, cognitive, emotional or integrative contact with their clients in order to initiate therapy. In a sense we are also bridging a gap. The clinical gap or pathology is not usually thought of as structural, as in an engineered bridge. Yet, in a sense all therapists try to bridge the gap of a client's disability or disorder. In this regard music therapy shares essential and common goals with all other treatment modalities. Symbolically and actually we strive to make a spark or "contact" with our clients toward rehabilitation, recovery or self-actualization.

Anatomically we have a miraculous and complex nervous system. The messages are conveyed across many millions of synapses (a very small gap between nerve endings). The nervous system may be thought of as a roadway with a multitude of bridges. This is the foundation for our communicative-both expressive and receptive skills, motor functions and sensory experiences.

Within the human body there are many micro - rhythms and longer cycles. From the first moment our heart beats, it is in synchronization with our mother's heartbeat at a 2:1 ratio. Our heartbeat, respiration, circulation, feminine cycles and many regenerative internal systems are rhythmic and cyclic. Therefore, we are innately rhythmic. We respond even on a subconscious level to rhythm, which is one of the most primitive and instinctual, yet powerful elements of music.

In the process of music therapy, music therapists may creatively use music to help overcome or bridge the gap between the client and his/her disability. This imaginative and creative element of music as therapy may stimulate new strengths and potentials, and open new channels of communication and awareness.

This symbolic bridge for contact is an inner introspective bridge between clients and their potential for rehabilitation and recovery, as well an interactive bridge between clients and therapists. These bridges can convey the full range of human feeling with all the nuance and subtlety that music evokes and communicates.

Music as therapy has the possibility to make contact with disabilities from autism to Alz-

heimer's, from birth to death. Music therapists can often get a positive response from clients who are unresponsive or show little or no progress with other treatment modalities. It is no small attribute to music and music therapy that it also brings joy, beauty and an enhanced quality of life into the lives of clients. In the words of Clive Robbins, Director of the Nordoff Robbins Music Therapy Center at New York University, "music is an everyday miracle". Music therapy may take a client from isolation into interaction. That can be truly miraculous.

4. Historical Perspective

It is only a little more than one hundred years since the fields of psychology and psychiatry have been established with university degree programs and credentialing boards. Sigmund Freud is the pivotal figure in the development of psychoanalysis as a means of interaction between client and therapist. The concept of catharsis was an early principle of Freud. Freud was also unique in his concern with the client's inner emotional life. He interacted directly with his clients, mostly with verbal dialogue. Catharsis of emotion and energy is also an integral part of the music therapy process and dialogue.

Freud was not met with approval by many of his peers. Some were even threatened by his focus on interaction rather than on medical, pharmaceutical or surgical procedures. To many, his approach was simply not professional. Everyone can talk about his or her problems! Why should the fields of psychiatry and psychology accept this commonplace behavior as a professional and clinical intervention between therapist and client?

Freud's approach and writing on topics such as psychoanalysis, stages of development, dreams and the unconscious, helped to improve the treatment and understanding of clients with a wide range of pathologies. Freud was one of the first therapists to write about and teach that a client's individuality is of great importance. Therapy and psychotherapy was not "a one size fits all" approach. He worked with clients case by case not pathology by pathology. This is an important concept for a "client-centered" approach to music therapy.

Music Therapy

The field of music therapy in the U.S. had its first organized beginnings in work with the Veterans Association (VA) upon the return of thousands of injured veterans following World War II. One of the most significant studies was done at the Walter Reed Army Hospital in Washington D.C.

Some of these veterans were simply traumatized, while others had serious injuries followed by depression, phobias, hallucinations, nightmares and/or misplaced and excessive aggression. Medical doctors, psychiatrists, psychologists, social workers and musicians worked together in an effort to try to help these veterans by music, at the same documenting the process as a research study on the therapeutic effects of music. Music as therapy was employed both actively (as in playing instruments live) and passively (as in listening to music on recordings).

The benefits to many of the veterans were substantial. This study helped to launch the first university degree programs in music therapy in the U.S. in the states of Kansas and Michigan. By 1950 the National Association For Music Therapy (NAMT) was formed.

In the U.S., in the1950s the school of behavioral psychology with B.F. Skinner as one of its most prominent figures was very influential. Music therapy and other therapeutic and educational programs were often behaviorally modeled. Many of these programs focused on results in isolated behaviors based on a reward incentive system. Behavioral studies often quantified information, behaviors, and results.

During the 1950s the field of music therapy, started out with most staff positions in psychiat-

ric hospitals where there was a great need due to many veterans who needed long-term treatment. It then expanded to work with delayed children as well as the elderly. Full-time positions for music therapists were relatively few but the field was growing. Several more university degree programs were established and music therapy gained more recognition from other health professionals.

Most music therapy programs in the 1950s employed a behavioral approach. For example, could having time out to listen to a new rock and roll record give John an incentive to finish his math examples correctly? Could the chance to play a drum help Mary to come to school on time or finish her homework? Could music as a reward help to reduce negative behaviors such as hitting or acting out in class? Could music help disabled students learn to read, expand their vocabulary, and memory?

In the 1960s and 1970s the humanistic and Gestalt schools of psychology became popular. A.H. Maslow, C. Rogers, and F. Perls were some of its most famous and influential psychologists and practitioners. America and other countries underwent a kind of cultural and societal revolution at this same time. This influence was felt in fields such as civil rights, the women's movement, educational systems, the media, psychology and the arts.

In the midst of this time of change a group of music therapists in the New England area of the U.S. felt that music therapy could realize a greater potential if it broke its alliance with the school of behavioral psychology and formed the American Association for Music Therapy (AAMT) in 1971.

Both the National and American Association for Music Therapy had their own journals, conferences, curriculums, certification boards and separate degree programs at a growing number of universities. The National Association for Music Therapy remained the larger association from the 1960s through the1990s. I think it is fair to say that there were not only philosophical differences but at times a sense of rivalry between the (NAMT) and (AAMT). Each association wanted to keep its own identity and educational and clinical approach more than it wanted to unify with the other.

This changed in 1998 when both the NAMT and AAMT decided to merge into one unified association for music therapy in the U.S.: the American Music Therapy Association (AMTA). In this way the field of music therapy was able to consolidate its resources, have one credentialing board and offer its members and the public better information and services through one well staffed central office.

At the present time there are approximately 5,000 professional music therapists and 2,200 music therapy students enrolled in over 70 university music therapy programs in the U.S.A list of significant recent advances in the U.S. follows:

(1) 1998-- Unification of the NAMT and AAMT into the AMTA.
(2) 1999-- First simultaneous music therapy satellite broadcast "Music Therapy and Medicine" sent to dozens of sites and seen by an audience of over 1,500 nurses, doctors and therapists across the U.S.
(3) 1999-- AMTA-Web site established on-line.
(4) 2000-- 50th Anniversary of Music Therapy in the U.S.
(5) 2000-- U.S. Department of Education Office of Special Education and Rehabilitative Services policy statement officially recognizes music therapy:

"If the IEP (individual education plan) team determines that music therapy is an appropriate service for a child, the team's determination must be reflected in the child's IEP, and the service must be provided at public expense and at no cost to the parents."

(6) 2001--New York City Music Therapy Relief Project established in response to the Sept. 11, 2001 terrorist attack on the World

Trade Center.

In closing this section on a historical perspective on music therapy in the U.S., I think it is fair to say that the U.S. has been an international leader in the field of music therapy. Other countries such as England, Germany, France, and the Scandinavian countries have established associations and have developed mature music therapy programs for twenty years or more.

Music therapy has developed international alliances via the World Federation for Music Therapy and the World Congress for Music Therapy. Most recently the 10th World Congress of Music Therapy," Dialogue and Debate, Music Therapy in the 21st Century: A Contemporary Force for Change" took place in Oxford, England during July of 2002. Other notable organizations include the International Society for Music and Medicine in Ludenscheid, Germany, and the North American and European Congresses for music therapy.

The field of music therapy in the U.S. has benefited from the interest and input of many foreign professionals and students. Some university programs in the U.S have even established informal alliances or exchange programs with universities in Japan and other countries. Music therapy in the U.S. continues to upgrade its university training programs, resource materials, research publications, and the availability of music therapy services in clinical, developmental, medical and geriatric settings.

In the U. S. as in Japan, life expectancy is rising and medical costs are escalating dramatically. Therefore, in terms of geriatric populations alone music therapists may expect to be in more demand in the years ahead. In addition, certain genetic diagnoses and yet undetermined disorders such as autism are increasing per 1,000 births. Music therapists are also more in demand in their work with AIDS, hospice, substance abuse, and emotionally and behaviorally disturbed clients.

5. Music Therapy Education and Clinical Training in the U.S.

In preface to this section it might be helpful to consider the study of music therapy in two main areas (1) psychology, abnormal psychology, different schools of psychology, group dynamics, developmental and psycho-pathology and to some extent anatomy and physiology; (2) the clinical use of music to affect and enhance, rehabilitation, developmental skills and emotional, psychological and behavioral adjustment or growth. This second area includes proficiencies on several instruments, vocal and movement skills. These are general areas of study, a simple framework for music therapy education. A detailed list will follow. Music therapy education and curriculum vary from university to university and even from one region of the U.S. to another.

The one unifying credential is the Board Certification (BC), which is obtained by the "successful passage of the national board certification exam designed and administered by the Certification Board for Music Therapists (CBMT). Certificants must re-certify every five years. Re-certification may be accomplished either through re-examination or through accrual of appropriate continuing education credits as specified by the CBMT".

Music therapy degree programs in the U.S. are on the bachelor's, master's and doctoral levels. The majority of practicing professional music therapists in the U.S. approximately 43% have a bachelor's degree, 20% have a master's degree and 4% have a doctoral degree. In 2001 5.3% of AMTA members lived in 35 foreign countries. Japan was the leader with 55 members, Canada is second with 37 members, and other countries have 10 or fewer members.

Populations Served by AMTA Music Therapists in 2001: Mental health accounts for 20%, developmental disabled 17%, elderly and Alzheimer's 15%, neurological disorders 10%, medical and surgical 9%, and all other populations

29%.

Work Settings Served in 2001: Geriatric facilities account for 20%, self employed and private music therapy agencies 17%, mental health settings 13%, medical settings 9%, "all other settings" (burn unit, church, community music school, domestic violence shelter, neurologic rehabilitation facility, neuro-psychiatric facility, non-profit organization, private special school program, research facility, sheltered workshop, speech therapy clinic), account for the 41%.

Clients in Music Therapy 2001: 935 respondents to an AMTA survey reported seeing a total of 63,099 clients each week, an average of 67 clients each week for every music therapist.

Age Groups Served 2001: Seniors (geriatric) 17%, mature adults 16%, adults 16%, young adults, 16%, teens 12%, preteens, 11%, infants and children 11%, prenatal 1%.

The following is a list of professional competencies approved by AMTA in its "Standards for Education and Clinical Training, Adopted 2000" pamphlet.

AMTA Professional Competencies

A. Musical Foundations

1) Music Theory and History
2) Composition and Arranging Skills
3) Major Performance Medium Skills (Demonstrate musicianship, technical proficiency, and interpretative understanding on a principal instrument/voice).
4) Keyboard Skills
5) Guitar Skills
6) Vocal Skills
7) Non-symphonic Instrument Skills
8) Improvisation Skills
9) Conducting Skills
10) Movement Skills

B. Clinical Foundations

11) Exceptionality: Demonstrate basic knowledge of the potentials, limitations and problems of exceptional individuals.
12) Principles of Therapy: Demonstrate a basic knowledge of a therapist-client relationship.
13) Therapeutic Relationship: Recognize the impact of one's feelings, attitudes, and actions on the client and the therapy process.

C. Music Therapy

14) Foundations and Principles: Demonstrate basic knowledge of existing music therapy methods, techniques, materials, and equipment with their appropriate applications.
15) Client Assessment: Communicate assessment findings and recommendations in written and verbal forms.
16) Treatment Planning: Select or create music therapy experiences that meet the client's objectives.
17) Therapy Implementation: Recognize, interpret and respond appropriately to significant events in music therapy sessions as they occur.
18) Therapy Evaluation: Modify treatment approaches based on the client's response to therapy.
19) Documentation: Write progress notes that accurately reflect client change and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.
20) Termination/Discharge Planning: Inform and prepare the client for approaching termination and establish closure.
21) Professional Role/ Ethics: Adhere to professional code of ethics.
22) Interdisciplinary Collaboration: Demonstrate a basic understanding of the roles and develop working relationships with other disciplines in the client's treatment program.
23) Supervision and Administration: Participate in and benefit from supervision and perform administrative duties.
24) Research Methods: Interpret information in the professional research literature and apply

selected findings to clinical practice.

These areas of competencies are flexible in their interpretation. The list is revised periodically to reflect growth in the field of music therapy. This list may also help to provide a cumulative definition of music therapy. However, to describe music or music therapy in words is simply impossible. I strongly suggest that readers who are new to music therapy and are interested in understanding it better seek out a music therapy program or a professionally credentialed music therapist, see one or more live sessions and video illustrations in order to experience and understand music therapy more fully.

In closing this section it is important to mention that there are intangible elements of music therapy training and practice that are difficult to grasp in words. Some of these elements include creativity, imagination, spontaneity, instinct, interpersonal skills and common sense. These qualities are of great value to a music therapist. They are difficult or impossible to teach via academic study. Therefore, an important aspect of music therapy training is experiential practice, internship and supervision.

6. Music Therapy in Japan

I am far from an authority on the development and present level of music therapy in Japan. Yet, I would like to share with you some professional and personal perspectives and give some background to my music therapy experiences and journeys throughout Japan.

I first had the wonderful experience of visiting Kyoto, Japan in January of 1983. I was a member of a group of Zen students. We stayed next to Doshisha University and directly opposite the Imperial Palace in an unheated Zen temple, Rinko-in part of the Shokokuji complex for approximately six weeks. It was a most wonderful time in my life. I was enchanted by the people, culture and all the new sights, smells and tastes of Kyoto, Japan.

I knew of no music therapists in Japan and I was not able to get information on any music therapy programs in Japan before I left the U.S. I wondered if the field of music therapy was being explored or developed in Japan.

A few days after my arrival I was invited to the home of Uta Arimoto, a lovely, sensitive and kind, elderly woman who taught the Suzuki piano method. Several of her students were blind and mentally delayed. I worked with Arimoto san and her disabled students during many visits to Japan.

Arimoto san knew of Tadafumi Yamamatsu, who was at that time a professor of psychology at Otemon-Gakuin University in Osaka. Yamamatsu sensei lived in Kyoto not far from Arimoto san. On my next trip to Japan in 1986, I had the opportunity to work with Yamamatsu sensei and his "Yamamatsu Study Group for Music Therapy" at Otemon-Gakuin University. Finally I was able to meet and work with music therapists (arbeit, a volunteer group) in Japan.

Yamamatsu sensei was and still is dedicated to the development of music therapy in Japan. I consider him one of the most significant pioneers of the field in Japan. He focused his work on autistic children and employed the use of the trampoline to integrate movement, rhythm and attention in the therapeutic process. Yamamatsu sensei taught and practiced a "client centered" approach allied with the humanistic school of psychology. His work reflected his dedication to music therapy, the children and his students. After several sessions with Yamamatsu sensei and the autistic children I felt that my music therapy adventure in Japan had begun, but I had no idea where it would lead.

I hope this background gives readers an idea of how I began to become involved in the development of music therapy in Japan. During my following trips to Japan in the late 1980s and early 1990s I worked with Yu Wakao sensei (Hiroshima University) and his "Music Child

Group" for music therapy and came to know Masami Inada sensei (Doshisha Women's College) in Kyoto.

Even in the early 1990s music therapy was not yet officially recognized in Japan and no association or federation represented or unified the field. However, it seems to me that in the early 1990s many music teachers, music students, psychologists and medical doctors felt that the development of music therapy training programs and services for clients could be of great benefit. Perhaps they also realized that many countries had established training and clinical programs in the field, and Japan was behind or slow in its development of music therapy.

During the 1990s many *kenkyukai* groups for music therapy study and practice developed all over Japan. The first introductory courses in music therapy were implemented, and the Japanese Music Therapy Association (JMTA) was established in April of 2001. The JMTA unified the two former prominent music therapy associations, the Japan Biomusic Association and the Association for Clinical Music Therapy. The JMTA membership quickly reached approximately 5000 members. It took 50 years for the AMTA to reach a similar level of membership!

The first officially recognized and supported music therapy projects, both public and private, also began Japan in the early and mid 1990s. Noteworthy are Gifu and Nara. Both started programs that were supported and funded by the mayor and prefectural office. An excellent private program such as the Kyoto International Center for Music Therapy was established by the talented and diligent Kazumi Yamamura in Kyoto. Yamamatsu sensei at age 90 coninues to be is its clinical director!

Before, during, and after my work with the Nara, Gifu and Kyoto programs I was fortunate to meet several orthopedic surgeons who believed in and strongly supported my music therapy work in Japan. They have done a great deal to support the development of music therapy in Japan. I would also like to mention Kazue Shinji san (Ritsumeikan University, Kyoto), who has been so kind and helpful to effectively and elegantly translate many of my seminars throughout Japan for almost 10 years.

Japan has made giant steps in its development of music therapy training and clinical programs. This is astonishing given that just twenty years ago it was difficult to find information about anyone doing music therapy in Japan. I often say in my seminars that Japan experienced a kind of "music therapy fever" or "music therapy boom" in the 1990s.

The sheer numbers, the quantitative aspect of the development of music therapy in Japan is certainly impressive. Qualitatively music therapy programs are young in their development and trying to find their way. Perhaps I am being too direct, but in my opinion the approach to music therapy in Japan has been and still can be rigid and systematic to the detriment of clinical contact and therapeutic process.

Many of my students seem to want a manual for music therapy that might explain music therapy by the numbers or a sequential systematic approach. This would be helpful from an academic and even a practical standpoint. However, every client is unique and every moment in every session, on some level is about exploration and the unpredictable. Therapy is a process of change and nuance that is entirely fluid. In this sense it is an art form as well as a clinical practice.

There has also been considerable confusion in regard to music therapy. "Mind relaxation", stress reduction, new age music, *karaoke* and even singalongs have been confused as music therapy. These musical experiences may feel good and even be therapeutic. However, therapy as a clinical and developmental profession in regard to disability and disorders is best approached by a trained therapist, not a mind relaxation disc.

Therefore, the Ministry of Health, Labor and

Welfare and Ministry of Education, Culture, Sports, Science and Technology could give great support if they recognized music therapy by the establishment of a license similar to occupational, physical and speech therapy. This would further establish the field and help to make music therapy services available to clients who might not have access to a music therapist and are substituting discs or singalongs for music therapy. The interest in music therapy in Japan is phenomenal! I have full confidence after working with many bright, talented and eager students that the quality of Japan's music therapy training and clinical programs will improve quickly. It has been wonderful to work with members of different groups and associations and watch their work develop and mature over the years. A number of Japanese students have completed their music therapy studies in the U.S., England, Germany, Australia and other countries and have brought back their experience and clinical skills to Japan. Some have completed doctorates in music therapy in foreign countries.

However, I would now like to comment on the JMTA credentialing system. The system has undergone a series of upgrades in Japan as it has in the US and other countries. I would like to take this opportunity to say that I strongly believe that a live, videotaped or otherwise documented demonstration (for example by the observation of a supervising certified music therapist), of an applicant's clinical and musical skills is essential for certification as a music therapist. A written exam alone is not sufficient to demonstrate competencies for the professional practice of music therapy.

I am aware that there has been some debate over recent years on the credentialing process in Japan. To insure that the field of music therapy is recognized and respected by other clinical and rehabilitative disciplines in Japan, the credentialing process and the competency and quality of newly credentialed music therapists must reflect their ability to practically (not only theoretically) utilize music therapy skills and be able to directly impact and enhance the development, rehabilitation and quality of life of the clients they work with. In short the credential of music therapist must validate the applicant's ability to successfully engage clients in the "music" within the process of music therapy. Information, theoretical understanding and written articles and exams (alone), do not necessarily insure that the candidate has the musical or clinical skills for the practice of music therapy.

In closing this section on music therapy in Japan a number of foreign music therapy professionals, most notably Clive Robbins, have positively influenced the development of music therapy in Japan. Through their seminars they have given a model that represents a high level of clinical training and professional experience. Live demonstrations, workshop activities and video analysis given by foreign professionals has helped to give a practical understanding of the field of music therapy (that I refer to in the above paragraph) to numerous Japanese seminar participants.

7. Japan and the U.S. a Cross Cultural Perspective

In this final section I would like to briefly comment on some basic cultural, educational and societal differences that might influence the practice and development of music therapy in Japan.

America is a young country, especially in comparison to Japan. It is diverse and strongly influenced by many different cultures and religions. At its roots America was founded on independence, individuality and a new spirit of freedom. At the same time there were and still are many injustices that have led to oppression, conflict and violence.

Japan has its traditions in Asian culture, strongly influenced by Buddhism and a predomi-

nately homogenous society. A small fraction of Japanese citizens are of foreign descent. Japanese systems, from industry to education, to the family, have been united by a strong sense of belonging to a whole.

This comparison is general and superficial. However, the psychological and cultural differences are significant and important in regard to music therapy. It is true that the elements of music are universal. A French child can fully appreciate and respond to the beat of an Irish jig, an elderly Russian man can feel the joy of a Japanese children's song and we can all feel the pulse and drive of an African rhythm. Yet music therapy in any country as distinct as Japan must draw upon its rich musical traditions (instrumental, vocal and dance) as well as benefit from a western concept of music therapy. Japanese music therapists may utilize traditional Japanese music to great advantage along with some of the clinical concepts developed in the West.

Therapeutic process and interventions must also take into consideration cultural norms and traditions. For example, Americans and Europeans, including women, often shake hands as a way of greeting. The honorable Japanese bow is a very different gesture. Body language, personal space, eye contact, inflection, nuance and intensity of emotion are different in many ways in Japan and the U.S. These are difficult customs for foreigners to understand and learn. The practice of music therapy in Japan must be sensitive to Japanese style and tradition, and be careful not to impose too strong a western musical and interpersonal influence.

Perhaps, to foreigners, Takeo Doi is the most widely read and best known Japanese psychiatrist. His book The Anatomy of Dependence and his concept of "Amae no Kozo" give insight not only to the mother-child relationship but to stages of development and maturation within Japanese society. Like Freud he is focused on understanding the inner emotional life of the individual at different stages of development. I feel his clinical and developmental concepts, although outdated, can be meaningful in the development of a wider, more flexible approach to the study and practice of music therapy in Japan. Takeo Doi's writings and concepts help to bridge the Eastern and Wesrern cultures clinically and developmentally.

Finally the real gift and essence of music therapy is the music itself. The elements of rhythm, melody and harmony overcome all boundaries. Music therapy is an important field to develop not only for the benefits it holds for Japanese clients but also as a field for international exchange that can promote understanding and friendship in music therapy and related clinical and medical fields.

Acknowledgement

It is a great honor to contribute to the Niigata Journal of Health and Welfare (NJHW). This edition of the journal will focus exclusively on the field of music therapy. This is an exceptional and progressive decision taken by the president of the university and the editors of this journal.

In selecting music therapy as the theme for this edition of the Niigata Journal of Health and Welfare (NUHW), the administration and the editors of the journal acknowledge music therapy as a clinical and developmental treatment modality and support the development of music therapy in Niigata and all of Japan.

In closing, I would like to express my deep thanks and gratitude to Hideaki E. Takahashi M.D., President of Niigata University of Health and Welfare, the administration of NUHW and the editors of this journal for inviting me to write this article and for making this publication possible.

I truly hope that students, therapists, clinicians and faculty members as well as the clients served by therapists will benefit from a better understanding of the field of music therapy and may

use this journal as a resource for further information and study.

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