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Community music therapy with unaccompanied child and adolescent refugees in a residential setting

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Mestrado em Musicoterapia

Community music therapy with unaccompanied child and adolescent refugees in a residential setting

Realizado por:
Isabel Ivin Pinto Basto

Supervisionado por:
Prof.ª Doutora Teresa Paula Rodrigues de Oliveira Leite Maurer

Orientado por:
Dr.ª Dora Cristina Contreira Estoura

Constituição do Júri:

Presidente:	Prof.ª Doutora Tânia Gaspar Sintra dos Santos
Supervisora:	Prof.ª Doutora Teresa Paula Rodrigues de Oliveira Leite Maurer
Arguente:	Prof.ª Doutora Susana Aurora Gutiérrez Jiménez

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Fogueiras
dança
tamtam
ritmo

Ritmo na luz
ritmo na cor
ritmo no som
ritmo no movimento
ritmo nas gretas sangrentas dos pés descalços
ritmo nas unhas arrancadas
Mas ritmo
ritmo

Ó vozes dolorosas de África!

Agostinho Neto

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Resumo

Este relatório visa descrever o processo e os efeitos de uma intervenção de Musicoterapia Comunitária num contexto e espaço residencial em Lisboa, Portugal, para crianças e adolescentes refugiados não acompanhados. Durante o processo de deslocação e realojamento, os refugiados passam por um leque diversificado de experiências, geralmente traumáticas que poderão ter um efeito prejudicial no seu bem-estar e afetar negativamente a sua saúde mental. O objetivo geral da intervenção foi criar um sentido de comunidade e de pertença, aliviando sintomas de ansiedade e depressão. A música representa a nossa identidade cultural e proporciona um canal alternativo para expressar emoções, estimulando a comunicação num ambiente multilingue. Uma amostra de 35 residentes (idades: 11-20) e 8 membros do *staff* provenientes de 17 países diferentes participaram na intervenção. As sessões realizaram-se em grupo aberto ou individualmente, consistindo principalmente em técnicas ativas musicais - improvisação, aprendizagem de repertório, escrita e gravação de canções, técnicas recetivas - audição e discussão de música – e outras atividades artísticas tais como pintura. Foi realizada uma avaliação inicial com cada participante (residente) e um questionário no final do estágio. Os comportamentos negativos reduziram e os resultados do questionário revelaram que a participação na Musicoterapia reduziu os sentimentos negativos (tristeza, raiva, depressão, frustração, *stress*) em 25%. A musicoterapia comunitária constitui uma intervenção adequada neste contexto. Intervenções futuras beneficiarão de um desenvolvimento de projetos mensais, trabalhando com residentes ao longo do seu processo de aculturação e de uma investigação mais detalhada sobre a música e os pontos de vista da saúde mental das culturas presentes na CACR.

Palavras-chave: refugiados, cultura, musicoterapia comunitária, aculturação, identidade

Abstract

This report aims to describe the process and effects of a Community Music Therapy intervention in a residential setting in Lisbon, Portugal for unaccompanied refugee children and adolescents. During the process of relocation refugees pass through a diverse range of traumatic experiences which can have a detrimental effect on their well-being and negatively affect their mental health. The overall purpose of the intervention was to create a sense of community and belonging and alleviate symptoms of anxiety and depression. Music represents our cultural identity and provides an alternative channel for expressing emotions and communication in a multilingual environment. A sample of 35 residents (ages 11-20) and 8 members of staff from 17 different countries participated in the intervention. Sessions were open group or individual consisting mostly of active music techniques; improvisation, learning repertoire, song writing and recording as well as receptive techniques; music listening and discussion and art activities such as painting. An initial evaluation was carried out with each participant (resident) and a questionnaire at the end of the internship. Negative behaviours were reduced, and results of the questionnaire revealed that participating in music therapy reduced negative feelings (sadness, anger, depression, frustration, stress) by 25%. Community music therapy is a suitable intervention in this setting. Future interventions would benefit from a development of monthly projects, working with residents further along their acculturation process and more detailed research on the music and views of mental health of the cultures present in CACR.

Keywords: refugees, culture, community music therapy, acculturation, identity

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ADHD – Attention Deficit Hyperactivity Disorder

CACR – Refugee Children Reception Centre | Casa de Acolhimento de Crianças Refugiadas

CoMT – Community Music Therapy

COVID-19 – Coronavirus Disease 2019

CPR – Portuguese Refugee Council | Conselho Português dos Refugiados

DGS – Directorate General for Health | Direcção-Geral de Saúde

DSM-5 – Diagnostic and Statistical Manual of Mental Disorders

MT – Music Therapy

PTSD – Post Traumatic Stress Disorder

SEF – Immigration and Borders Service | Serviços Estrangeiros e Fronteiras

UNHCR – United Nations High Commissioner for Refugees

WHO – World Health Organisation

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Introduction

This report aims to document the work carried out over the course of the internship undertaken during the second year of the master's programme in Music Therapy at Universidade Lusíada, Lisbon. The internship was under the supervision of a professor of Music Therapy at University Lusíada, and also the director of the institution as local internship advisor.

The internship took place in the *Casa de Acolhimento para Crianças Refugiadas* (Refugee Children Reception Centre), in Lisbon, between October 2019 and August 2020. The main goal for this internship was to implement a music therapy intervention from a community approach in a multicultural residential setting for unaccompanied refugee minors, asylum seekers and beneficiaries of humanitarian protection. The choice of this target-population was motivated by the professional and personal interest in working with a multicultural population, integrating music therapy's trauma intervention model with a community music therapy model in accordance with the knowledge reflected in the literature.

The intern's background as an immigrant from London with limitations in Portuguese proficiency was an additional influential factor in the choice of target population. An interest in world music, previous experience of working with a multicultural population, and willingness to undertake the challenge of working with traumatised children and adolescents were motivating factors. This was the second time a music therapy intern was placed at such location, which provided an opportunity to further the benefits of music therapy in this setting.

This report aims to reflect on the knowledge acquired during the internship, outline the processes of observation, intervention and evaluation, and provide a critical reflection of the music therapy intervention provided, supported by the relevant theoretical models of music therapy.

This report therefore aims to contribute to the study of the effects of music therapy in the adolescent refugee population in Portugal within a residential context. Music therapy aimed to promote cohesion, build a sense of community and belonging, reduce feelings of depression, anxiety and frustration while supporting the process of integration within the community and reducing stress related to acculturation.

Characterisation of the institution

The Refugee Children Reception Centre '*Casa de Acolhimento para Crianças Refugiadas'* (CACR), is a residential setting run by the Portuguese Refugee Council '*Conselho Portugues para os Refugiados'* (CPR) for temporary stays of unaccompanied minors who are asylum seekers, refugees or beneficiaries of humanitarian protection. Its basic principles are to promote the rights of the residents and to actively participate in the social services provided (CPR, 2019).

The general objectives of the CACR are to receive unaccompanied children, asylum seekers, refugees or beneficiaries of humanitarian protection, while providing them with assistance in their relocation, guaranteeing adequate care for their needs, and providing them with conditions to receive proper education, wellbeing and integrated development in Portugal. Its specific objectives are to diagnose and provide intervention in terms of health, psycho-affective, socialisation and education, in order to satisfy their basic needs, providing a family type experience and life project integrating the child into the community (CPR, 2019).

The CACR located in the middle of Bela Vista park in Lisbon started operating in 2012. It has 5 bedrooms with 5 beds per room, 3 bathrooms, a library/study room, medical post, director's office, educational team room, dining/living room, laundry, kitchen and outdoor space. In the space behind the house are the CPR offices which during the week have good access to many services (legal, etc). The house operates 24 hours a day, 7 days a week, and its functioning is ensured by employees who work in rotating shifts. The team includes: 1 social worker/director, 1 social educator, 1 lawyer, 1 accountant, 1 educational assistant, 5 general service assistants/auxiliaries and 1 cook and 2 assistant cooks. There are also one or two interns or volunteers who help the team in the general/administrative functioning of the house and occasionally groups of partner institutions which carry out activities inside the house, such as team building or football.

Psychosocial intervention in CACR is based on the RAISE model created by Estoura & Roberto (2019), established on the theoretical base that child and adolescent refugees and asylum seekers have lived traumatic experiences but who can eventually be enabled to overcome these traumas using their individual and collective capacity. It uses an ecological approach to integrate the young people into the host country whilst maintaining their individual cultures. The five essential pillars of the RAISE model are: Protection/Security, Relationships, Identity(s), Participation and Citizenship (Estoura & Roberto, 2019). These theoretical pillars influence the intervention and activities provided as well as the objectives established within the four phases of intervention, with an estimated duration of 6 months, which are co-constructed with the residents. 'Welcome': 1 month, to fulfil basic health care, legal and educational needs as well as familiarise the child with the house, language, local area and country. 'Discover': 2 months, to develop social and personal skills and promote and understand the culture of the individual and multiculturalism. 'Integrate': 2 months, to promote integration with host society and culture. 'Empower': 1 month, preparation for all aspects of autonomous living. (Estoura & Roberto, 2019).

The residents spend most of their time at home, but go out to school, appointments, events or group outings and sports. Older residents can go out without supervision within the hours defined. Depending on their level of knowledge of Portuguese and age, they attend either a Portuguese language school or general education (school or college). The residents participate in activities such as sports, social educational activities (e.g. finance, health), arts and cooking (share typical dishes from their countries). A Portuguese teacher supports the residents with their schoolwork or language instruction, using the library three days a week in the morning. In addition, young people are accompanied to appointments with the Immigration and Borders Service (*Servicos de Estrangeiros e Fronteiros* - SEF), public services related to finances (*Finanças*) and social security (*Segurança Social*) and medical or legal appointments. No

psychological intervention or support groups were implemented at CACR, but residents were referred to psychologists or psychiatrists in public hospitals by members of the team when symptoms were present, or if requested by the residents.

Characterisation of the target population

In its central mission the CACR is dedicated to the reception of young migrants - the turnover of residents is high and the characterisation of its population changes often. Details of each young person's life stories in the CACR are confidential and therefore this section has been written in a general way based on the CACR handbook, personal observations and informal conversations with the team and the young people throughout the internship.

CACR is ready to welcome 13 children between the ages of 6 and 18 (or up to 21 in specific cases). Throughout the internship there were close to 30 young people between the ages of 16 and 19, with two exceptions, 11 and 12 years old. There were also around 15 young refugees living autonomously or semi-autonomously in the other CPR temporary homes for adults and families in Bobadela, Loures. Those living autonomously received financial support for essential supplies (food, transport etc.) and those living semi-autonomously received this support through CACR/CPR.

In some cases, the new arrivals appeared to be over 18 years old. If proven, at the request of the court, using chest and jaw x-ray examinations, these cases must follow the legal process as adults, and are housed in CPR accommodations for adult refugees.

The estimated time of stay in the CACR is 6 months, which is the time estimated to adapt to life in Portugal and learn to live independently according to the RAISE model previously mentioned. Residents can stay less than this, or for 2 years or more depending on their needs, CPR resources, as well as their age and legal status. Cases of abandonment of the institution are frequent, either because of the difficulty of integration in the institution or country or cases in which young people return to their biological family.

During the internship, most of the residents in CACR were West African males aged between 16-19 - a refugee from Azerbaijan and an Iraqi were the exceptions. Despite the need for Portuguese to be the common language within the house, the predominant language spoken

was Fula. French, Portuguese and English were the main European languages used, and Spanish and Italian as a result of the journey taken by the young people since their arrival in Europe. Fula, Mandinka, Creole, Lingala, Wolof and Arabic were the main non-European languages spoken. Within the African languages spoken by young people, some residents explained that specific dialects exist within each country, region and even from village to village: for example in Guinea Bissau there are about 20 dialects or languages (Birmingham, 2020) and 39 in Senegal (Camara, 2021).

In general, the residents of CACR had great difficulty in sharing their life stories or talking about experiences, especially those considered to be traumatic. Communication was difficult due to language barriers, but beyond this factor, there was still a strong resistance to reveal the circumstances of their migratory journeys, due to the fear that this would interfere with the legal process of requesting asylum. Informal questions and conversations with staff revealed the majority had left their country of origin to escape extreme poverty. Some fled for political reasons or because of violence, abandonment, sexual abuse or persecution, or a combination of these. Most young people experienced one or more traumas before arriving to CACR, and there were significant disparities in variety and reporting: some were victims of sexual abuse, human trafficking, torture, or had witnessed violence, some had seen people drowning on their way across the Mediterranean.

The levels of academic education of young people was varied, with many having a low level of education i.e., a few years of school during childhood. For example, during the internship, of the 20 residents who spoke Fula only one was able to read and write in that language.

The musical preferences of the young people in CACR were similar: hip-hop (USA, Europe and West Africa), kizomba (Guinea-Bissau and Angola), gumbé (Guinea-Bissau) reggae (Jamaica) and afro reggae (Ivory Coast and Senegal) were the styles most heard, as well

as pop (Western and African) and gospel (Brazil and Angola). Through informal conversations, some young people revealed that they also liked "traditional music" transmitted by families and communities while living in their home country, but they spoke vaguely of these experiences. Most residents listened to music on their mobile phones, especially on YouTube where it is easier to find videos from their countries, cities or villages. Others downloaded their music to their mobile phone in case they did not have access to Wi-Fi/internet. Some had portable speakers and listened to the music in a group while others used their mobile phone speakers or headphones. Young people generally showed experience of singing in groups and playing percussion instruments (djembe or equivalent), and many claimed to enjoy dancing. However, it has not been confirmed that any of these young people have had musical training and few residents were seen dancing during the internship.

Literature Review

In this section, a brief description of the migration phenomena and an overview of the theoretical knowledge on music, health and culture is presented, as well as a review of the music therapy literature focusing on its application with migrants and refugees. The most frequently encountered psychological disorders among the refugee population are described and cultural considerations highlighted. It is important to convey a broad perspective of the experiences and difficulties faced by refugees with and without accompaniment, and which approaches to music therapy are applied with this population. As the refugee and migrant situation is a relatively new area of application in music therapy, and considering the diversity of possible interventions, knowledge acquired in working with refugees in general, with families and with accompanied refugee minors is included.

Migration phenomena and the current world refugee crisis

Of the 79.5 million people forcibly displaced around the world, 26 million are refugees and half are under 18 (United Nations High Commissioner for Refugees, 2020). These figures only count officially identified refugees and the United Nations High Commissioner for Refugees (UNHCR) estimates that there are many million refugees unaccounted for. The United Nations Convention relating to the Status of Refugees defines the concept of refugee as ‘someone who is unable or unwilling to return to the country from which he or she came because of a well-founded fear of persecution on grounds of race, religion, nationality, membership of a particular social group or political opinion’ (UNHCR, 1951, p.3). 80% of refugees live on the other side of the border from their country, usually in camps such as in Sudan, Uganda, Pakistan and Turkey (United Nations High Commissioner for Refugees, 2020).

There was a total of 1,849 asylum applications in Portugal in 2019. This figure includes adults, families and unaccompanied minors, mostly from Africa (72%). There was an increase

(45.3%) in applicants from the previous year due to commitments as part of the EU relocation scheme. From this total, 46 were unaccompanied minors requesting asylum (2015 received the most, 78) (SEF, 2019). Once the unaccompanied refugee minor arrives in Portugal, the bureaucratic, medical and educational process begins. They are detained for up to 7 days by SEF and are then welcomed at CACR or other facilities and accompanied by CPR (AIDA, 2018).

Climate change and political unrest are the main interlinking factors driving people to leave their homes in search of safety (Abel et al., 2019; United Nations High Commissioner for Refugees, n.d.), but situations of intense conflict have led organisations to predict that the refugee population is likely to continue to increase.

The most vulnerable group of refugees are the unaccompanied minors, those who travel without adult protection, and who face the most danger on their journey - if they survive at all (Estoura & Roberto, 2019). There is a great lack of information on unaccompanied minors, as they easily go unnoticed and unaccounted for in the statistics and are more subject to criminal activity.

The danger and suffering inflicted on young people in their countries of origin are the greatest catalysts for flight. Some leave in search of work to be able to support themselves or their family financially. Other situations resulting in a young person being unaccompanied include the death of family members along the journey, those orphaned in their home country, exploited or grow up away from family from an early age (e.g. in cases of human trafficking). Once settled in the host country, unaccompanied minors face difficulties dealing with legal procedures, learning the language, adapting to the host culture and are likely to be confronted with racism, discrimination and poverty (Kirmayer et al., 2010; Malm et al., 2020; Pieloch et al., 2016).

In addition to the social, emotional and cultural difficulties related to travel and the re-housing process, unaccompanied minor refugees may also carry memories of traumatic events suffered in the country of origin and in the migration process (Marsh, 2012). Furthermore, unaccompanied refugee minors are processing the loss of family, friends and personal belongings, whilst at the same time navigating the stresses of adolescence (Baker & Jones, 2005) and constructing their personal identity. The developmental tasks of adolescence can only add to the enormous emotional and social difficulties that are implicit in the process of forced migration.

Common psychological disorders in refugee populations

As explained above, refugees often face many dangerous or frightening situations before they arrive in a place where they feel safe, guided and settled. These traumatic experiences, left untreated, place refugees in a position of great vulnerability to developing psychological problems.

Disparities exist between the type of trauma experienced, such as: type (physical, emotional, sexual etc.), intensity and frequency of traumatic experiences. This makes it difficult to generalise the pathology of migrants or refugees. There are different risk factors associated with each phase of relocation: pre-migration, migration and post-migration (Pieloch et al., 2016; Kirmayer et al., 2011; Bhugra & Jones, 2001). The process of relocation can cause stress (Wolf et al., 2017) which can develop into mental illness. Systematic studies demonstrate the psychological illnesses which are most prevalent in this population. Refugees are ten times more likely to develop Post-Traumatic Stress Disorder (PTSD) than the general population, and have high levels of depression, chronic pain, other somatic complaints (Kirmayer et al., 2011; LeMaster et al., 2018), anxiety and psychosis (Blackmore et al., 2020).

The most frequently found topics in refugee literature relate to trauma and trauma-related disorders (Comte, 2016). A traumatic life event can evoke a wide range of emotions

that usually pass after a while. It is known that one in three people facing a traumatic event will develop PTSD (NHS website, 2021). This implies that these people will continue to feel scared or stressed even when far (in time or distance) from the source of threat or danger. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013), the four criteria of PTSD include: intrusion symptoms, avoidance symptoms, negative effects on mood and alterations in arousal and reactivity (APA, 2013). In order to guarantee such diagnosis, at least one specific sub-category or symptom must be present for a month or more within each criterion, for example: nightmares, flashbacks (intrusion symptoms), dissociative amnesia, social isolation (negative effects), irritability or aggression, hypervigilance (alterations arousal/reactivity) among others. The symptoms have debilitating effects on a person's daily social or occupational areas, and the symptoms can be short-term or chronic. The symptoms may manifest soon after the traumatic event or appear months or even years later. To make a diagnosis it is necessary to know the nature of the traumatic event, the degree of emotional intensity which was experienced at the time, whether the person was directly or indirectly affected by the event, as well as the duration of the symptoms and the lack of other substances causing similar symptoms (APA, 2013). Depression and substance abuse can accompany PTSD.

A study by Smid et al. (2011) reveals the link between depressive and anxious disorders and late-onset PTSD in a group of unaccompanied refugee minors. Factors such as being close to adulthood and having low levels of education (evident in most of the residents of the CACR) and the number of traumatic events experienced have been identified as indicators of risk for late onset PTSD in this population.

In addition to PTSD, other disorders commonly observed in refugees are major depressive disorder or generalised anxiety disorder caused by traumatic experiences, fear, feelings of grief and coping difficulties (F. Baker & Jones, 2005; Blackmore et al., 2020;

Kirmayer et al., 2010). Prevalence rates of depression and anxiety were 40% in a study of refugee and labour migrant populations (Lindert et al., 2009). Depression can manifest itself through a reserved attitude, social isolation, prolonged feelings of sadness or boredom, a lack of willingness to do leisure activities, tasks or to take care of oneself, or even thoughts of death and suicide (APA, 2013).

Chronic disorders within the refugee or migrant populations such as PTSD and depression can complicate or impede the process of acculturation and language acquisition, exacerbating further the symptoms of these disorders (LeMaster et al., 2018).

Some adult survivors of torture, political violence and flight have increased auditive sensitivity as a result of auditive trauma i.e. sounds of war. A study by Metzner et al., (2018) revealed that patients with complex PTSD have altered acoustic perception and suggest that music therapists working with such groups of patients should adapt their practice to address the acoustic sensitivity vulnerabilities of these clients.

Nevertheless, considering the high incidence of traumatic experiences among the refugee population, it is important not to generalise to the whole target population, so that personal dynamics and cultural identity factors can be considered in the therapeutic relationship, and not unduly classified as victims of trauma (Comte, 2016).

Considering the elevated levels of some psychological disorders among the refugee population, it is less common that mental health services will be procured or referred to (Kirmayer et al., 2011). Mental health literacy, i.e. recognising symptoms and routes of treatment varies within different cultures. For example, Sudanese and Iraqi immigrants in Australia showed more favour towards spiritual and supernatural causes and cures for mental health symptoms than their Australian counterparts (May et al., 2013). There are also cultural stigmas associated with some illnesses, particularly in the field of mental health, which can lead to misunderstandings and explanations of mysticism about the cause of certain illnesses

(Puvimanasinghe et al., 2015). Thus the use of health services is affected, particularly within multicultural societies (Mascayano et al., 2019; Stangl et al., 2019; Thornicroft, 2008).

The acculturation process and its challenges

Culture is a broad term used to refer to the set of traditions, beliefs, arts, ideals, laws of a society or within family and social groups (‘Culture’, 2020; Jahoda, 2012; Prinz, 2020). Culture defines and is part of an individual's identity and the way the individual relates to himself or herself and to others (Amir, 2004).

When an individual moves to another country or place they bring their own culture with them and must learn and adapt to the host culture in which they find themselves. Acculturation is a term used to describe this process of adaptation (Baker & Jones, 2005; Lakey, 2003; Schwartz et al., 2010). Refugees and asylum seekers go through this process while simultaneously dealing with any traumatic events they have experienced.

Baker & Jones (2005) state that the acculturation process can take up to 5-7 years and involves various predictable stages: intense sorrow, fear of the unknown and feelings of loneliness and deprivation (1 week-6 months), destabilisation, hostility and resistance to host culture and feelings of persecution, anxiety and depression (6 months-3 years), experimentation and stabilisation (3-5 years) and normal life (5-7 years) where intergenerational conflict can still occur. They also suggest that working with refugees in the initial stage of acculturation may not be the most appropriate stage to work with young refugees due to their instability of emotions, grieving for what is lost and fearing the unknown. The second stage (from 6 months onwards) may be a more suitable period to provide a music therapy intervention, when the young refugee is slightly more settled and in the process of navigating the host culture.

Many challenges arise in this process as the individual tries to maintain ties with their own culture and identity while simultaneously trying to establish a new identity and navigating the host culture. In these circumstances the internal conflict generated by the attempt to merge

the old culture with the new is exacerbated (Jones et al., 2004). In addition, intergenerational rifts may arise which increase the difficulty of integration into the host culture (Baker & Jones, 2005). This process can trigger an increase in anxiety and even a traumatic set of experiences when the culture of the host country is vastly different from the culture of origin of the individual. These difficulties in the process may cause some psychological disorders (Beck et al., 2018).

In the context of psychosocial intervention, language can make communication between client and professional more challenging. A broad vocabulary is necessary to describe symptoms, feelings, experiences, and in order to express internal experiences. This depends largely on the process of the client's acculturation (Puvimanasinghe et al., 2015). The acquisition of a new language is part of the acculturation process, and language acquisition can be negatively affected by acculturation stress and the appearance of other psychological disorders.

As mentioned earlier, culture is part of how we relate to others, including how we behave when we are happy, angry or sad and how we solve problems. This diversity of behaviour can be interpreted as a failure of education or social skills. Comparing behaviours and actions with Western norms without first considering the client's cultural norms can lead to cultural misunderstanding and may be detrimental to the client's development. In a study of young Sudanese refugees in Australia who were receiving music therapy sessions, the authors identified a significant percentage of cases that were referred to music therapy for involvement in aggressive physical conflicts. It emerged from their research that in Sudan most disagreements are resolved by physical confrontation before they make up and become friends again (Jones et al., 2004). In a Western school context, this way of resolving conflicts is considered inadequate, as it is in the professional world, bringing serious disciplinary

consequences and giving these young people a more pathological connotation than one would expect in their culture of origin.

The DSM-5 (APA, 2013) presents some explanations of cultural impacts in relation to mental disorders in three categories: cultural syndromes, cultural expressions of distress, and cultural explanations or perceived causes. These steps represent a significant step in the right direction for cultural awareness in mental health.

The use of music in health promotion

Over time and in all civilisations the definition of health has varied according to culture, beliefs, history and the evolution of scientific knowledge. The definition of health currently adopted by the World Health Organization (WHO) states that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organisation, 2006, p.1). In Ancient Greece, health was defined as a balance between the individual and environment and in the union of body and soul (Kleisiaris et al., 2014). The way in which a society views health had an influence on the methods of health promotion. For example, in traditional African medicine physiological and spiritual illnesses are interrelated. There is also a connection between environmental and human health. When an individual is ill, their suffering can affect the community, and a sick community can in turn cause illness in the individual, so working as a community to maintain good health prevents illness (Nzewi, 2002).

In most societies music has been used to improve well-being for health promotion. Used as a cultural immunogen by the Ancient Greeks, including Pythagoras, the Sufis of North Africa, and indigenous tribes around the world (Ruud, 2008, 2013), music has been used to promote the maintenance of individual and community well-being.

In sub-Saharan Africa, music, rhythm and dance are seen as one entity, that is spiritual and material. It is a medicine used to heal various pathologies, alter states of consciousness, as

well as a powerful nature-affecting force that can communicate with the spirits and change the weather (Mereni, 1996).

The use of music within the community as a treatment for disease existed in African medicine long before the emergence of pioneering Western music therapists and continues to be practiced *en masse* in some cultures on the African continent in a recuperative and preventive approach:

> this music can be incidental, or background (dispersing the stress of daily subsistence), cumulative (a purging of collective pollution of the human sphere for a period of time, usually an annual event), and regenerating (re-energising the community and individual psyche)", (Nzewi, 2002).

This use of music, in particular to decrease stress and re-energise the community and individual well-being, can be compared to community music therapy practice, described below. Traditional African music therapy is also inherent in the treatment of psychotic or neurotic disorders (psychosis, schizophrenia or depression, also autism, anxiety and pain relief, in Western terminology), whether regarded as 'occult forces' or recognised psychiatric disorders (Mereni, 1996). Understanding the therapeutic uses of music in Africa may help gain a deeper cultural understanding of the residents' reactions during a music intervention in the CACR.

Music therapy

The use of music as a preventive and curative treatment, also known as music therapy, is relatively recent in the Western health professional community. Music therapy continues to gain recognition in the medical community and is considered a complementary, or in some cases a substitute treatment (Bulfone et al., 2009; Fusar-Poli et al., 2017; Gold et al., 2004; Hanser, 2002) that can focus on biological or psychosocial factors. The application of music therapy principles towards individual and community well-being is even more recent within

the MT field though it has been documented for centuries under the influence of spiritual, mystical and communal traditions as previously mentioned.

Music therapy (MT) can be defined as a form of therapy that uses musical experiences to establish and develop the therapeutic relationship between client and music therapist that enhances the health of the client. Bruscia's latest working definition (2014) attempts to incorporate all aspects of the different types of music therapy possible, highlighting that it is a reflexive process which uses music, and the relationships developed through music, as an "impetus for change".

Music therapy can be applied in many types of setting: medical care, social intervention, education, forensic and community. The music therapist can focus on various functional aspects such as attention, emotions, communication, behaviour, cognition or a combination of these. Music therapy can be applied to babies (before and after birth), children and young people, adults and elderly, individually and in groups (Associação Portuguesa de Musicoterapia, n.d.).

Music therapy uses active (making) and receptive (listening) methods in its practice (Dieterich-Hartwell & Koch, 2017). One active technique used is called *musicking*. *Musicking*, a term coined by Small (1998), is a verb to describe participation in a musical performance, 'whether performing, listening, rehearsing or practising, composing or dancing'. This author also highlights that the relations that are established between the participants during the act is an important factor of *musicking*.

The development of music therapy practice involves obtaining empirical evidence through academic studies and qualitative and quantitative data to support the underlying theories and the adaptation of practices to the specific conditions of each target population (Hillecke, 2005). Thus, each model has a set of theoretical proposals which support it. The application of MT in an individual setting is more characteristic of clinical approaches and less

prevalent in working with groups such as refugees. In these cases, the institutional context and the nature of the population make individualised intervention more difficult, therefore group work and musical experiences which promote community organisation and group identity building are more relevant and pragmatic. The most appropriate approach, best adjusted to the target population within CACR, is the community music therapy model. This model will be explored below.

The community music therapy paradigm

Community Music Therapy (CoMT) is a more recent approach to, or new direction for music therapy, a result of a theoretical and methodological effort to integrate the psychoanalytic, Nordoff-Robbins and behavioural models, extending the intervention to settings inside and outside the institutions where music therapists were already working. Stige (2002) prefers to describe CoMT as a new area of practice rather than a paradigm as it is defined by the needs of the client or community in which one is working. There is much debate among music therapists related to defining CoMT. Stige (2015) references several different definitions, noting that they are often complex and controversial, but provides the acronym PREPARE (Participatory, Resource-oriented, Ecological, Performative, Activist, Reflexive, Ethics-driven) to describe the characteristics or qualities found in CoMT.

Procter (2018) describes CoMT through its differences to traditional music therapy practice as a way of escaping the psychoanalytical, behavioural and medical models, as a re-evaluation of musical-social practices, a focus on the communal as well as individual, a contemporary view of social health and well-being, and using music to work towards individual and community health. CoMT encourages interactions between individual, family and social network as a natural extension of the music therapy space, working musically with people in context and bridging the gap between the individual and the community. In this sense *musicking* can strengthen the spirit of community within the institution (Aasgaard, 1999, as

cited in Ansdell, 2002). The clinical, individual and private settings required to follow the mentioned methods are seen to isolate the client and their problems to the therapy room without inviting them to explore their needs of identity construction, adaptation and communication within the community.

CoMT is often referred to in refugee MT literature as well as 'community music' which has some theoretical and practical similarities (O'Grady & McFerran, 2007). Community music practices usually involve professional musicians (rather than certified music therapists). The focus of community music is working with groups and bringing people together as opposed to individual work (Ansdell, 2002). Community music organisations or charities present musical programmes in a community that would not otherwise have access to the arts, such as the Musicians Without Borders project (https://www.musicianswithoutborders.org/). The differences between community music and CoMT are in the approach of the music therapist, the setting of therapeutic boundaries and the organisation of musical experiences. The ultimate objectives of CoMT are community involvement and construction, rehabilitation and development (O'Grady & McFerran, 2007; Ansdell, 2002).

Ansdell (2002) argues that the two disciplines are beginning to cross over and share more similarities. For this reason the author describes CoMT as working on the individual-community continuum. Inclusion and integration are some of the main challenges faced by refugees in the host country and can be a source of stress that can lead to the psychological disorders as previously mentioned. A focus of the RAISE model (Estoura & Roberts, 2019) and CoMT is working to integrate the individual into the community, and CoMT can prepare the community to accept the individual (Stige & Aarø, 2011).

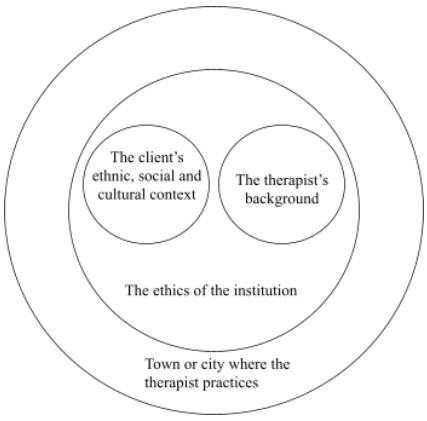
In preparing the music therapy intervention plan for the population in the CACR it was useful to remember the practices of CoMT are 'context-sensitive and resource-oriented, focusing on collaborative music production and attending to the voices of disadvantaged

people' (Stige, 2015, p.233). In this sense the needs and culture of the residents and institution, resources available and methods involved together will influence the music therapy intervention.

Another feature of CoMT that is relevant to the population of CACR is the awareness of and consideration for different cultural contexts. It has been compared to Culture-centred music therapy (Stige, 2002) which focuses on the link between music, culture, the client's self and society (Kim & Whitehead-Pleaux, 2015). CoMT embraces different cultures and uses this diversity to involve and mobilize all clients, generating broad group experiences inserted into the day-to-day life of the institution and the community. Figure 1 is a representation of this awareness of the institution and community when adopting the CoMT approach. The background of client and therapist are different, but they work together within the ethics of the institution where the intervention occurs, within the location where the therapist practices. As in other areas of medicine, one treatment does not cure all, and the importance lies in understanding the client, which in this case includes their community.

Figure 1

Community in CoMT



Note: Adapted from Zharinova-Sanderson (2004)

The flexibility that is integral to CoMT can lead to challenges when establishing traditional therapeutic boundaries. Traditional views of boundaries come from psychodynamic theories and are related to the time and setting of therapy, confidentiality and specifics of the relationship between therapist and client which provide a safe, predictable space for therapeutic work (Medcalf, 2016). While boundary violations are seen as detrimental to the therapeutic process, this author argues that these rigid guidelines can reduce interpersonal connections making the therapy feel distant or clinical. They also highlight that these boundaries may not be suitable when working in the community and that the context, music and client's social, spiritual and cultural views should be considered when setting boundaries. The diverse cultures presented in CACR and the residents' limited or non-existent experience of Western psychotherapy required an adapted approach to boundary setting to facilitate the building of the therapeutic relationship by not appearing rigid or impersonal while avoiding violating therapeutic boundaries. Flexibility in boundary setting can humanise and personalise the therapeutic process and be more inclusive of different cultures.

Ansdell (2002) highlights that in practices with multicultural clients the Western concept of music therapy may be abstract, but *musicking* is a socially and culturally recognised activity that must be developed and expanded as part of health promotion. Stige (2002) highlights the importance of being culturally sensitive through development of knowledge of traditional music healing rituals. There are similarities between the use of music in traditional African music therapy and CoMT such as *musicking* for health promotion, to decrease stress and to re-energise with a focus not only on the individual but also on community health and well-being. Using CoMT with this in mind can be more effective than implementing an unfamiliar Western medical approach when working with young Africans in music therapy. In the context of CACR, as intervention takes place in public areas and open to all, *musicking* could constitute a central component of the music therapy intervention.

Literature on music therapy intervention with refugees

Literature on music therapy intervention with refugees refers to a variety of contexts such as refugee camps (Storsve et al., 2010), mental health centres for immigrants (Amir, 2004; Orth, 2005; Zharinova-Sanderson 2004), community centres (Harrison et al., 2019; Kim, 2013), schools for refugees, asylum seekers and newly arrived immigrants (Baker & Jones, 2005; Hunt, 2005; Jones et al., 2004; Marsh, 2012), special music therapy programs for refugee adolescents (Choi, 2010) and detention centres (Lenette et al., 2016). These projects differ in terms of geographical location, age, legal and family situation, trauma levels and nationality of the target population. What the participants in these studies have in common is that they are in the process of acculturation and have similar issues regarding identity (maintenance and construction) and well-being (presenting varying levels of symptoms of psychological disorders), while musical improvisation is the predominant technique used. The studies involve a mixture of individual and group practices, differences in objectives and duration of intervention. Objectives mentioned in the literature include decreasing symptoms of trauma or PTSD, promoting integration into the host culture, facilitating the acculturation process, dealing with feelings of homesickness or reducing anxiety caused by the current life situation. In these studies, some music therapists have access to translators to facilitate communication with the client, while others involve specialists from the specific cultures concerned to support the music therapist.

Despite the interest on this subject, literature on music therapy with refugees is scarce when it comes to studies with clients in the same age range and nationalities as the residents of CACR or in a residential setting. Within the literature referring to music therapy intervention groups with refugee children, it is not clear in the methodology if they were unaccompanied refugee minors. Therefore, a variety of practices referring to different ages and other similar clientele groups in pathology with refugee children was reviewed. This included, for example,

traumatised children in a school in South Africa (Pavlicevic, 1994) which provided music and movement methods used with African children that could be adapted to use with the CACR residents with the objective of addressing trauma. This also included musical interventions using music therapy techniques but without certified music therapists to provide the programme (Henderson et al., 2016) as they described interventions with a mostly adolescent population. Some music therapy studies with refugees also include art activities as a closure to a session (Choi, 2010) or to release memories (Dieterich-Hartwell & Koch, 2017). Painting was used as an alternative form of creative communication that is inclusive for those who might not participate in music for religious or other reasons. These studies provided a theoretical basis and methods which could be used.

The studies referring to English language schools for refugees, asylum seekers and newly arrived immigrants in Australia could be compared to CACR. The estimated time for students to acquire the necessary level of language proficiency to integrate into the 'normal' school is six months, and there is a constant flow of new students. However, those studies involve students living with their families, unlike the residents of CACR. Music education, music therapy or '*musicking*' experiences were used to support social cohesion and celebrate diversity among isolated migrants (Marsh, 2012).

The advantages of music therapy, when compared to verbal therapeutic interventions which target emotional, behavioural and adjustment issues, lie in the non-threatening (Choi, 2010), non-verbal qualities of music which still make communication and the development of a therapeutic link possible. When the nationalities of clients are completely different, music making allows for group members to create a feeling of being together. Moreover, as music is a symbol of cultural and personal identity and can be easily shared with others, it also nurtures cultural well-being within the individual.

Along with language barriers and acculturation, trauma is a common theme in the literature regarding music therapy with refugees. Several studies refer to the high prevalence of PTSD among refugees. In the Netherlands, Orth (2005) treats the psychological problems associated with trauma in a highly specialised treatment unit for refugees and asylum seekers. Orth states that music therapy has been able to reduce levels of anxiety, channel emotions into healthier responses, and a progressive experience of physical and psychological relaxation. The importance of programming the approach, activities and goals according to the clients' nationality and cultural origin is mentioned. This author notes that his practice changed from homogeneous groups of Vietnamese refugees in the 1980s to heterogeneous groups with a wide range of nationalities. Under these circumstances, his work became more individual to enable him to focus on the client and their cultural needs in a safe environment, avoiding feelings of anxiety or shame which arise when dealing with trauma within a group.

The results and benefits of music therapy are well documented in the disciplines of mental health, behavioural health and well-being. Music therapy, in conjunction with other traditional treatment approaches, reduces levels of depression and anxiety (Aalbers S et al., 2017), symptoms of psychosis (Geretsegger et al., 2017) and core symptoms of PTSD, as well as increasing social functioning, hope and resilience in adults and children (Beck et al., 2018). In relation to trauma, studies have shown that music therapy has a positive effect in reducing symptoms (Comte, 2016) and community-based intervention has improved results in mental health among refugees (Lenette et al., 2016).

Some studies mention the specific effects of MT with refugee populations. The power of music to positively affect humour was the subject of a systematic review of seven studies with migrants and participatory music activities, conducted by Henderson et al. (2016). The authors divided the results into four categories: social well-being, stress reduction, improving/enhancing mental health and supporting mental health. Four studies showed that

MT delineated boundaries between cultures and allowed the participants to be recognised and promoted acculturation. The results of a study by Marsh (2012) include increased self-confidence, enhanced social-skills, promotion of emotional well-being and identity preservation. Three studies from the systematic review mentioned that communication and language acquisition through music resulted in academic achievement and stress reduction. Two studies showed that music enhances mental health by measuring self-esteem. Music participation also promotes self-identity, trust and a sense of connectedness that can reduce negative behaviours such as aggression. One study revealed that music therapy supported emotional health in a group of migrants who were mourning the loss of a colleague.

Some common themes that arose in one study with mostly unaccompanied North Korean adolescent refugees were: avoidance (avoiding negative emotions), distrust (among family members), loneliness (no meaningful relationships), feelings of loss (past experiences), fear (for the future in new country) (Choi, 2010). These themes are identified as internalising behaviours, linked to depression, anxiety and PTSD. Therefore, the objectives of the intervention are based on the following themes: to teach productive coping strategies, experience positive relationships, build a social support system and express emotions. The participants in this study learnt to interact with others, share their thoughts and feelings, hold positive views, build a social support system among the group, express their repressed negative emotions in a constructive way (through music) and recognise other's feelings. Their psychological symptoms and behavioural problems improved along the program.

The results of the Baker & Jones study (2005) indicate that music therapy can be a means for a viable intervention in the management of maladjusted behaviour and to stabilise young refugees, which facilitates their navigation of the educational system and therefore increase chances of professional and economic success in the future.

As mentioned before, music therapy literature concerning refugees, adults and/or children, is diverse in methods, participants and setting. Research data from music therapy intervention programs seems to indicate a positive outcome, but there are shortcomings in methodologies and discrepancies in results, attributed to a multitude of factors such as language barriers in data collection, cultural differences in presentation of symptoms, lack of control groups in the studies, small and very distinct groups which prevent the generalisation of results (Baker & Jones, 2005) and short-term studies or interruptions in procedure.

There are some cultural issues that can arise in music therapy with multicultural populations which may require adaptations to accommodate the client. Zharinova-Sanderson (2004) published a case study highlighting the case of a Kurdish man from Turkey who gave up going to music therapy sessions because he felt uncomfortable being alone in the sessions with a younger woman. Eventually, the sessions took place in the presence of a male translator to overcome this obstacle to allow a focus on the client's depression. Amir (2004) notes that traditional songs of one's country of origin can also be a source of shame and some resistance can occur when invited to share with people of other nationalities, due to cultural or political reasons. Awareness during group sessions is required for signs of distress or strong disagreement.

A lack of awareness of the client's culture could prevent the establishment of a therapeutic relationship. In relation to work with refugees, Valentino (2006) describes the harmful effects that can arise for the client when the music therapist does not know or ignores the characteristics of the client's culture of origin. In this study, it was found that the music therapist may not recognise the singularity, the symbols or the idiosyncrasies within the musical production or in the behaviour of the connection with the client. These dynamics can make the client feel misunderstood and consider the therapy irrelevant to their personal needs. Given that the current medical model leans towards white male privilege (Baines, 2016) it is

necessary for music therapists to be concerned with understanding the cultural differences of each client, as well as reflect on their own identity and cultural perspective, to enable therapeutic change (Brown, 2002, Mahoney, 2015). A music therapist, to be sensitive to the cultural differences of his clients, needs to have an open mind, curiosity and respect for the cultural differences that clients present and be available to change their practices whenever necessary.

Music therapy methods applied in work with refugees

The working methodology in the application of music therapy with refugee minors is similar to that used with children or adolescents (Hunt, 2005). The techniques often need to be adapted for cross-cultural target populations (Jones et al., 2004). The methods mentioned in the literature are predominantly active, involving playing instruments, singing or writing lyrics, and composing music. These activities are described in more detail below, along with the benefits and challenges which can arise among this population.

Improvisation (in group and individual). Improvisation in music therapy, as opposed to playing repertoire, positively influences health and well-being and can be used for different purposes depending on target population. 10 of the 11 articles reviewed by Comte (2016) of the literature related to refugees refers to the use of musical improvisation developing alternative and non-threatening (Choi, 2010) forms of communication without the need for a common language. Participation in musical improvisation can be one of the few opportunities to communicate with others and establish interpersonal relations when there is no common language between the music therapist and refugee participants.

Ruud (1998) argues that music is not a language but a symbolic representation of communication, and that improvisation can be viewed as a mini social system or an illustration of communication providing a simulation of real-life social situations. Communication in this way can assist in alleviating some of the feelings of isolation that are common amongst the

refugee population. While improvisation can open up another route towards communication and establishing relationships.

If the focus of musical improvisation is to work on trauma, the symbolism within the music allows the client to express themselves when it is still too difficult to use words. Orth (2005) uses improvisation with very traumatised refugees to express difficult emotions in a controlled environment. He checks with the client that the rhythm, chord structure and style reflect their current thoughts in preparation for the improvisation.

Music can reach our unconscious and stir emotive memories, images, metaphors and associations (Erkkilä et al., 2019) providing a means to express oneself and reveal inner stories and unresolved issues (Choi, 2010). The creative nature of improvisation allows for exploration of emotions such as current emotional states, underlying mood or associations to images, experiences or aspirations (Bunt, 2012). As mentioned by Kim (2013), some cultures have difficulty in expressing emotions verbally, and musical improvisation can provide a means to express oneself and understand others. The tone, volume, speed etc. used in spontaneous music making can serve as indicators of personality traits, affective states of the moment and availability for the relationship to the music therapist, taking into consideration the cultural differences previously mentioned. It allows the client to access the unconscious, using creativity to interact and express emotions (MacDonald & Wilson, 2014). This exploration and play then allows for verbal dialogue (if possible) and therapeutic engagement.

Western music therapists imposing Western musical conventions can ignore many cultural nuances which can occur within the music (Valentino, 2006). Awareness of cultural musical stylistic differences or extra-musical associations avoid what Comte (2016) defines as ‘neo-Colonial music therapy’, facilitating a feeling of belonging (Gadberry, 2014), and is a step towards culture-centred practice (Brown, 2002).

Music plays an important role in building orientations, forming relationships to others and defining ourselves within our culture (ethnicity, gender, class etc.) as well as providing experiences that can strengthen identity by providing meaning and significance in our lives (Miranda, 2013; Ruud, 1998). The music we listen to and our musical improvisations reveal our identity, personality and style (Vougioukalou et al., 2019). When improvising musically, one is playing their identity for others to see and simultaneously strengthening it. This is important in music therapy as Ruud (1998) also argues that music, identity and health are connected, in that a strong sense of identity is associated with a higher quality of life and can be achieved through *musicking*. The Sudanese students in Baker & Jones' (2005) study used drum rhythms from their own culture to express their identity as African youth. Green (n.d.) notes that African music is percussive and uses the voice, hand claps or percussion instruments such as djembes and it is rare to find traditional African music that uses melodic instruments to lead a dance. Therefore, making a range of percussion instruments, including djembes, available in the music therapy intervention in CACR, will accommodate the process of identity exploration among African youth as the instruments provide the tools to connect to their cultures.

Listening to, replicating and teaching repertoire. In addition to the therapeutic effects of singing presented by Gridley et al. (2011) there are also emotional benefits when the repertoire has personal and cultural significance. Replicating traditional music that the client identifies with validates their cultural identity (Lenette et al., 2016) and to some extent satisfies the emotional need for contact with their country of origin. Musical appreciation also allows one to address themes such as homesickness, loneliness, isolation and acculturation stress (Kim, 2013). When the client teaches the group a song from their cultural repertoire, they become the 'expert' and the facilitator, their skills are valued and self-esteem is re-enforced. Sharing songs from their home country also celebrates diversity (Marsh, 2012), encouraging

integration and creative expression. Sharing the songs that represent our identity and culture allows us to teach and meet people from different cultures and welcome them into their new community. This can be a facilitator of acceptance among people from different cultures if the experience is facilitated in an empathetic and secure way by the therapist (Abdulbaki & Berger, 2019; Amir, 2004; Zharinova-Sanderson, 2004).

Composing songs (in particular rap). Hip-hop and rap are one of the most popular genres among young people today (*2017 U.S. Music Year-End Report*, 2018), and the young people of CACR are no exception to this rule. The structure of rap music has easily predictable elements (verse-chorus-verse), making it musically accessible to all. This type of repertoire, due to its tradition of rebellion and aesthetic acceptance among young people, can serve to circumvent the resistance to participate in 'therapy' sessions. Rap and Hip-hop is a genre that goes beyond race, ethnicity, culture and geography and musical themes include coping mechanisms, representations of identity, culture, social justice, activism and empowering themes that promote individual and community health (Travis, 2012), all of which are relevant to adolescent refugees. One lyric writing activity that involves writing the chorus as a group and verses individually, in the client's own language if necessary, allows the young people to express their own feelings and emotions, value each group member's individual identity while simultaneously supporting the group during the chorus. Jones et al. (2004) concluded that writing rap lyrics promotes introspection (insight), is a vehicle for processing experiences and feelings, group validation and develops a social understanding of the youth community as well as creating a song of which the participant can be proud.

Music and movement. Onwuekwe (2009) and Green (n.d.) state that in African culture music and dance are entwined, and found in all aspects of life (lullabies, children's games and adult responsibilities, rites of passage, celebrations of love, life or death). Where there is music, there is always dance, and vice versa. Most African languages do not have a word for music

alone, except for those introduced by colonisers. It is common in most African languages that a word or term exists that represents music, dance and song. For example, in Igbo (Nigeria) there are at least four words that can represent song, music, dance, play etc. (Onwuekwe, 2009). One of the frequent findings in literature on setting music therapy with clients of African origin is that they sing, dance and improvise more easily than their Western counterparts (Orth, 2005). Incorporating movement into music therapy sessions with clients from Africa has been recommended. Jones et al. (2004) stress that Sudanese students who received music therapy had a great rhythmic expression and an enthusiastic response to music. These authors highlighted the case of a teenager who did not react to music therapy until the therapist used body movement with music to communicate with him. These authors also noted that the 'empathy techniques' defined by Bruscia (1987) such as imitation or synchrony were ineffective with their Sudanese students because Sudanese music uses interconnected independent rhythms, polyphony, as opposed to varied versions of the same melody, monophony or heterophony. Pavlicevic (1994) used music and body movements with traumatised children living in a deprived community in South Africa marked by violence, poverty and social conflict. Although the movements allow children to release energy and be uninhibited, the fact that they are practised in groups and accompanied by music has both an expressive and container effect. Movements are also used to represent each participant and a number of animals with different personalities, in a contained playful and symbolic expression.

In summary, there are many aspects to be aware of when working with unaccompanied minor refugees. They have passed through a multitude of different potentially unpleasant or traumatic events without the supervision of an adult, while going through the developmental physical and emotional changes related to adolescence. Trauma-related issues such as PTSD as well as depression and anxiety symptoms as well as the stresses related to the acculturation process could be present, although perhaps displayed in culturally different ways. Other issues

associated with self-identity, isolation, communication and integration could arise. Music's ability to cut across cultural and linguistic barriers, provide the tools to explore identity constructs, and to promote empowerment makes music therapy intervention well suited to the refugee population.

Reflecting on the functioning of the target population of CACR, which is predominantly West African, CoMT intervention is suitable because of its awareness of cultural context, its focus on the individual within the community in aspects of integration and inclusion, social health and well-being and flexibility. Methods such as improvisation, song sharing, composing of rap songs and dance are most frequently used with this population. Common objectives include increasing communication and trust, creating a social support system and reducing loneliness and stress, enhancing mental health and well-being, behaviour management, and facilitating the acculturation process or a focus on trauma and mental health. CoMT also shares some similarities with traditional African music therapy in that it uses *musicking* for individual and communal health promotion which could make music therapy more accessible and effective with the CACR population.

Internship goals

Considering the information presented in the literature review and the characteristics of CACR, the objectives defined for this internship were the following:

- To install at CACR a musical interaction space where residents could spontaneously enact their cultural identity
- To use music to facilitate a healthy process of acculturation, by promoting the link between the residents' cultural identity and their new host environment
- To provide a secure space for the residents to freely express the full range of emotions
- To decrease the residents' symptoms of anxiety and depression such as feelings of sadness, stress, frustration and anger
- To promote community cohesion and the residents' sense of belonging through group music practice.

Methodology

This section reports the practical aspects of the music therapy intervention in CACR. It describes the group of participants, data collection instruments and music therapy methods that were utilised, the session structure, weekly schedule and procedure. Given that the internship took place during the COVID-19 pandemic year, the challenges for and effects on the participants will also be described.

Participants

Throughout the internship, a total of 35 young people were registered to participate in at least one music therapy session, eight members of staff, interns or volunteers also took part. In addition to the residents and members of staff, the residents' acquaintances and a group of volunteers participated in one off sessions. These are not presented in the data.

Tables 1-4 present a general characterization of the participants, including their initials, gender, year of birth, country of origin, dates of admission and exit (last updated October 2020) from CPR services, number of sessions attended and whether they were group sessions (G) or individual (I). 65 sessions (group and individual) took place during the internship. Attendance was logged post-session from the intern's memory or using the session videos. Table 1 represents participants that attended more than 9 sessions, and the number of individual or group sessions is registered. The following tables represent participants who attended less than 9 sessions, Table 2: 4-8 sessions, Table 3: 2-3 sessions and Table 4 those that participated in one session. Table 5 presents the adult participants, their role, nationality and number of sessions. The staff participated only in group sessions.

Table 1

Music therapy participant data (9 sessions or more)

Name	**Sex**	**Year**	**Country**	**Admission date**	**Exit date**	**Nº of sessions**	**Setting**
D.F.	M	2003	Guinea Bissau	09/08/19	-	11	G – 10 I – 2
B.C.	M	2003	Gambia	28/10/19	11/09/20	14	G – 12 I – 2
N.M.	F	2007	Azerbaijan	19/09/19	-	29	G – 13 I – 16
A.D.	M	2002	Guinea Conakry	14/10/19	01/09/20	9	G – 7 I – 2

The participants from Table 1 participated mostly in group sessions, often together, with the exception of N.M. The group sessions used improvisation and music listening and served as a means to build and strengthen the therapeutic relationship. D.F., B.C. and A. D. only participated in individual sessions later in the internship once trust was built and personal projects were decided. These participants showed greater change in behaviour than those who participated in fewer sessions, such as less depressive behaviours, reduction in aggressivity, less hyperactive and more leadership and sharing of personal feelings and stories.

Table 2

Music therapy participant data (4-8 sessions)

Name	**Sex**	**Year**	**Country**	**Admission date**	**Exit date**	**Nº of sessions**	**Setting**
S	M	2002	Gambia	24/04/19	01/06/20	4	G
S.C.	M	2002	Gambia	01/10/19	29/11/19	6	G & I
O	M	2002	Guinea B.	04/07/19	-	5	G
N	F	2002	Angola	24/07/19	03/08/20	5	I
S	F	2000	Ethiopia	29/09/17	04/03/20	4	G & I
F	M	2008	Angola	29/11/19	05/02/20	4	G & I
B	M	2002	Senegal	08/05/19	-	6	G & I
I.S.S.	M	2002	Guinea B.	06/11/19	-	4	G & I
A	M	2003	Morocco	13/12/19	-	4	G
S	M	2002	Ivory Coast	12/02/20	-	4	G
M	M	2002	Guinea B.	03/05/19	13/09/20	4	G & I
K	M	2002	Senegal	24/06/19	-	5	G
L	M	2003	Gambia	25/11/19	-	5	G

Table 3

Music therapy participant data (2-3 sessions)

Name	**Sex**	**Year**	**Country**	**Admission date**	**Exit date**	**Nº of sessions**	**Setting**
D	M	2002	Nigeria	08/10/19	08/07/20	2	G
L.J.	M	2001	Gambia	23/09/19	01/06/20	3	G
Y	M	2002	Gambia	05/09/19	18/05/20	3	G
D	F	2003	D.R. Congo	06/03/19	14/06/20	2	G & I
B	M	2002	Gambia	08/05/19	08/05/20	2	G
S.K.	M	2002	Senegal	03/07/19	-	2	G
M.A.D	M	2002	Guinea Conakry	16/10/19	15/08/20	2	G
M.D.	M	2001	Guinea Conakry	01/10/19	07/02/20	3	G
M	M	2003	Guinea Bissau	29/11/19	-	3	G
E.N	M	2002	Gambia	13/12/19	-	3	G & I
T	M	2002	Ghana	17/07/18	16/03/20	3	G

Table 4

Music therapy participant data (one session)

Name	**Sex**	**Year**	**Country**	**Admission date**	**Exit date**	**Nº of sessions**	**Setting**
A	M	2002	Guinea Bissau	01/09/19	12/19	1	G
C	M	2002	Guinea Bissau	24/07/19	-	1	G
E	M	2002	Guinea Bissau	11/06/19	-	1	G
M.L.C.	M	2002	Gambia	03/12/19	-	1	G
E	M	2003	Guinea Conakry	14/10/19	21/02/20	1	G
M	M	2003	Guinea Conakry	18/11/19	04/06/20	1	G (art)
D	M	2002	Guinea Conakry	17/01/20	-	1	G

Table 5

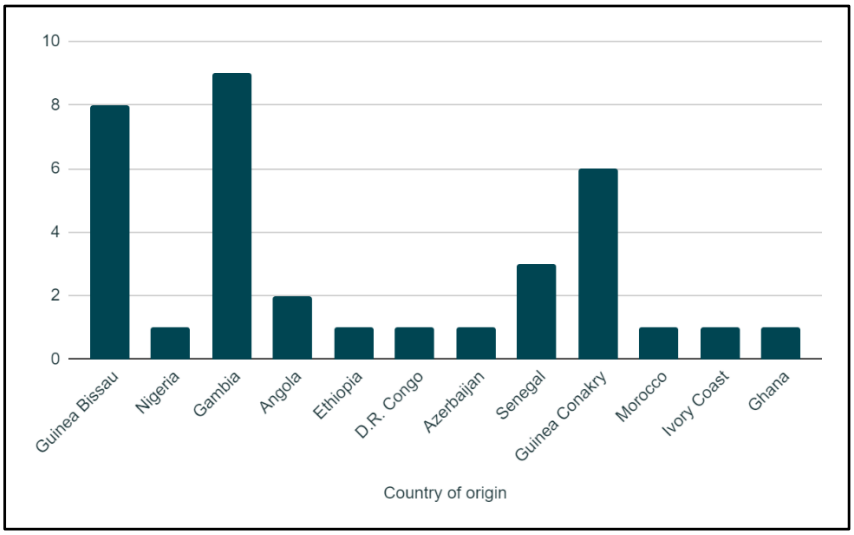
Staff participants in music therapy

Name (function) Nationality	Nº of sessions
S. (intern) Belgium	2
R. (intern) Brazil	1
L.S. (auxiliary) Portugal	3
A. (auxiliary) Portugal/Cape Verde	3
M. (auxiliary) D.R. Congo	2
M. (intern/volunteer) Spain	2
V. (auxiliary) Kenya	6
V. (Social Educator) Portugal	2

The majority of the participants were male and, as presented in Figure 2, they mostly originated from countries such as the Gambia, Guinea-Bissau and Guinea-Conakry, a reflection of the population of CACR at the time. The female residents participated in individual sessions more than the males. Of the staff participating in the music therapy sessions, the majority were auxiliaries, only one was from the CACR office team, and none from the offices of CPR. In general, the auxiliaries participated for a maximum of 10-15 minutes, sometimes more than once a day, while they were completing their daily tasks.

Figure 2

Participating resident's country of origin



Evaluation instruments/tools

The selection of appropriate initial evaluations pre-intervention was made difficult by language and communication barriers, which meant that these were not implemented. Translation into at least three languages - English, Portuguese and French - would have been necessary, however there was no young person who was completely fluent in these European languages. Translations into African dialects would have been almost impossible and furthermore many young people were illiterate in their mother tongue. A distrust or aversion to evaluations or interview style questions was observed - sensitivity was therefore used when questioning the young people so they did not feel interrogated. Despite the importance to the music therapist of knowing the history of each person's life and health, this information could not be shared by the director or young people - in a few cases however the young people revealed this information themselves over time. Informal observations by the intern were applied in specific situations and this assisted in planning individual objectives. Areas of observation suggested by the course coordinator included positive/normal behaviours, signs of pathology/dysfunction as well as interpersonal interactions.

After each session, a group and individual session registry (see Appendix A and B) was completed which described the session in summary, central themes, specific observations, music produced, any changes noted, and also the personal reaction of the music therapist. This assisted in the preparation of future sessions, determination of resources required, review of progress over time and also in the personal reflection of the intern.

At the end of the internship a final questionnaire (see Appendix C) was created by the intern to assess whether the internship objectives had been met and to what level the music therapy sessions had altered the mood positively or negatively of the young people. The questionnaire included open questions regarding the activities they had undertaken, what they had learned about other people and their cultures, and a Likert scale question was included in two parts to discover what emotions the young people felt normally in CACR and during or after a music therapy session. Emojis were used to help to overcome the language barrier. The questionnaires were completed verbally with the young people present in the house at the time. Young people who did not participate in music therapy were also asked for their reasons for not participating.

Procedures

The internship ran from October 2019 to August 2020, following initial meetings in July and September 2019. At these meetings the director described the institution, the residents and their needs, the team and the few musical instruments available. Occasional meetings were arranged with the director to give an update on progress made in the sessions and to raise any concerns or questions in relation to the residents.

The internship can be divided into three stages: observation, integration and planning; intervention; and intervention and evaluation. The final two stages were interrupted due to COVID-19. The proximity to the end of the academic year and the intern's difficulty in going

to the institution due to the COVID-19 complications shortened the internship. Each stage is described in more detail below.

Observation, integration and planning stage. The first month of the internship was devoted to observation of the operation of the institution, the young people and planning the intervention defined by the needs of the residents and community (Stige, 2002). This stage was necessary to best adapt the music therapy practice to the institution.

The director highlighted several residents who could potentially benefit from music therapy intervention due to their traumatic experiences or challenging behaviour displayed. An informal meeting was organised with one resident, N.M., because of her concerning behaviour and sessions began the following week. The details can be found in Case Study 1.

Informal observation took place mainly in the common/dining room as well as in the outside space. In the multicultural context of CACR, this stage also enabled the intern to learn and understand more about the culture of the residents and the traditional and popular music from their countries. The start of the intervention stage involved establishing and facilitating a connection with the institution (staff and residents), planning activities and mobilising the community.

Intervention stage. Open group and individual sessions began in November 2019 following the schedule mentioned further below. Throughout these sessions musical experiences were developed between the young people and the intern, following the needs of the young people at the time of the session. The arrival of new instruments (djembes and other larger percussion instruments more appropriate (Green, n.d.) for the ages and cultures of the young people), bought by CPR and intern, increased the attendance to sessions. Video recordings proved to be more useful compared to the written records of the sessions, as they allowed the analysis of important details not detected during the sessions and made it possible to compare and perceive the evolution of the sessions over time.

The COVID-19 pandemic declared by the WHO on the 11th of March 2020 and the 'state of emergency' declared by the Portuguese government on 15th March 2020 resulted in a 3-month period of lockdown, where non-essential staff were restricted from entering.

During this phase, no opportunities to maintain contact with the residents arose. The Directorate General for Health (DGS) recommended continuing to work at a distance through video calls – however this was not possible with the residents of CACR. The situation was complicated by access to resources such as microphones and speakers, storage and disinfection of the musical instruments before and after use, as well as technical support to carry out a distance music therapy session, as well as communication difficulties which already existed.

In June, following a conversation with the Director, the internship was resumed following the restrictions and hygiene rules set by the DGS: body temperature measured upon arrival, outside shoes changed or plastic covers used, obligatory mask use and frequent hand washing or disinfection. Group sessions were limited to six people maintaining a 1.5m distance from other group members, and musical instruments had to be disinfected at the end of each session.

Intervention and evaluation stage. Music therapy sessions resumed on 9th June 2020. Although open group and individual sessions began again, the routine did not return to the same as pre-COVID-19 intervention stage. The change in the mood of the young people affected their motivation to participate in music therapy sessions. The needs of some of the young people had changed as a result of the period of confinement. It was decided to vary the activities to include other art forms to appeal to and include all the residents.

On 14th July 2020 it was confirmed that one member of staff had tested positive for COVID-19 and the internship was interrupted again. Two weeks later all residents, CACR and CPR staff and interns were tested, and the internship resumed the following week when results were confirmed negative.

In August, the intern's reduced availability to run sessions together with the break in routine and the growing freedom in relation to the young people leaving the house further reduced attendance at the sessions. The population of the house continued to reduce, young people from other CPR residences were still prohibited from entering CACR, and there were no new arrivals. Individual projects developed between the young people and the intern, such as the recording of songs, city tours as well as musical improvisation sessions, were completed in the remaining time.

Music therapy evaluations were carried out in the form of questionnaires (see Appendix C) designed by the intern. They were completed verbally with the young people present in the house (7) on the last day of the internship, on 18th August 2020. The young people present who never took part in music therapy sessions (5) gave their reasons and did not complete evaluations.

Limitations of interventions and flux of CACR community. Several challenges arose in the different phases of intervention related to acquiring adequate instruments, adapting to the flux of residents, communicating with the residents, finding a suitable setting and establishing a schedule that matched with the availability of the residents. In the initial phases the language barrier hindered the explanation of the advantages of music therapy as a process of integration and identity - terms such as 'music therapy', 'therapy' or 'psychology' were new to the majority of the residents. Using a CoMT approach, the intervention was 'context-sensitive and resource-oriented' (Stige, 2015 p.233) and so it was necessary to pilot what worked to find the best process.

Finding adequate physical conditions, i.e., a private space that did not interfere with others, which would allow more adequate group management, facilitate communication and create a safe space to explore trauma, was not possible. Without a designated music therapy

room free from interruptions or an understanding of boundaries, flexibility in boundary setting was necessary (Medcalf, 2016) to be more inclusive.

Communication with the members of staff aided in the planning of sessions and encouraging their participation mobilised the community and facilitated new connections between the staff and residents (Procter, 2018). Understanding of self, character of the institution and population and wider community was necessary to provide an effective CoMT intervention as illustrated in Figure 1 and continued until the end of the internship. The continual flux of residents in the period up until COVID-19 necessitated constant adaptation to the population and its needs.

COVID-19 was the biggest obstacle faced. During the first COVID-19 lockdown the residents of CACR were confined in the house as schools were closed and the times they were allowed out of the house were reduced. When the internship began again it was clear that the atmosphere in the house had changed significantly since pre-COVID-19. There were fewer residents, the house was calmer, as the young people of the other CPR residences were prohibited from entering and the CPR offices remained closed. The influx of new arrivals in Portugal claiming refugee status almost completely stopped during this period. Despite this, there was an air of frustration among the young people - one resident had run away, presumably due to the stress of a long period of confinement. There were strict rules, delays in the paperwork related to SEF and the relocation of some but not all of the young people. There were high levels of boredom due to the cancellation of extra-curricular activities and the closure of schools.

Techniques applied. After a review of the literature relating to refugees and community music therapy, the resources available to the intern at CACR and the needs of the young people were considered in the preparation of the intervention. It was clear that enhancing a sense of cohesion and togetherness while valuing each personal cultural identity was of

absolute importance to facilitate the process of acculturation. A combination of receptive and active techniques were explored to support inclusion which at the same time aimed to meet general and specific individual objectives.

Receptive techniques such as music listening and discussion assisted in the maintenance of cultural identity and acculturation, at the same time embracing multiculturalism. Music listening concerns memories and emotions, reminiscence and consequently touches on homesickness. Residents and staff were encouraged to share their favourite music to create group experiences of identities and embrace cultures (Stige, 2002). Sharing of music from one's own culture with others enforces cultural identity, while listening to music from the host culture assists in the process of acculturation and acquisition of the host language.

Used more often, active techniques were based on vocal and instrumental improvisation. *Musicking* was frequently used for health promotion (Ansdell, 2002). Dance and movement was encouraged. Acquisition of repertoire and the composition and recording of rap lyrics were used more in individual contexts as personal projects. The application of these techniques helped the young people to express feelings and emotions and/or acted as a distraction or alleviation of anxiety, frustration and depression. Group improvisation promoted communication between the intern and the young people, encouraged creativity, strengthened cultural ties and the therapeutic bond, welcomed newcomers into the community and promoted cohesion and a sense of belonging. In an individual context the young people were able to create their own or recreate music, promoting a sense of achievement and acquisition of new skills as well as providing the benefits listed above.

As well as music, art was also used in some sessions. Painting, individually and communally (on one big piece of paper), while listening to music promoted creativity, and

created a sense of belonging and community, and opened up another channel of communication.

Session structure and organisation. After the initial observation and assessment of the organisation's dynamics the sessions were designed to be open, flexible and available to all young people and staff within the house. Individual sessions were organised on a one-to-one basis when requested or suggested and depended on the young person's availability.

Once it had been established that a fixed routine was not the best way to mobilize the residents, the music therapy days were loosely structured as follows:

Upon arrival (10:30) the intern greeted the staff and received an update on the latest circumstances of the residents from members of staff or the logbook. A quick tour of the house was carried out to greet the residents, to find out who was present and reiterate the invitation to and times of the sessions. By 11:00 the instruments were set up, normally in the dining room (see Appendix E) and the intern waited for participants to commence the session. The chairs were arranged in a circle with instruments laid out on the table and in the middle of the room on the floor. During the session the dining room/common room was also used by other residents or visitors to watch television, cut hair, socialise, use the Wi-Fi, and as a passage to the outdoor space. The staff in the kitchen were present preparing lunch and the daily service staff carried out their tasks around the session. The sessions finished by lunchtime (12:30). During lunch time the intern confirmed and/or organised the afternoon sessions with the young people who were available. After lunch (13:30-14:00) individual or group sessions were conducted in the library, dining room or outside space until the end of the day at 14:00 or 16:00-17:00 (see Appendix D).

The sessions were mostly directed by the young people, following on from activities or themes they wanted to do or repeat/continue from previous sessions, or depending on their emotional state that day. Specific topics or themes were planned and prepared by the intern for

group sessions but there was little success in directing a session verbally due to the communication difficulties or lack of attendance.

Resources used included percussion instruments (4 x djembes, cajon, 2 x bongos, hand drums, ocean drum, tambourine, maracas, triangles and other small hand percussion) harmonic instruments (1 large and 1 mini electronic keyboard, ukulele and a guitar) melodic instruments (individual glockenspiel bars, xylophone and kalimba). An Amazon Kindle device was used to film the sessions, a mobile phone and Bluetooth speaker to listen to music and for translations, a laptop, a microphone and Ableton Push 2 for composition of electronic music and recording songs and some art materials (paint, paint brushes and paper).

Weekly schedule. The weekly schedule was adapted throughout the internship according to the resident's school timetables. This translated to being present, on average, 10-15 hours a week. Some flexibility was needed to reach as many young people as possible.

In the observation stage the intern was present in the mornings, five days a week, from 09:00. The majority of the young people did not wake up before 10:30, and so the arrival time and days were altered with this in mind, eventually including weekends. The music therapy sessions proved more productive at the weekend and during public and school holidays because the offices were closed and there were more spaces where noise was not an issue. In the last phase of the internship, school and extra-curricular activities were suspended because of COVID-19 and the intern returned to the weekdays sporadically when possible.

In the initial phases of the internship the residents were consulted to choose a suitable time for music therapy (see Appendix D), in groups of up to 6. A timetable was sent to the director and displayed in various places in CACR. In the first week of intervention, no young person appeared in the group they had scheduled themselves for - they either arrived at the end of the session, in the wrong session or not at all. Attempts to locate the participants within the house were not successful. This problem was less notable amongst the female residents.

After unsuccessful attempts to hold closed group sessions at the beginning of the intervention phase, all the group sessions were open. The most successful time was between 10:30-14:00 during the week and 10:30-16:00 or 17:00 on Saturdays, with open group sessions in the morning and individual or smaller group sessions after lunch (see Appendix D) when most of the young people had gone to school and the house was quieter. When there were no music therapy sessions taking place, the intern used this time to prepare sessions and resources, meet with the staff or establish informal contact with new residents.

Reasons for the non-success of allocated sessions include: the young person was asleep, away from CACR (medical or legal appointments or other reasons), doing their house chores, in a CPR consultation or in a meeting with the director or social educator. Notice of absence was not passed on to the music therapist in advance.

Case Studies

The following case studies were selected based on the number of sessions attended, progress made throughout the sessions and therapeutic alliance. The two residents in the case studies had different geographic and musical backgrounds, which in itself demonstrates the diversity and varied needs of the target population.

Case Study 1 - N.M.

The following case study shows the reader the progress made by an isolated, both physically and culturally, young adolescent girl. This case study shows how MT can enhance mental health, provide alternative means of communication to create a social support system, build trust, reduce loneliness and integrate the individual into the community. There were many challenges faced and moments of regression during the internship. This case was chosen as a result of the stronger therapeutic relationship formed and high number of sessions attended.

Case description. N.M. female, 12 years old, from Azerbaijan. Documented human rights violations in Azerbaijan include: prosecution of anyone who criticises the government, political interference in the judicial system, control of the press and media in general, and torture and ill-treatment of prisoners and detainees (Human Rights Watch, 2021).

N.M., her older brother (+2 years) and parents lived in Baku, the capital of Azerbaijan. They left Azerbaijan in 2016 when N.M. was about eight years old, for political reasons. The family stayed in Armenia for a while, where her mother died. When N.M. was 10 years-old, the remaining family relocated to Sweden. For reasons unknown to the intern, her father brought N.M. to Portugal, her brother stayed in Sweden. Her father returned to Sweden and left N.M. alone in a hotel in Lisbon. It was at this point that the Portuguese authorities intervened and N.M. was taken to CACR. Her father lived in another residence of CPR and visited her almost every day.

N.M. received education in Azerbaijan, Sweden and now in Portugal. She appeared to be very intelligent, as she understood and/or spoke more than five languages: Azerbaijani, Turkish, Russian, English, Swedish and was learning Portuguese. Her hobbies included painting and drawing, studying, gymnastics and listening to music.

N.M. had an eclectic taste of music, partly because of the different cultures she had experienced and also because of her country's history. For the most part, she enjoyed pop music from Azerbaijan, Turkey, Russia, Norway, Sweden, Denmark and the USA. N.M. knew some Azerbaijani children's or patriotic songs. In Sweden she took piano lessons and learned some traditional Christmas songs.

At the beginning of the internship, N.M. had no clinical diagnosis or medical intervention. Following the intern's feedback to the staff about her more concerning behaviour such as the content of the videos she was watching (e.g. decapitations of women in Afghanistan), talking about the loss of the mother, depression and signs of self-harm, appointments with a child psychologist were organised by the social education team. No other information about these sessions was shared with the intern.

Referral to music therapy. The director of CACR recommended working individually with N.M. because it was assumed that there existed some trauma. N.M. was extremely shy, refused to eat, avoided eye contact and didn’t talk to anyone. When the other residents communicated with her, she recoiled and appeared uncomfortable and nervous. The CACR team was unable to establish a relationship to find out more about her. The urgency of the situation resulted in the beginning of the music therapy sessions in the second week of the internship.

Initial assessment phase. Through observation of N.M.’s reserved behaviour it was apparent that she was exhibiting some signs of depression, but the seriousness of her situation was still to be revealed. In an individual context, she spoke more willingly but very quietly, in

short phrases and quickly, and N.M. gradually began to reveal more of her personality and her songs.

Therapeutic plan. The intervention focused on social isolation, potential trauma and lack of communication or emotional expression. An absence of daily creative activities or a personal project to build confidence and self-esteem or explore themes of identity resulted in the following goal and objectives:

Table 6

Music therapy plan N.M. - problem 1

PROBLEM NO.1: Absence of structured leisure activities or personal projects		
Area: Behavioural-social		
Goal: Acquisition of new skills (learning the piano)		
Objectives		
Bring songs with personal meaning to learn	Work with the intern to transfer the song to the piano	Practise the piano in free time

As a result of the absence of leisure activities, N.M. had few opportunities for social interaction. N.M. rarely communicated with any other young people or staff and consequently did not socialise or express her thoughts or feelings. She had not integrated into the CACR community and was isolated. The following two objectives were defined to address this:

Table 7

Music therapy plan N.M. - problem 2

PROBLEM NO.2: Little communication of thoughts and feelings.		
Area: Communication/emotional expression		
Goal: Increase creative and emotional expression		
Objectives		
One musical improvisation per session	Express different emotions musically	Communicate verbally how she is feeling

Table 8

Music therapy plan N.M. - problem 3

PROBLEM NO.3: Isolation and refusal to socialise with residents or staff		
Area: Social		
Goal: Increase social interactions		
Objectives		
Attend one group session per week	Interact musically with others (listen and improvise with one or more residents or staff)	Increase social contact with other residents and staff

Therapeutic process. N.M. participated in 29 sessions mostly in an individual context (16) but also in group (13). English was the main language used to communicate. She

occasionally insisted on speaking Portuguese but a difficulty in communication resulted in reverting to speaking English again.

In the 1st session the main concern was to establish a therapeutic relationship, to get to know N.M. and identify therapeutic goals. It was observed that N.M. felt uncomfortable talking and so using music was the less intrusive or threatening means of communication (Choi, 2010) at this stage. N.M. had stated that she wanted to play the piano, so after sharing some songs she liked these songs were recreated on the keyboard. She didn't want, or didn't understand how to improvise, and resisted playing anything without copying the intern. It is well known that musical improvisations can provoke negative and anxious emotions in people with depression and it is easier for these clients to avoid it (Erkkilä et al., 2019) so the intern did not insist.

At the end of the 2nd session she built an Azerbaijani soldier out of paper and cardboard (using the remains of the resources of a Christmas project) without explaining her motive. It became clear that there were some issues related to her past experiences that she wanted to share, but still did not have the confidence to disclose.

In the 3rd session N.M. suggested learning a Swedish Christmas song '*Tre Pepparkaksgubbar'* and sang for the first time. While teaching this song, she was becoming comfortable around the intern, her body language was less tense and shy, the music was giving her emotional contact to a place where she was happier. She mastered the song quickly on the piano and also translated the lyrics from Swedish into English for the intern, showing off her linguistic abilities. Her skills were being valued and her self-esteem strengthened (Marsh, 2012) as she was singing alone to teach the lyrics.

N.M. participated in two group sessions in the dining room, 2nd and 4th sessions. There were many opportunities to encourage interactions between N.M. and social networks (Procter, 2018) through musical improvisation but N.M. frequently maintained eye contact with the

intern and often didn't play in the same pulse or rhythms as the rest of the group. Whether due to cultural differences or not, her playing left her out of the group, blocking the sense of togetherness and simulating her real-life experience of the social system in CACR through improvisation (Ruud, 1998).

By the 6th session, N.M. had been in CACR for three months mostly isolated with few meaningful social interactions. N.M. had previously revealed that she felt depressed so a piano improvisation representing how N.M. was feeling in the moment was attempted. This format of improvisation would support the bond between inner feeling states and verbal dialogue, support self-esteem and sharing emotions through relating experiences and improve regulation of emotions and relating with others (Trondalen & Skårderud, 2007), and is a technique used 'to connect with emotional memories and images' (Erkkilä et al., 2011). She played the piano for 10 seconds and stopped, perhaps this activity was too revealing for her and she was still not yet ready. She was in a silly mood, playing with the soft toys, making strange faces (e.g. forced smiles, manic laughter). It wasn't clear if she was trying to communicate a playful side or hide her depression. Her behaviour was confusing.

After the Christmas break, N.M. had regressed a little, but slowly began to regain her confidence over the eight sessions in January. In her 11th session (group) she had moments of musical communication with other members of the group and members of staff, interacting with others, and was beginning to create new relations (Aasgaard, 1999 as cited in Ansdell, 2002) and communicate musically with more confidence (Choi, 2010). It was necessary to clarify the difference between individual sessions where she had the full attention of the intern, and group sessions. A flexible approach to boundaries was applied (Medcalf, 2016) but it was of great importance that she did not become too reliant on the therapist or confuse the therapeutic relationship for friendship. This would support her in the third objective to increase her social interactions with others not including the intern.

In the 15th session N.M. talked about her parents' history and her childhood in Azerbaijan, shared her journey to Portugal with T. (Ghana), and then talked about the differences between their cultures. She did not recoil when T. spoke directly to her and spoke with confidence. She was making progress in the social field (problem 2).

N.M. was beginning to embrace other cultures and share music with other residents. In the 17th session she wanted to listen and dance to the music that was listened to by most of the residents (Innoss'B Ft Diamond Platnumz - *Yope Remix*, Gaz Mawete – *Kibokolo*, MHD – *Bebe*). Prior to this she had not shown any interest in listening to African music, her closer relationship with the other female residents perhaps had resulted in her being influenced into listening to different styles of music and her acceptance was a sign of her trying to fit in and form friendships (Franken et al., 2017; Rentfrow, 2012; Selfhout et al., 2009).

When N.M. started to attend school she was in the house less during the week. She was making academic progress and making friends her own age. Her mood seemed to be more positive in general, and she appeared more confident and comfortable around the house. She was more present in the group sessions and spent less time isolated. An increase in social and creative activities was having a positive effect on her mood (problem 1).

In the 20th session N.M. brought a traditional Azerbaijani children's song - *Cip Cip Cucelerim*, to learn on the piano in the dining room and wrote the lyrics to be sung by the intern (see Appendix F). With less reservation she wrote, played and sang in the dining room, correcting the intern's pronunciation and melody, providing a further boost in her self-esteem (Marsh, 2012). When some other residents wanted to join in, she didn't recoil, stop playing the song or leave. She was revealing her cultural identity (Vougioukalou et al., 2019) and was being accepted by the others. Music was building bridges (Procter 2018) between N.M. and the community in CACR. She was communicating with more residents and staff with increasing confidence.

During the three-month pause in the internship due to COVID-19 N.M. stayed mostly in her room with her two roommates, she revealed later that this period was lonely and extremely boring. Her father visited her occasionally but had to stay outside and they talked through the window in the presence of a staff member.

N.M. had previously been resistant to improvising yet as she showed an interest in art, improvisation based on an image could be a less direct way of encouraging improvisation. In the 25th session an illustration in a book was used as the basis for purpose, initially N.M. attempted to maintain her resistance to extended expressions of spontaneous music making. Eventually she improvised on the keyboard for longer periods, she was exploring (Bunt, 2012) and expressing her emotions (MacDonald & Wilson, 2014), playing descending patterns with uncertainty. Her playing and behaviour became erratic, contrasting between gentle and frustrated. Musical improvisation facilitated verbal dialogue (Orth, 2005) and she revealed that she was feeling depressed because she had not left the house in over 3 months. N.M. was communicating her feelings - progress in the emotional-communication domain (problem 2).

In July N.M. became the only female resident of CACR and was feeling more depressed because she hardly ever left the house and did not socialise. After explaining the situation to the social educator, an outing in Lisbon was organised. The intern prepared a checklist (see Appendix M) and provided a handheld Zoom recorder and headphones to record specific sounds, to be edited in future sessions into a soundscape project to increase creative activity. However due to lack of time this did not happen. A sketchbook and colouring pens were also provided as an alternative if N.M. did not feel confident or prepared to use the device to record sounds. On both outings there was a significant improvement of N.M.'s mood compared to inside CACR, she was more relaxed, less reserved, and talked and laughed a lot. She had difficulty walking for extended periods, complained of pains in her feet and legs due to the prolonged time spent inside her bedroom with minimal physical activity during the lockdown.

During the last music therapy session in the library, she played through the repertoire learnt over the year. She revealed that she had attempted self-harming by showing the faint cut marks on her arms. Together we explored the reasons she was not happy. The intern helped identify and verbalise the problem, that she was extremely bored and lonely. Again, music had assisted N.M. in exploring her emotions (Bunt, 2012) and she was subsequently able to verbally express them.

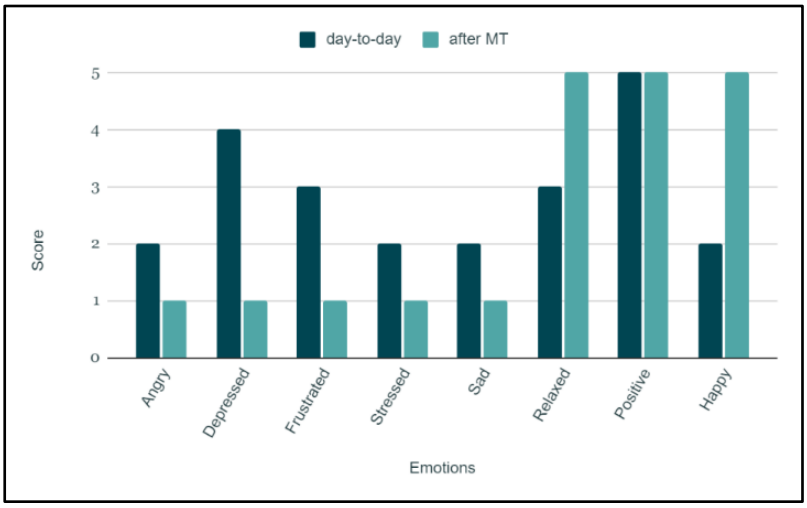
Final results and discussion. By reviewing the 29 sessions carried out over the year, it can be concluded that most objectives from the therapeutic plan were fulfilled. There were many challenges and occurrences through the year that slowed therapeutic progress. The building of the therapeutic relationship was fundamental in achieving the objectives.

There were three events that affected N.M.'s progress: the Christmas break and the two pauses due to COVID-19. After each interruption N.M. was more depressed and isolated than before. Consequently, it was more difficult to work on expressing herself creatively (problem 2) as N.M. was not as willing to share her thoughts and feelings until she felt more confident with the intern again.

The results of the Likert style questionnaire revealed that the music therapy sessions had a positive effect on N.M.'s emotions (Figure 3) and, at least during and in the short time after a session, her symptoms of depression were alleviated. N.M. always felt happy and relaxed and never felt any negative emotions during or after a music therapy session. The emotion that showed the biggest change was in feeling depressed, which changed from 'most of the time' to 'never'.

Figure 3

Average emotions day-to-day vs after music therapy session – N.M.



Curiously, N.M. stated that she always felt positive in her day-to-day life and during MT, which contradicts some of the other results and what she said about not feeling positive about the future. Either she did not understand the meaning of positive in English or Portuguese, or she is resilient and maintains a positive outlook regarding her future like many young refugees (Pieloch et al., 2016; Puvimanasinghe et al., 2015). Due to her connection with the intern, her results could have been influenced by a desire to please in stating that the sessions were extremely successful.

In the open-ended question about sharing music from her culture N.M. responded that she was embarrassed about the music from Azerbaijan and didn't share it with other residents or staff, except the intern, for fear that they might laugh at her. This issue, highlighted by Amir (2004), did not arise in the 20th session, when the intern was singing a traditional Azerbaijani song in front of the African residents. As the only resident not from Africa perhaps made acculturation more challenging as she had to not only navigate Portuguese culture, but West African culture at the same time while in the CACR. N.M. preferred individual sessions rather

than group because she had more attention from the intern, showing that her more challenging behaviours could have been a call for attention. Perhaps she also felt she was in a safe space to reveal her cultural identity.

The main concern of the director at the beginning of the internship was that N.M. was traumatised and depressed and that she would not talk to anyone about how she was feeling. Over the internship as the trust between N.M. and the intern developed, N.M. revealed some things of great concern that had to be communicated to the staff. N.M. showed the intern videos of women being executed, constructed soldiers with machine guns, talked about death and showed the intern marks on her arm from self-harm. It was unclear whether each event was a sign of trauma (or PTSD), depression, or a call for attention.

Free improvisation activities should have been attempted more often as a way of allowing N.M. to connect with her emotions and allow for transferences and creative imagery (Erkkilä et al., 2011). Signs of resistance from N.M. were read as warning signs and perhaps a more assertive stance from the intern would have borne results. There was always a risk someone would enter the therapy room and her hesitance was understandable.

It was communicated to the intern that the uncertainty of her future was a contributing factor to her depression. Her worries included when she would be able to leave the CACR and live with her father, and whether she would stay in Portugal or return to Sweden or move to a different country altogether. Had the music therapy intervention continued this would be a vital area on which to focus. N.M. was beginning to communicate her worries and feelings to other members of staff as well as the intern.

On reflection, N.M. should have been better prepared for the termination of internship and music therapy intervention. It was difficult to ensure that N.M. didn't become too reliant on the intern for support in social situations and was integrated into the community with confidence to socialise. It was clear when informed of the intern's last day that she was upset

and unprepared for the end of the intervention, and this could have been managed better. The unpredictability of the intern's schedule during this phase of the intervention made this difficult.

Case Study 2 - D.F.

The following case study was selected to show the flexibility of CoMT to adapt to a community, and as a contrast to Case Study 1. It shows the linguistic and cultural barriers which were overcome using music as a form of communication to build a therapeutic alliance. As well as improving inter-personal communication and exploration of self-identity, music therapy was used to reduce maladjusted behaviours. The route to therapy began through group sessions where a connection was made and a personal project developed through building trust and understanding, resulting in the organisation of individual sessions.

Case description. D.F. was born 2003 in Bissau, the capital city of Guinea-Bissau, and had documentation. Almost nothing was known about the history of D.F.'s life or why or how he was in Portugal or his legal status. His mother tongue was Creole, but he also spoke Portuguese well (compared to the other residents from Guinea-Bissau).

Guinea-Bissau is one of the smallest and poorest African nations, with a large foreign debt and an economy reliant on foreign aid (BBC News, 2020a). The judicial system is highly dysfunctional and allows for corruption (UN, 2015) and human-trafficking, particularly of children (Human Rights Watch, 2010). The country is exploited by cocaine traffickers from Latin countries as a gateway to Europe (Shaw & Gomes, 2020).

Unlike the majority of the CACR population, D.F. received schooling in his home country. Finding a vacancy in the 9th grade of a suitable school in Lisbon was slow and prolonged due to the need to be fully vaccinated. Just before COVID-19, he was finally enrolled in a school, but sometimes skipped classes. The staff were unsuccessful in their attempts to encourage him. D.F. had no clinical diagnosis or prescriptions.

In terms of musical experience, D.F. revealed that he played drums in Guinea-Bissau, in what context or for how long was unknown. His hobbies included football and listening to music. He did not reveal his religious beliefs, he was not seen praying at the CACR with other Muslim residents and did not discuss this subject with other young people or the intern.

Referral to music therapy. The director suggested working with D.F. because of his behaviour. Although 16 years old, he was immature and hyperactive. He was often extremely loud and boisterous and seemed as if he had not changed since his arrival at CACR. His interest in music and previous experience was a motivation for him to begin sessions.

Initial assessment phase. What was known about D.F. was based on his behaviour at CACR. Observing D.F. interacting with other young people it seemed that in general he was liked and made the others laugh, although the intern did not understand Creole. However he sometimes irritated the other residents with his energetic behaviour. He did not show any signs of anxiety or discomfort that were culturally recognised. When not playing or joking with his peers D.F. was observed spending a lot of time alone on the sofa using his mobile phone and tablet simultaneously and seemed bored because he had nothing else to do. Despite this he showed some resistance in joining in group activities - whether it was a result of teenage apathy, depression, social anxiety or a lack of interest was unknown. Attempts to start conversations resulted in short responses as if to hurry the conversation or there were misunderstandings. Throughout the first few months the only way of communicating was through musical improvisation.

Therapeutic plan. The objectives focused on self-identity, reducing social isolation, community integration and reduction of maladapted behaviours. D.F. was observed in CACR with little structured activity in his daily routine - this resulted in minimal verbal interaction with staff and residents. For the same reasons, not much was known about D.F. and verbal communication remained challenging. The third problem and sub-objectives below were

defined in response to the more challenging behaviours such as hyperactivity displayed by D.F. in CACR. Although D.F. did not have a clinical diagnosis, the co-morbidity of Attention Deficit Hyperactivity Disorder (ADHD) with depression, anxiety or negative behavioural effects such as substance abuse or criminal activity might result in a decrease in professional opportunities, highlighting the importance of focusing in this area. His behaviour at times seemed a result of being bored and having little responsibility. Facilitating a project chosen by D.F. would aid in attaining organisational skills and the expected skills from the RAISE model (Estoura & Roberto, 2019) such as to mobilise resources to increase his self-esteem and to encourage creativity. This would assist D.F. in improving social interactions, attain useful life skills as well as facilitate the process of acculturation.

Table 9

Music therapy plan D.F. - problem 1

PROBLEM NO.1: Little participation in structured/leisure activities		
Area: Social adaptation		
Goal: Increase participation and interest in new activities and in-person social interactions within CACR		
Objectives		
Attend one group session per week	Participate in sessions without use of mobile phone or tablet	Practise the drums in free time

Table 10

Music therapy plan D.F. - problem 2

PROBLEM NO.2: Lack of communication or knowledge about D.F.'s personality or culture		
Area: Social and Emotional (identity)		
Goals: Increase communication related to aspects of cultural and personal identity		
Objectives		
Bring songs with personal or cultural meaning to sessions	Play, sing or teach these songs to the group	Communicate verbally or musically how he is feeling today

Table 11

Music therapy plan D.F. - problem 3

PROBLEM NO.3: Displaying immature behaviours		
Area: Behavioural social		
Goals: Increase activities that promote focus and self-organisation		
Objectives		
Focus continuously on the musical activity for 10 minutes, gradually increasing time every fortnight	Create a personal project to focus attention	Write lyrics or do music research in free time

Therapeutic process. Over the 12 sessions in which D.F. participated he used musical experiences to explore, reveal and communicate his personal and cultural identity and interests,

integrate into the CACR community and develop a personal project. This progress can be divided simply into three phases: exploration, discovery and integration. Details of these will be described below.

During the exploration phase, sessions 1-3, D.F. participated in group sessions, with a minimum of 5 other participants. He explored all the instruments with ease and showed an interest in the reco-reco in the form of a frog. When playing it, he seemed childish and laughed when it made the same sound as a frog, perhaps a funny memory from his childhood (Erkkilä et al., 2019). When improvising he continually changed between percussion instruments, playing fast tempos and African rhythms throughout, until he settled on his preferred instruments: djembe and cajon. D.F. was exploring his cultural identity through his rhythm patterns and instrument choice (Baker & Jones, 2005). He clearly had more experience and confidence playing the drums than the others and his playing was difficult for others to keep up with, but he maintained a steady beat and didn't interact verbally with other group members. D.F.'s ability to sustain a steady beat suggested that he was not impulsive or had ADHD (Rickson, 2006). He would become bored and restless if the music didn't sound very good, music he liked was the key to maintaining his focus. D.F. seemed to be the gathering element in the group.

D.F.'s more advanced drumming abilities habitually made him the centre of attention or the leader of the group. In the discovery phase, the group began to learn a bit more about D.F. in his improvisations. This strengthened his identity and had a positive impact on his well-being (Miranda, 2013; Marsh, 2012; Ruud, 1998). In the 4th session he played his favourite music (Djidji de Malaika – singer from Guinea-Bissau) and the group played along while he also taught them the songs which were similar to his playing style - fast. The intern began to associate aspects of his behaviour and musical playing style as cultural differences (Valentino, 2006) and not as maladjusted behaviours. Through improvisation on the djembes, mainly using

call and response D.F. was able to simulate real-life social situations (Ruud, 1998) when he communicated musically with another resident that he wasn't normally seen talking to K. (Senegal – did not speak Creole or Portuguese). D.F.'s social skills were being enhanced (Marsh, 2012) through music.

As well as the group discovering more about D.F., he was also discovering new instruments and modes of expressing himself, which would lead into the development of his personal project. In the 5th session D.F. discovered the drum beat machine on the keyboards while improvising with A.D. (Guinea-Conakry). The length of time that D.F. was able to focus on the music increased every session, his behaviour was stabilising (Baker & Jones, 2005).

A change in behaviour could be seen in D.F. by the 8th and 9th session. He had been allocated a place at a school and was more relaxed and slightly more confident in himself. He played an integral role in the group session in the morning by holding the music together playing the cajon. He did not lead the group but was encouraged to play by other group members, he only left the session when his hands hurt and couldn't play anymore. Reflecting on D.F.'s role from a group dynamics perspective he had moved from a *cautionary* role - more reserved behaviour, individually exploring instruments with little commitment or patience for the group, to a *sociable* role - aware of the relations in the group but playing in his own style that didn't always match the emotion of other group members (Rutan, 2001).

In the afternoon D.F. attended his first individual session in the library that included the first extended verbal exchanges with the intern. He was becoming more verbally communicative, instigating conversation and showing interest in different topics - despite the language difficulties a connection was formed. It was in this session that the inspiration for his personal project originated - from this point he always confirmed with the intern when the microphone would be available again. Unfortunately, at this pivotal moment in the therapeutic process there was the 3-month pause due to COVID-19.

During the 3-month interruption it is understood that D.F. spent most of the time on his phone and tablet, as there was little else to do in the CACR. Later he described this time as boring.

The period after the first lockdown can be defined as the integration phase. D.F. was in general calmer and displaying less immature behaviour. In the 10th session after a prolonged period improvising on the djembe in group, he began sharing music from his cultural identity with other residents and staff. In between playing the djembe for the group he explained the different types of drum used by comparing with the djembes in the CACR "*tipo isto mas mais grande…*" ("like this one but bigger") and how they are played. As highlighted by Marsh (2012) teaching aspects of his musical culture enhanced D.F.'s social skills and recognition by others. He was showing more initiative and leadership within the group by signalling when the rhythm changed and demonstrating how to play, it was in this session that he moved from *sociable* to *structural* role, showing leadership skills (Rutan, 2001).

D.F. had written lyrics during the 3-week pause in July and arranged a future date to record. This project had made him more organised and motivated. His lyrics were in Creole about political corruption in Guinea-Bissau, which he explained in more detail after the session giving the intern some cultural context. In the two recording sessions he acted more maturely and was extremely focused. Residents and staff who listened were impressed with D.F.'s musical skills, he had been able to carve his identity (Ruud,1998), was validated by the group, proud of himself (Jones et al., 2004) and his self-esteem reinforced (Marsh, 2012). The intern visited the CACR in October and D.F. revealed that he had written three more songs and wanted to organise a day for the intern to return to record them.

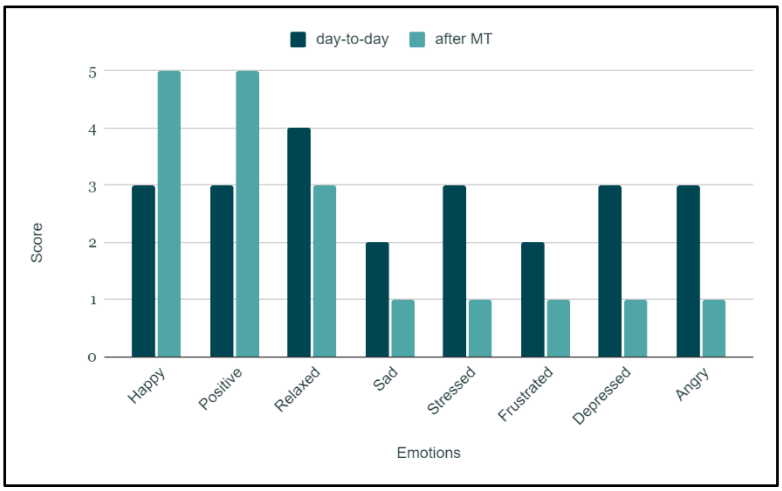
Final results and discussion. From the continuous informal observation and a review of D.F's 12 sessions it was clear that there had been success in reaching the first and second goals of increasing participation in creative activities and communication of cultural and

personal identity. Two major challenges confronted the intern in this case: the language barrier and the inconsistency of the sessions – just at a point where the therapeutic relationship was beginning to develop and progress was being made there were two breaks in the internship due to COVID-19.

The results from the Likert style question in the questionnaire (Figure 4) revealed that music therapy had a positive effect on D.F.'s emotions, reducing negative emotions and increasing positive emotions by 2 points. It also revealed that D.F. sometimes felt stressed, depressed and angry in the CACR. From informal observation this was not obvious. His results showed that music therapy made him less relaxed, it could be interpreted that music made him stimulated or motivated as he did not show signs of agitation or distress.

Figure 4

Average emotions day-to-day vs after music therapy session – D.F.



In response to the open-end questions in the questionnaire, D.F. stated that he did not get to know the other residents better during MT sessions as they knew each other well already. Despite this, the sharing of his music was beneficial for D.F. to contact his home culture, to validate his cultural identity (Lenette et al., 2016,) and to target homesickness and loneliness

(Kim, 2013). It also benefitted the intern, staff and residents in meeting and accepting D.F. into the group (Marsh, 2012; Abdulbaki & Berger, 2019). D.F.'s favourite artist Djidji da Malaika conveyed political messages in his music, and the reactions of the other residents from Guinea-Bissau was observed in case there was resistance (Amir, 2004).

It was important to reduce the time D.F. spent on his mobile phone or tablet, and in maintaining his focus on creative tasks. The need for technology to play music, show videos or as a translator meant that this challenge was always present, however D.F began to manage his usage during music therapy sessions.

By the end of the internship D.F. was able to maintain conversation appropriate for his age and showed interest in others by asking questions, was less isolated and more integrated into the community. His undesirable hyperactive behaviours had reduced (at least when the intern was present) and he was showing more maturity around others. From his participation in music therapy sessions D.F. was recognised, accepted and able to gain respect amongst his peers and the staff, who perhaps had not appreciated his creative potential. His peers would encourage him to participate as they enjoyed his style of drumming and would complement his playing regularly. Two members of staff were pleasantly surprised upon hearing the song he had recorded and did not know that he could write lyrics and sing. It is difficult to know how much the music therapy intervention contributed as other factors such as starting school, growing older, and settling into life in CACR and Portugal would have helped his progress in this area.

Other interventions

Including the two case studies mentioned, at least 35 young people and eight staff participated in music therapy sessions during the internship. The principal objective of the group sessions was the creation of a sense of belonging and togetherness within the CACR. A total of 39 open group sessions took place with a different combination of residents and staff taking part every session. A brief description of the open group sessions as well as some significant individual cases follow.

Open group sessions

Despite the lack of continuity from session to session, the group sessions developed by adapting them and integrating them into the CACR community. This can be described in three phases: observation, exploration and integration. Observation involved getting to know the individuals and community by learning about their relationships, needs and different cultures. Exploration was related to trial and error of setting, activity and adapting the sessions to the needs of the group. Finally when the group sessions had been established as part of the CACR routine and community the integration phase was reached. These will be described below in more detail with examples from specific sessions.

In the first phase of intervention, free improvisation gave the intern an opportunity to observe the interactions between participants, personal and cultural musical styles and plan future sessions (setting, group size, instruments etc.) to involve and mobilize all residents. Sessions took place in the library and small office which were unfortunately not suitable for the purpose and inconvenienced the office staff. There were few musical instruments available in the first sessions and the improvisations generally sounded dislocated with an unidentifiable pulse or beat, indicating the need to strengthen, unify and construct the sense of community. Most young people would play individually at the same time while some had more internalised rhythm and would play a leading role in the music. The arrival of new musical instruments in

December 2019, including some large percussion instruments that they could identify with (Baker & Jones, 2005), assisted in gaining more interest from the young people in the music therapy intervention.

The next phase, exploration, began in December around the 8th session. The new instruments sounded better, encouraged prolonged improvisations and invited more residents to experiment. The sessions were beginning to fall into a routine as part of the CACR day. Enforcing or directing musical activities was unsuccessful and ignored so the sessions were directed by the residents and their needs and interests. Spontaneous group sessions would develop for example, in the 14th group session, T. (Ghana) and D.F. (Guinea-Bissau) requested to play the electronic drum sounds on the keyboard. They were not usually seen socialising in CACR but they connected in their music. The residents showed interest in electronic music, and the intern began to bring the computer, MIDI controller and microphone to future sessions to accommodate this. Throughout the internship the intern wanted to arrange a karaoke machine or speaker with a microphone to encourage the residents to sing, however this did not materialise for financial reasons.

Continuous observation and conversation with A. (auxiliary) supported the research literature describing the power of incidental music to create a trance-like state and disperse stress (Nzewi, 2002) in traditional African communities. The extending lengths of musical improvisations in the group sessions were beginning to have a positive effect on the group psyche (Nzewi, 2002) with regard to alleviating stress, promoting cultural identity and integration into the community. For example in the 24th session an average of five residents played musical instruments for over an hour in one continuous improvisation. D.F. sang a two bar rhythm that had an offbeat African feel "*baaaa.. ba ba ba*" (sic) that was replicated by the intern and other participants. Other residents and staff stopped to listen, showed curiosity or

danced, involving a lot of participants in the act of *musicking*. The music was energetic and loud and created an animated atmosphere in the room.

Exploration of setting due to noise complaints from the kitchen staff meant that the instruments were set up in the outside space for the 26th session. There were a lot of young people present in the outside space, some socialising and some playing basketball – the session was difficult for the intern to control and musical production was minimal. The change of setting, while not safe, predictable or functional, generated broad group experiences as part of day-to-day life, and there were moments of cultural identity sharing and musical communication using the djembes.

The 26th to 27th sessions signalled the beginning of the phase of integration. The routine and predictability of the sessions had encouraged regular participants and a stronger sense of community. This change was observed in a notable group improvisation with five residents and A. (Gambia), who was invited to play by B.C. while waiting for the services of CPR. The music was heavily djembe based and a strong, energetic and unified rhythm developed. The young people (I.S.S., S., B.C.) began to sing '*Paranaué, Parana*' - the lyrics from the chorus of a Brazilian capoeira song *Paranué*, which in the moment was misunderstood as a song of African origin from one of the members' hometowns. Some dropped their instruments and started to clap, dance, scream or sing louder. Staff and residents passing by stopped to listen or dance or join in briefly. When the music stopped the group cheered, laughed and clapped and the mood was relaxed. The participants of this session attended music therapy sessions more frequently and would often remind the intern of this session as a result of the improvisation showing the positive effect the music had on their emotions.

As previously mentioned, the group sessions did not return to the same dynamic after the COVID-19 interruption. They involved more talking with the residents, seeing how they were and how they had coped during the three-month lockdown.

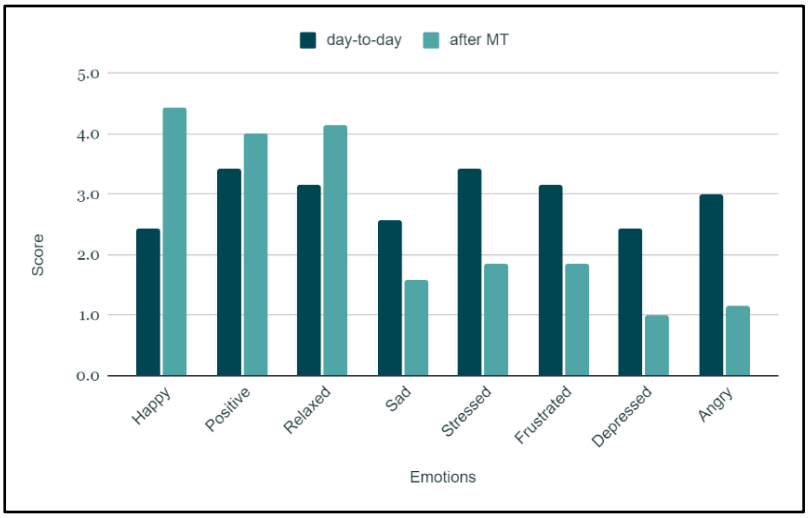
The 34th session focused on the music, culture, client's self and society (Kim & Whitehead-Pleaux, 2015). It was attended by B. (Senegal), B.C. (Gambia), V. (Auxiliary) and D.F. (Guinea-Bissau) as well as others that passed by. Playing together the group felt unified by the music, after each improvisation conversation about the various cultures and musical styles promoted their individual cultural identity. The group members encouraged the others to play or suggested different rhythms or themes, there was an increase in verbal dialogue between participants and they were recognising the culture and personality of the others. The presence of a staff member strengthened the link between members of the institution and their relations.

Final results and discussion. Some group sessions appeared to have succeeded in creating and strengthening a sense of community and belonging, but others seemed to lack direction. With time the residents habituated themselves to the routine and activities and trust was strengthened. There were many examples of participants spontaneously enacting their cultural identity, which provided the intern and others with alternative insight into the personality and culture of each resident. The aim of creating a safe space to express emotions was challenging due to the setting available, and this objective was not clearly met. Some residents were able to share this individually with the intern, but few did so within the group.

The questionnaire at the end of the internship (Figure 5) showed that group and individual sessions increased positive emotions and decreased negative emotions particularly of stress, depression and anger. This could be observed at the end of each session where residents seemed more relaxed, talkative and content, and was reflected in the log book and in feedback from staff.

Figure 5

Average emotions day-to-day vs after music therapy



Figures 6 and 7 show that the young people felt approximately 25% more positive, or 25% less negative, after the music therapy intervention.

Figure 6

Positive emotions vs negative emotions – day-to-day

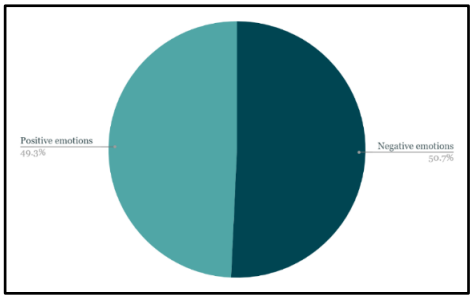
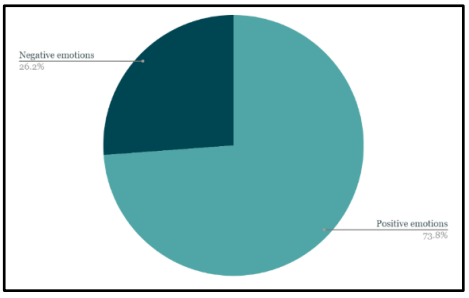


Figure 7

Positive emotions vs negative emotions – after music therapy



Reduction in negative feelings such as stress and depression enabled the young people to adapt to life in Portugal more easily by facilitating education and strengthening cultural and personal identity. The process of acculturation was less challenging when young people were

not depressed, stressed or socially isolated. The group sessions provided an opportunity to socialise without a common language allowing the more isolated young people to create new friendships and establish social networks (Batt-Rawden, 2010).

Musicking constituted the base of all activities in CACR. The main activity was free improvisation using a range of percussion and melody instruments as language barriers made it difficult to suggest specific improvisation-based activities. Music listening was also used as a stimulus for improvisational themes or ideas - it allowed residents who were less willing to play instruments to participate and build their confidence, taking part in more active techniques and enabling them to share parts of their identity and culture with others. The act of *musicking* establishes relations (Small, 1998), strengthens the spirit of community within the institution (Aasgaard, 1999, as cited in Ansdell, 2002) and considering almost all residents were African, was a familiar activity used for health promotion (Ansdell, 2002; Stige, 2002). It had a beneficial effect on the well-being of the community, as well as the emotional effects shown in Figure 6 and Figure 7. The residents were able to form new, maintain and strengthen relations between themselves, the intern and the staff. The spirit of community seemed stronger and an improved mood led to better behaviour and a more relaxed atmosphere around the house.

The preferred activities mentioned by the residents in the end of internship questionnaire were playing the drums, keyboard, djembes and drum machine on the keyboard, learning songs, writing lyrics and recording them, singing, listening to the sessions and making djembes. Two out of seven stated they preferred group sessions because “it’s better to play and sing in a group” (sic) and “I like being with my friends” (sic). Four stated that they did not get to know any of the other residents during music therapy as they already knew everybody well. The residents had trouble remembering the music therapy process and whether they had shared or experienced music from other residents’ cultures. This was understandably due to the time frame and interruptions.

One benefit of the group sessions was that they enabled the intern to build a therapeutic relationship with the young people and set individual targets within the group. Participants D.F., A.D. and B.C., for example, began participating in group sessions before feeling more confident to participate in individual sessions. The group sessions served as a less intrusive way for the intern and residents to meet each other and to make the bridge between the community and individual Ansdell (2002). Many of the individual cases described would have been more challenging without a group intervention.

The open session format in a communal space made boundary setting challenging - participants would enter and leave as they pleased. By January the intern had got to know most of the young people and their different cultures and was aware which young people wanted to participate. It was necessary for the intern to adapt from a more Western approach to be flexible to this style of open group to make progress in the intervention. After the first interruption due to COVID-19 the residents of Bobadela were prohibited from entering CACR and the population of CACR did not change much, although the pandemic was detrimental to the therapeutic progress, the stabilising of the population allowed the intern to focus on individual needs more easily.

There were many communication difficulties in the multilingual community, which inhibited giving extended instructions for activities. Verbal exchanges were difficult and the intern misunderstood behaviours. For example one participant sang what was thought to be a traditional song in Fula, but another participant explained that he was singing about "*uma rapariga bonita*" (sic) (a beautiful girl). Several Fula speaking residents began laughing and the intern did not know if he was being inappropriate.

More time and less COVID-19 would have been needed to achieve more consistent participation and thus make more progress. A suitable space to provide a safe and predictable setting would have made the sessions more manageable for the intern. Specific techniques such

as improvisations based on emotions, stories, images or specific themes, were planned and developed to meet the needs of the residents. For example improvising a particular emotion or a story of a journey, this could have provided the residents to explore different emotions or memories in a creative way. The open session format and unpredictability of participants inhibited the residents from sharing their personal feelings, thoughts and fears. In future work, it would be advantageous to develop methods and activities that do not require verbal instructions to vary the sessions and begin to focus on the themes mentioned. Encouraging participation of all members of staff, including those in the offices of CPR, would help to strengthen and widen the community while also integrating them into community life.

Individual cases

Individual cases mostly drawn from the group sessions are presented below. Where the language of a resident is presented this is as understood by the intern - some residents spoke or understood a number of regional dialects. The aim is to briefly describe the young person, their participation in music therapy and their therapeutic progress.

Case 3 - B.C. Male, born 2003 in the Gambia, took part in 14 music therapy sessions, mainly in a group. B.C. spoke Fula, Mandinka, English, Spanish and Portuguese. His oppositional behaviour was mentioned in the logbook, as well as his undefined psychological problems and insomnia. He was referred to a psychologist and was prescribed medication to help him sleep. B.C. had a negative outlook on life in Portugal and blamed his problems on the director of CACR.

B.C. was very creative and often acted as leader of group sessions. When playing the djembe, he would often play the same rhythm in the same tempo and volume making other participants adapt their playing to fit in with his tempo. Over time he built his technical abilities and would play a variety of instruments and different rhythms improving his musical communication (Ruud, 1998) and interaction with others (MacDonald & Wilson, 2014).

B.C. would describe his negative thoughts as "something is not right in my head" (sic), an example of the cultural differences in mental health (Puvimanasinghe et al., 2015), but did not expand on this. Through creative activities a therapeutic relationship was developed, B.C. expressed his frustrations and began to integrate into the CACR community. V. (auxiliary) commented at the end of the internship that since he began participating in music therapy his overall behaviour had improved, he seemed calmer and was more compliant in the house and had less altercations with members of staff. Communication difficulties as well as his insomnia, which affected his participation in sessions, impeded further progress in music therapy. He ran away from the CACR in September 2020 and left Portugal.

Case 4 - A.D., male, born 2003 in Conakry, Guinea-Conakry, participated in 9 music therapy sessions, 6 in group and 3 individually. A.D. spoke Fula, French and Portuguese. In the first informal conversation with A.D. he spoke of the violence and political corruption he had witnessed in Conakry. He also mentioned drugs and stated that he smoked marijuana. He showed a photo of himself in a recording studio and was interested in music therapy.

His name was mentioned frequently in the logbook in his first few months in the CACR due to negative behaviours such as smoking on the premises and in the park, not sleeping in the house and aggressive/intimidating behaviours towards staff or residents. In passing, the intern always greeted A.D. and tried to build a connection in the hope that he might begin to attend music therapy sessions. At the end of the internship, he referred to these conversations and stated that the intern was the only person that took the time to talk to him and he learnt a lot about music and other cultures as well as having the opportunity to share his own.

In his first session he improvised on the piano for 30 minutes with another resident. He appeared almost in a trance-like state, playing a consistent rhythm on the piano. As mentioned by Mereni (1996), music is used in Africa to alter states of consciousness for psychological transformation. From this point he participated more frequently in group sessions. A.D.

recorded 5 original songs in French and Fula (one about corruption in Guinea Conakry) and sometimes improvised raps in Portuguese. One of his dreams was to be a musician (rapper).

During music therapy sessions he did not show signs of aggression or intimidation to other residents. His name was mentioned less in the logbook and he seemed calmer, he was considered capable of self-autonomy and moved into his own accommodation. Other staff members commented on his improved behaviour inside the house, that he was more mature, less aggressive and more polite towards staff and residents.

Case 5 – D. female, born 2003 in the R.D. de Congo, victim of human trafficking and torture. D. spoke French, Lingala and Portuguese. D.'s favourite music was Angolan Christian music as well as pop music from the Congo, and she liked to sing and play the piano. In the two individual sessions she improvised on the piano over the intern's accompaniment (chords I-VI-IV-V). During a 10-minute improvisation she explored emotions musically and the intern saw potential to create therapeutic goals for future sessions to work with emotions and memories. Few sessions took place as she was busy at school and often went out at the weekend. During the three-month COVID-19 lockdown she ran away, most likely due to the restrictive measures put in place at this time.

Case 5 – S. female, born 2000, Ethiopia, victim of human trafficking and torture. She spoke Amharic, Portuguese, Italian and a little Arabic. Staff mentioned that her behaviour when she first arrived was challenging and that she had calmed down a lot over the 3 years she had been living in CACR. S. showed an interest in the ukulele and wanted to learn the piano. She struggled to maintain a steady rhythm, had poor fine motor skills and coordination. It was not possible to build a therapeutic connection or make therapeutic progress. She had a busy schedule at school and found mastering any of the instruments a challenge so lost interest in music therapy and stopped attending.

Case 6 – N. female, born 2002, from Angola participated in five individual sessions. She spoke Portuguese. Nothing is known about N.'s personal history. She showed interest in learning the ukulele and wanted to sing and play at the same time, which was challenging for her and eventually she became frustrated in being unable to master this skill. N. listened mostly to Brazilian Gospel music as well as the other songs popular within the CACR. The last song that she brought to a session was a Brazilian pop song, '*Hey Pai*' by Isadora Pompeo, it would have been interesting to learn more about N.'s family through this song. She learnt the chords and would practise the ukulele in her free time. She began an internship which resulted in the termination of the music therapy intervention.

With the exception of N.M., it was more difficult to establish a therapeutic relationship with the female residents of the CACR. Reasons for this might have included: cultural and linguistic differences, too few sessions or lack of understanding of their past including traumatic experiences. With more time and persistence to have them attend music therapy sessions it might have been possible to establish a therapeutic relationship, work towards individual objectives and see therapeutic progress.

Case 7 – B. and K. Two male residents with whom it was difficult to communicate and establish a therapeutic relationship were from Senegal: B. and K., both born 2002, nothing was known about their past. They came from the same region of Senegal and spoke Wolof, Fula, French and basic Portuguese. Other West African residents commented that the Senegalese are well known for their musical abilities. K. came to three sessions in the initial phase of intervention in January, then no more until the arts project in June. In the group sessions attended he shared two songs in Wolof about family and played the djembes. In the last session he attended it appeared that he was the victim of bullying from some of the Gambian residents, possibly a reason that he did not continue to attend. The language differences made it difficult to establish a safe space.

B. participated in more group sessions than K., two before COVID-19 and three after. He shared his favourite music, pop and traditional Senegalese artists in listening sessions and demonstrated his cultural identity on the djembes. B. also liked to improvise alone on the piano. When improvising on the djembes he often seemed irritated when the intern played with him, as if the intern was playing out of time causing a detrimental effect on the therapeutic relationship (Valentino, 2006). As he often seemed pleased to see the intern it was difficult to decipher his behaviour. He did not communicate verbally to express what was bothering him, increasing his communication through music would have been beneficial if the intervention had continued.

Case 8 – F. The youngest resident, F., a boy from Angola, supposedly 11 years old but potentially younger, was a victim of human trafficking. He spoke Portuguese and Lingala. He participated in four group sessions. F. was extremely thin and small with a slight gait imbalance and one arm that was significantly weaker than the other. F. loved music and was often seen singing and dancing alone. F. stated that he sang at church in Angola and liked other Afro-dance/pop. In the few sessions in which he participated the intern tried to gain his attention through drumming and communicate with him musically, for example using imitation and call and response techniques. This elicited a reaction from F. such as eye contact or a smile. He tired quickly when playing the drums and could only use one hand - more easily with a beater. He presented many ideas for improvisation and reacted happily when others imitated or joined him in playing, he integrated easily into the group musically. He had a limited ability to sustain attention on one activity for an extended time. Unfortunately the opportunity to work with F. ended abruptly when he was transferred to a different foster home with children of similar ages.

Case 9 - I.S.S. male, born 2002, from Guinea-Bissau, participated in four sessions, three in group and one individual. I.S.S. spoke Creole and Portuguese. I.S.S. was socially isolated, agitated for reasons unknown to the intern and displayed aggressive outbursts towards

his peers. He had difficulties communicating and understanding others. It seemed as though the other residents avoided him, perhaps due to his eccentric, unpredictable and reactive behaviour. Despite the communication difficulties between I.S.S. and intern, with persistent encouragement to join a music therapy session, he became an important member of the group sessions.

Inspired by other residents I.S.S. wrote rap lyrics in Creole. He had difficulty focusing and his handwriting was difficult to understand (see Appendix H) so the intern was unable to assist. He did not record his lyrics as he never finished them. He improvised on the djembes, sang and would encourage others to sing and join in as he liked to create a positive atmosphere in the group. Participating in music therapy sessions allowed him to communicate and share other dimensions of his personality and identity with others. It seemed that over time I.S.S. became less aggressive and had less altercations with his peers, although his eccentricities did not change. With more sessions and further along in the process of acculturation perhaps a bigger change in I.S.S.'s behaviour would have been observable.

Case 10 – S. and L. both born 2002, male, from The Gambia. L. and S. both spoke English well which facilitated verbal communication, S. speaks Fula and L. Mandinka, S. was more fluent than L. in Portuguese as he arrived earlier. S. participated in many sessions although he stated that he did not feel confident playing instruments and would often talk or preferred to paint.

L. was a keen footballer and part of a team based in Lisbon. His goal in life was to become a professional footballer but a lack of documentation complicated his hopes. Occasionally L. would sit in a group session with the ukulele but rarely play, sometimes he would dance. Although less active musically he would verbally share his frustrations with the intern and appreciated someone listening to him. Interestingly, at the end of the internship questionnaire he stated that he liked listening in on the music therapy sessions as they brought

back memories and images of home and he was able to feel different emotions. The intern was not aware of this effect at the time. Through the act of *musicking* S. and L. participated in sessions (listening and dancing). Without playing instruments they were able to verbally or artistically act their cultural identity, express emotions, decrease feelings of stress and frustration and integrate into the community.

Other activities in addition to music were used in an effort to integrate the participants, strengthen their sense of the community, involving and mobilising all residents.

Other activities

In addition to the music therapy sessions described above, the intern organised and participated in other activities to supplement the creative activities in CACR, adapting these to the changing needs of the young people and herself becoming a more integral part of the community.

In the initial phase of the internship a Christmas art project (to make an elf) was proposed and organised by another intern. The project's aim was to win tickets for the residents to a Christmas themed fun park "*Capital do Natal*" in Alges, Oeiras. The intern volunteered assistance to the young people taking part - this assisted in meeting the residents.

In January the intern decided to begin to construct a wall display in the library to exhibit photos and art works from the sessions as a visual representation to promote music therapy for residents, staff, new arrivals and visitors. The residents' paintings and artwork as well as some photos were displayed.

On three occasions painting was used with music listening. Music listening to songs selected by various young people increased social interaction, distracted from negative mood and provided an opportunity for the young people to demonstrate their cultural identities while promoting community cohesion. As noted by Ansdell (2002) the aims of community music therapy are to take the client from therapy to the community, using all resources necessary,

including the use of other musicians or other disciplines or modalities. Painting provided an additional outlet for the young people to express themselves and appealed to the residents who felt that they were 'less talented' musically or for religious reasons avoided playing instruments. A large piece of paper was set up in the dining room or pinned to the wall outside (see Appendix J). Watercolours, paint brushes of different sizes and a speaker and phone were connected by Bluetooth on which the young people were free to select their music - sharing of resources and taking turns when deciding which song to listen to improved socialisation skills. In individual cases the intern painted in collaboration with the young person with the aim of creating or strengthening the therapeutic bond.

One Saturday afternoon on 15th February 2020 a group of about ten young volunteers participated in a music therapy session (see Appendix I). They came every month or two to run a range of activities with the young people. The volunteers were made up of mainly Portuguese nationals and they taught the traditional songs and dances such as "*Ó malhão malhão*", listened to the residents singing, took part in open musical improvisations and dancing. The session promoted acculturation through learning of traditional Portuguese music and created new relationships between the residents, staff and volunteers. The residents appeared less stressed or frustrated, some had enacted their cultural identity for the volunteers and it had promoted a wider community cohesion.

In addition to painting, on 25th June the intern prepared an afternoon of arts and crafts in the form of 'djembe making', the intention being to also leave more instruments in the house once the internship had finished. Resources provided included plastic buckets, adhesive paper in different colours, duct tape and electrical tape in different colours, bells, ribbons, stickers and diamantes. Resources were set up outside under a tree where the young people were congregating, along with a Bluetooth speaker and phone for the young people to select their music. The majority of the male population in the house participated that day, including some

who had previously never shown an interest in music therapy. The young people worked together (assisting with the materials, creative direction, cutting and sticking) to produce 7 'djembes' which they had pride in once finished (see Appendix K). V.R., the Social Educator, noted in the logbook that day "*hoje o dia foi muito tranquilo e no geral os jovens estiveram tranquilos e cumpridores e com um melhor comportamento*." (see Appendix L). Translation: "Today the day was very tranquil and in general the young people were calm and compliant and behaved better". This sense of calmness and belonging could be a result of working creatively as a group to create a product.

As well as combining music with art, during the final phase of the internship the intern organised outings with case study 1 in Lisbon – however these only actually took place twice. The intern understood that individual music therapy sessions inside the house would not relieve symptoms of depression, so it was necessary to leave the institution/environment to experience something different. The trips were considered a success in alleviating the negative mood of N.M. and it was unfortunate that the circumstances were not favourable (time limit/COVID-19) to allow them to occur more regularly and frequently. With more time the soundscape project could have been followed through and turned into a mini project for N.M. and developed for use with other residents.

Conclusion

The research literature shows that music therapy intervention with refugee populations is effective in the emotional and social domains, the results from this internship support it. The Likert style questionnaire revealed a 25% positive change in emotions, and the atmosphere in the house was observably lighter after a music therapy session. Feelings of depression, stress and anxiety can negatively affect the process of acculturation or signal the development of late-onset PTSD - for this reason it was seen as beneficial to intervene in these areas instead of focusing on trauma.

Verbal and written feedback from the staff indicated that the music therapy intervention was able to reduce some undesirable behaviours and improve social cohesion. It is difficult to determine to what extent the music therapy played a role as other factors in the residents' lives also would have contributed. Nevertheless, a frequent opportunity to build social capital, express emotions and strengthen identity through music supported the changes in the residents' lives.

There were many opportunities throughout the internship to celebrate diversity and promote multiculturalism. Musical improvisation and listening allowed the intern and other participants to gain insight into the cultural context of other group members, as well as promote personal and cultural identity preservation.

While most members of the auxiliary team participated, a wider sense of community could have been achieved with more participation from other staff to bridge the gap between the residents and CPR. However there were already many participants, which at times was overwhelming.

It would have been interesting to have conducted evaluative interviews with the staff to assess how participation affected their mood, relationship with the residents and other observations. Quantitative data, particularly related to levels of depression and anxiety or

acculturative stress, could have been used to measure and analyse session progress. When completing the questionnaires, some words or terms had to be explained, and as a result some answers may have been influenced by the intern's explanation. Translation or adaptation of evaluations were necessary in for example the creation of a more visual questionnaire (using images) however time was limited.

The language barrier meant that verbal communication was minimal and misunderstandings were common. Communication was primarily through musical improvisation, using the symbolic representation (Ruud, 1998) in the music to gain a deeper understanding of the participant. Without verbal communication it was still possible to establish a therapeutic relationship however more time was necessary, demonstrating that the longer the intervention the greater the alleviation of symptoms.

Access to the personal histories of each resident would have been advantageous in the music therapy process, particularly as time was limited. This would have helped in the identification of objectives and planning of the intervention. Normally personal histories are described in the initial phases of the therapy process to build rapport, assess the present and look to the future (Andrews, 2006). Without this information musical improvisation facilitated the therapeutic relationship by experiencing and communicating issues within the music (Kim, 2016a), the non-verbal communicational qualities of music proved beneficial in the absence of a common language. Working in the here-and-now, interacting with the client's current mood and focusing on what could be observed was the best strategy in this intervention.

Reflecting on the cooperation of the institution throughout the internship, it might have been beneficial to educate and familiarise the staff with the process and benefits of music therapy. Some staff continued to call the sessions music lessons and call the intern "*professora*" despite being corrected, showing that this was an issue that should have been more clearly

addressed. A clear representation of the music therapy profession could have improved community interaction and involvement.

COVID-19 was the main challenge to therapeutic progress during the music therapy intervention. The 3-month interruption had a negative impact on the emotional wellbeing of many of the residents and disrupted the routine which was becoming established in the preceding months. There was also a reduction in participation as a consequence of the restrictions, re-housing and the reduction in new arrivals. Adapting to the new regulations and changes posed a new challenge but enabled a focus on individual sessions.

Taking into account the positive outcomes and challenges faced during the internship, there were some areas that could be improved in future work with this institution and population. These might include further development of the open group sessions, for example monthly projects which could be made public to increase participation and integration into the wider community, or themes for improvisation to encourage emotional exploration and expression; continuous research into the musical culture of all the nationalities found within CACR as well as how mental health is understood in their countries; a suitable private setting to run sessions and work on any emotional or trauma issues that cannot be worked on in open group; the sharing of knowledge of personal histories that could be relevant to the music therapy intervention. More time would have given the intern an opportunity to further understand and mobilise the CACR and CPR communities and develop the practice to integrate better into day-to-day life and involve wider community participation.

Personal Reflection

My upbringing in London, one of the most culturally diverse cities in the world, was a definite advantage when undertaking my internship with a multinational target population. Even so there were always opportunities to learn about the 17 different nationalities of the 35 young people and 8 staff members who participated, although this proved at times to be an overwhelming task. The residents and staff of CACR taught me a great deal - I will be forever grateful for this experience as I continue to expand my cultural awareness.

As an incomer myself, albeit with some Portuguese heritage, it was interesting working with refugees. I could understand the difficulties in the process of acculturation, and not having Portuguese nationality was something we had in common. Although it was more complicated to facilitate acculturation by teaching traditional Portuguese songs or other aspects of Portuguese culture. The curiosity and questioning from residents about my life in the UK made it at times difficult to maintain therapeutic boundaries.

Working with adolescents was not a new experience for me - in my work in schools in London I have taught students from around the world, including some refugees. It would have been interesting to have worked in the CPR accommodation for adults and families with accompanied children to gain more experience working with refugees of different ages.

Working in a residential setting was a new experience for me, and at times I felt as if I was invading the personal, physical and psychological space of the residents. However I found that music therapy provided an alternative space within the physical context of this temporary home. Music gave the residents the chance to escape the physical space and enter their own psychological space, to achieve a sense of calm or experience emotions or memories. However the sound of djembes can be an inconvenience at times if you just want to relax on the sofa.

In addition to the challenges caused by COVID-19 mentioned above, the pandemic created difficulties for me personally in managing levels of stress and anxiety regarding

uncertainty about the internship and the future. COVID-19 also caused difficulties in the professional, financial and academic aspects of my life. During the internship it became clear that there was a high risk of infection from the refugees - this was reflected at the end of my internship when a screening for tuberculosis was necessary.

From the first year of studies and throughout the literature I reviewed, my understanding of music therapy had been clinical and more often individual or in closed groups with clearly defined boundaries and structured sessions. In the initial months of the internship it was difficult to re-adjust my expectations of a music therapy intervention. It was necessary to adapt my approach to the institution, and not compare it to other practices. Once a routine had been established and I felt more integrated into the CACR community it was easier to adjust to these differences.

Despite the challenges, adaptation was not impossible. It was necessary however to improve my focus, concentration and active listening skills so as not be distracted during a session. In addition, my language and communication skills developed. By the end of the internship I was able to switch between languages with more ease, my Portuguese and French improved and I could greet the residents in Fula. I had to become more assertive and decisive and lose my shyness when leading a group so as to maintain control of the session.

In conclusion, the internship provided me with an opportunity to develop as a music therapist and allowed me to discover more community-based approaches which I personally align with and will continue to develop in the future. Adaptation to and integration into the setting and research of the different cultures was important to provide the most effective intervention. Through the establishment of therapeutic relationships and *musicking* I was able to provide a positive distraction from negative feelings and help build a sense of community and belonging for the residents.

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List of Appendices

Appendix A

Group session register

REGISTO DE SESSÃO DE GRUPO - MT

IDENTIFICAÇÃO DO GRUPO: _____

DATA: _____TERAPEUTA: _____

PRESENTES:
DESCRIÇÃO SUMÁRIA DA SESSÃO:
TEMAS CENTRAIS:
OBSERVAÇÕES ESPECÍFICAS (aspetos individuais ou processo de grupo)
MÚSICA PRODUZIDA (atividade, instrumentos, repertório)
NOVIDADES OU MUDANÇAS:
REAÇÕES PESSOAIS:
A FAZER...

Appendix B

Individual session register

REGISTO DE SESSÃO INDIVIDUAL - MT

NOME DO UTENTE: _____

DATA: _____TERAPEUTA: _____

OBSERVAÇÃO DIRETA DO UTENTE:
DESCRIÇÃO SUMÁRIA DA SESSÃO:
TEMAS CENTRAIS:
NOVIDADES OU MUDANÇAS:
MÚSICA PRODUZIDA (instrumentos, repertório)
REAÇÕES PESSOAIS:
A FAZER…

Appendix C

End of internship questionnaire

Musicoterapia Questionário

Fim do estágio questionário

1. Quantos vezes participaste numa sessão de musicoterapia ou outros atividades? Porque?

0

1-5

6-10

10+

2. Qual atividade ou instrumento que preferes fazer?

3. Preferes sessões individuais ou em grupo? Porquê?

4. Conheceste alguém (pela primeira vez ou melhor) através duma sessão de musicoterapia? Sim / Não Exemplo(s):

5. Lembras-te de alguma sessão de musicoterapia em que tenhas conseguido expressar alguma emoção/sentimento?

Não

Não me lembro

Sim, exemplo(s):

6. Partilhaste alguma música tua (i.e. do teu país) com os colegas/equipa durante alguma das sessões de musicoterapia?

Não. Porque? Sim, exemplo(s):

7. Ouviste alguma música nova dos teus colegas/da equipa durante alguma das sessões de musicoterapia? Não. Sim, exemplo(s):

8. Aprendeste alguma coisa nova sobre o país ou cultura dos colegas/equipa durante alguma das sessões de musicoterapia? Não

Sim, exemplo(s):

9. Normalmente / dia a dia em casa sinto me:

	Nunca	Poucas vezes	Às vezes	Muitas vezes	Sempre
	1	2	3	4	5

Feliz

Triste

Frustrado

Relaxado

Stressado

Positivo

Deprimido

Raivoso

10. Durante/depois uma sessão de musicoterapia sinto me:

	Nunca	Poucas vezes	Às vezes	Muitas vezes	Sempre
	1	2	3	4	5
Feliz					
Triste					
Frustrado					
Relaxado					
Stressado					
Positivo					
Deprimido					
Raivoso					

Appendix D

Example timetables

Original timetable created in November 2019

Musicoterapia horário

	Quarta-feira	Quinta-feira	Sexta-feira
10:30-11:15	Grupo (residentes e staff) Refeitório Aberto para todos	Studio grupo Gabinete A. A.	Grupo Biblioteca B. M.L.C. S.K. M. L.J. O.
11:15-12:00	Grupo Biblioteca D.F. I. B. S.C.	Grupo Gabinete C. K. B.	Grupo Biblioteca N. D. S. A.
12:00-12:30	_____	M.	S.C.
12:30-13:30	ALMOÇO		
13:30-14:00	N.M.	S.	

Datas 2019:

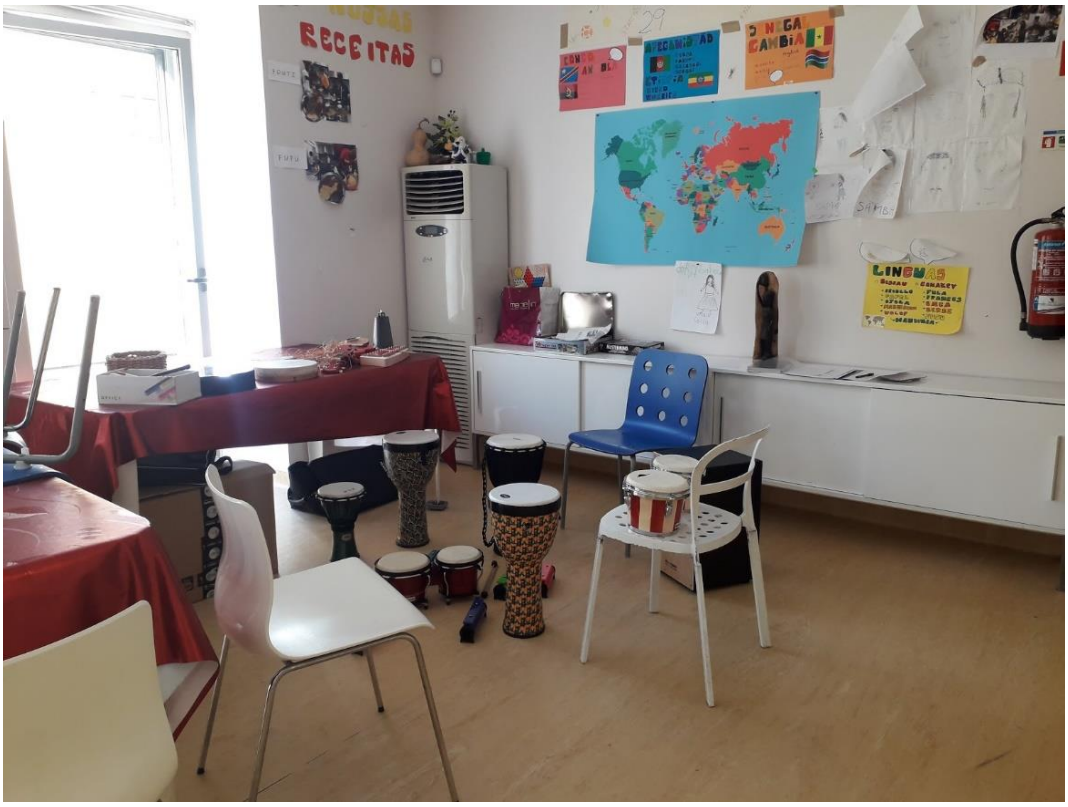
20-21-22 Nov, 27-28-29 Nov, 4-5-6 Dec, 11-12-13 Dec, 18-19-20 Dec (férias escolares + 14-16h)

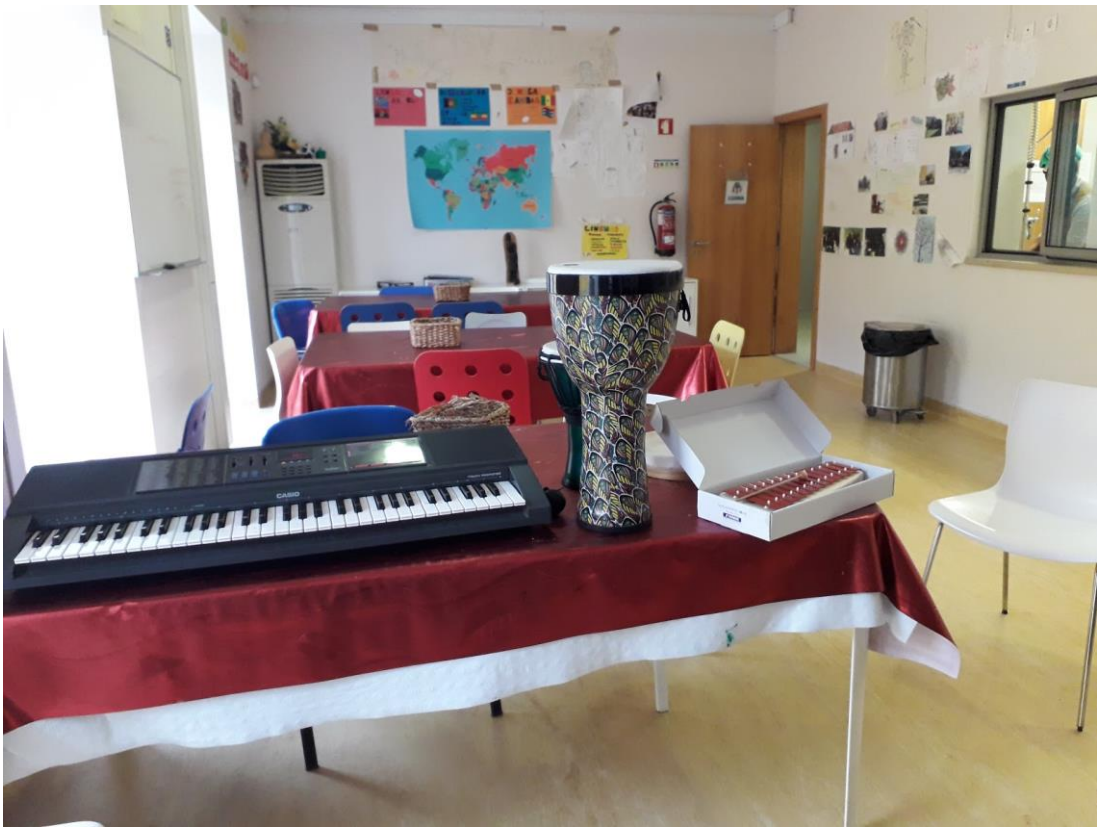
Timetable pre-COVID-19

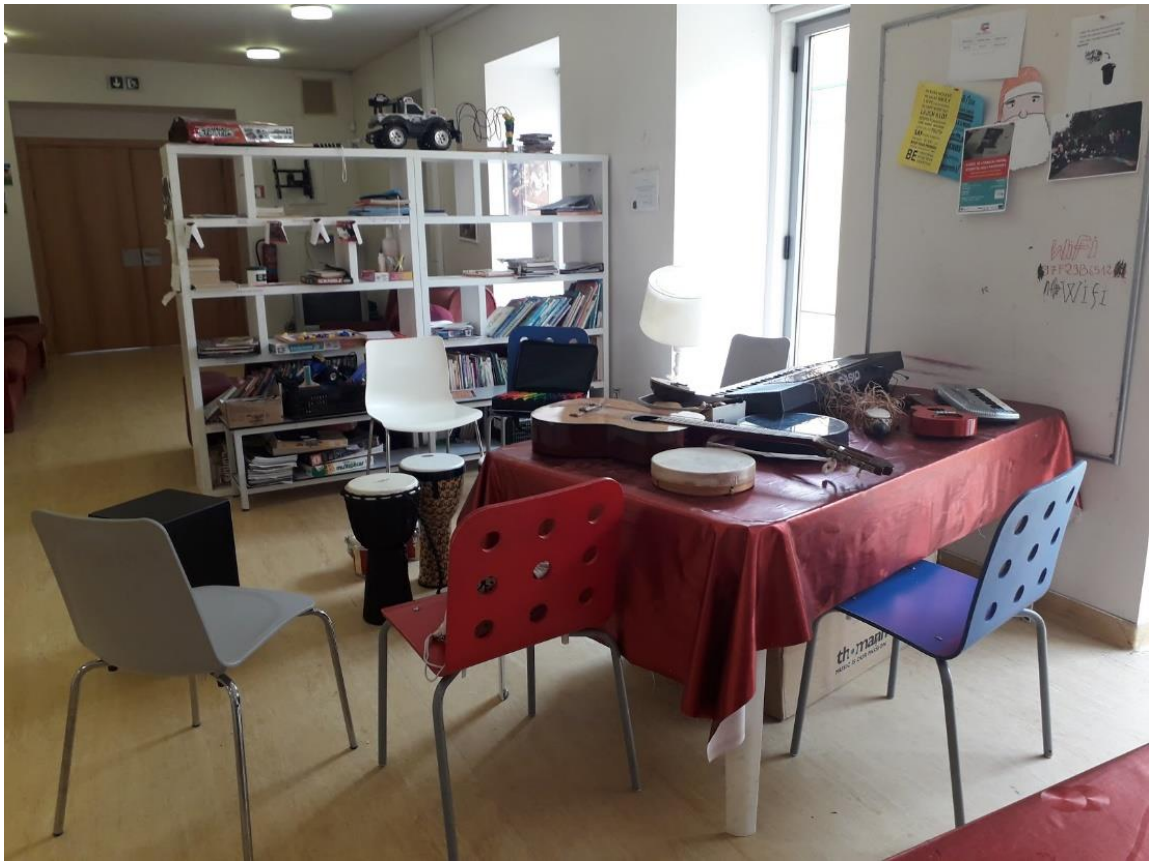
Horas	**Terça-feira**	**Sexta-feira**	**Sábado**
10:30-11:00	Informe-se as novidades da casa / Preparação da sala	Informe-se as novidades da casa / Preparação da sala	Informe-se as novidades da casa / Preparação da sala
11:00-12:30	Grupo - refeitório	Grupo com arte - biblioteca	Grupo - biblioteca
12:30-14:00	Registo da sessão / Almoço	Registo da sessão / Almoço	Registo da sessão / Almoço
14:00-14:45	N.M.		D.
14:45-15:00	Registo da sessão		Registo da sessão
15:00-15:45	N.		Free time open to suggestions from young people
15:45-16:00	Registo da sessão		Registo da sessão

Appendix E

Photos of set up of instruments in dining room

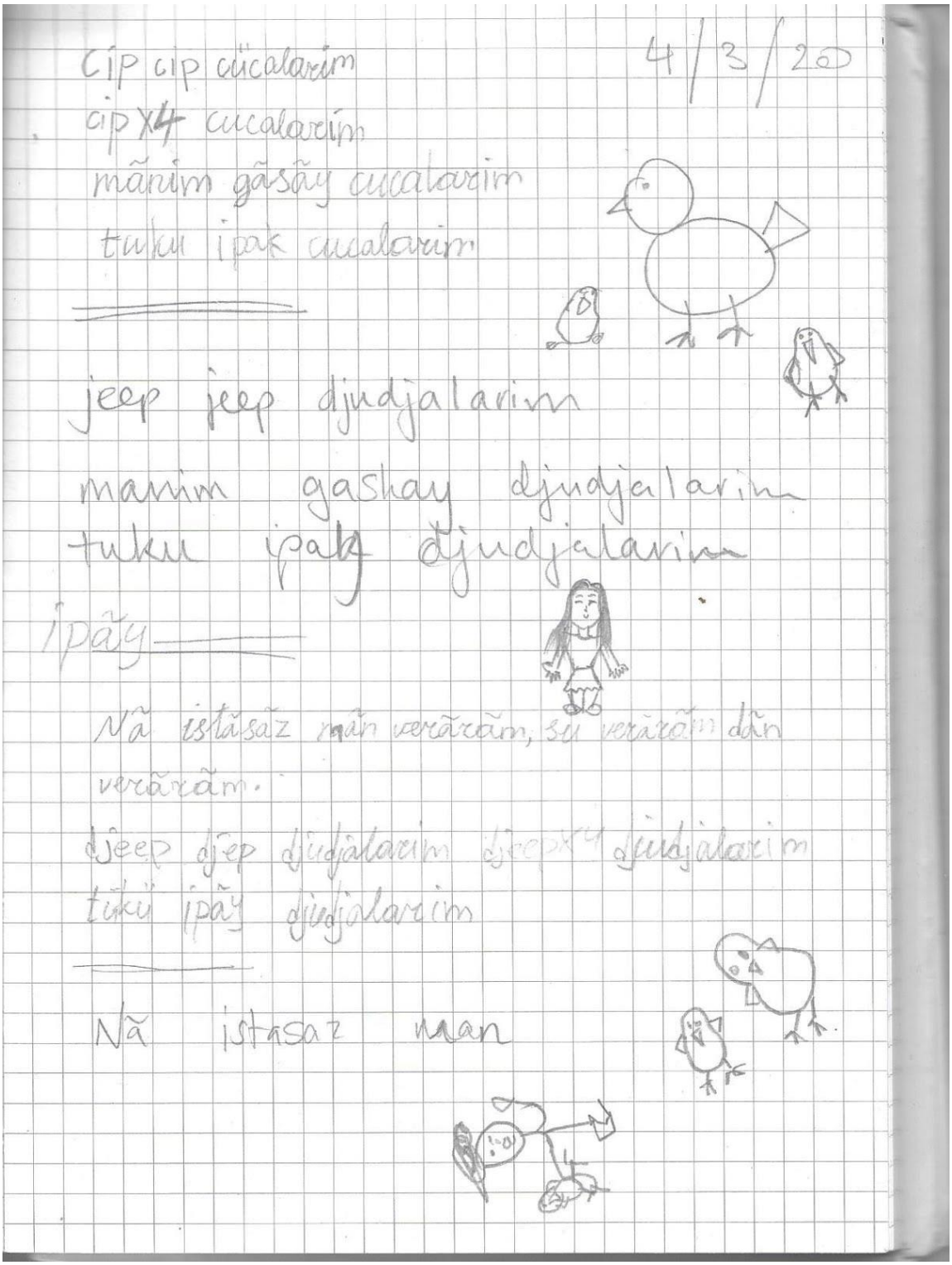






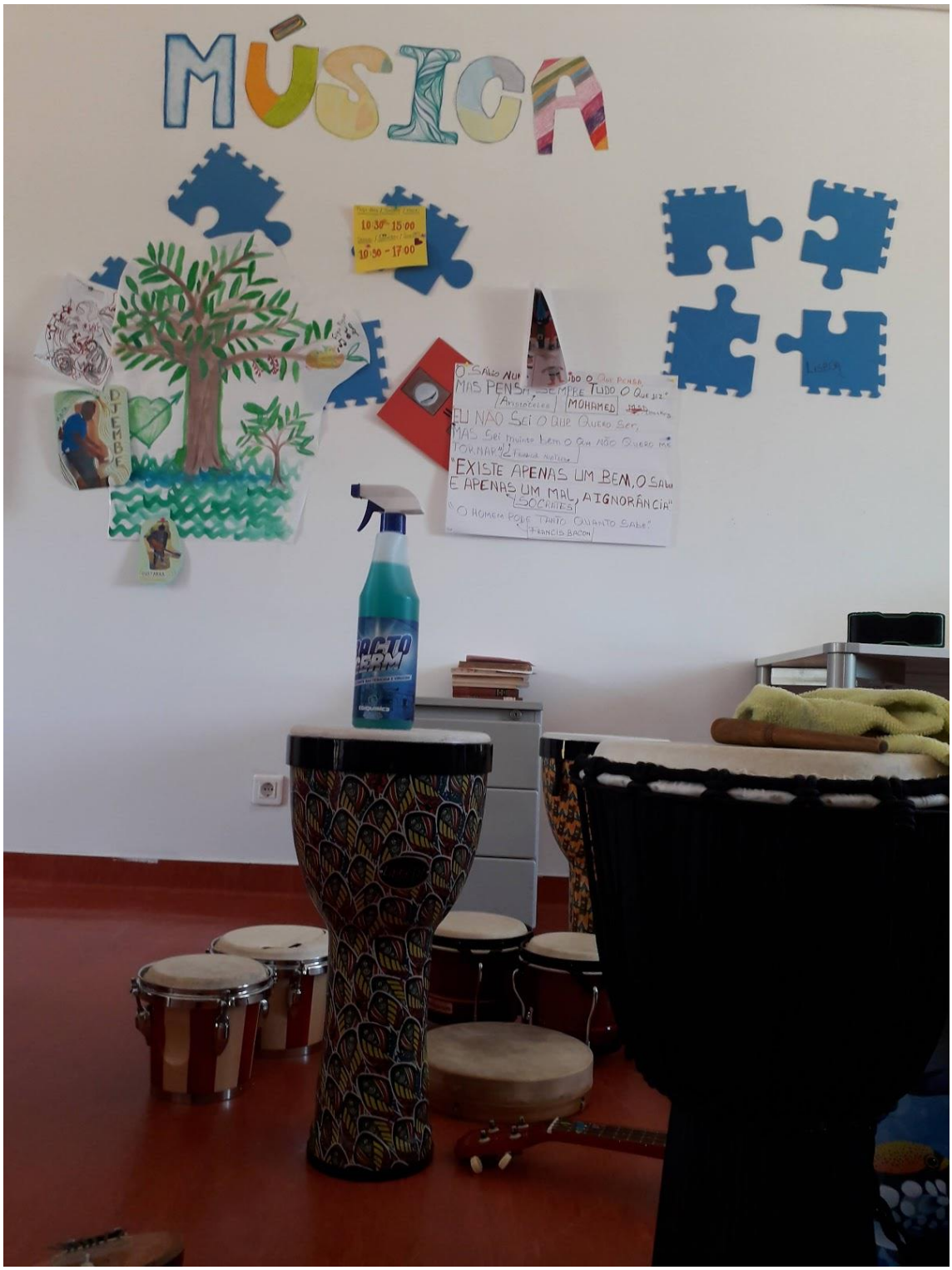
Appendix F

Lyrics written by N.M. and intern '*cip cip cucerlarim*'



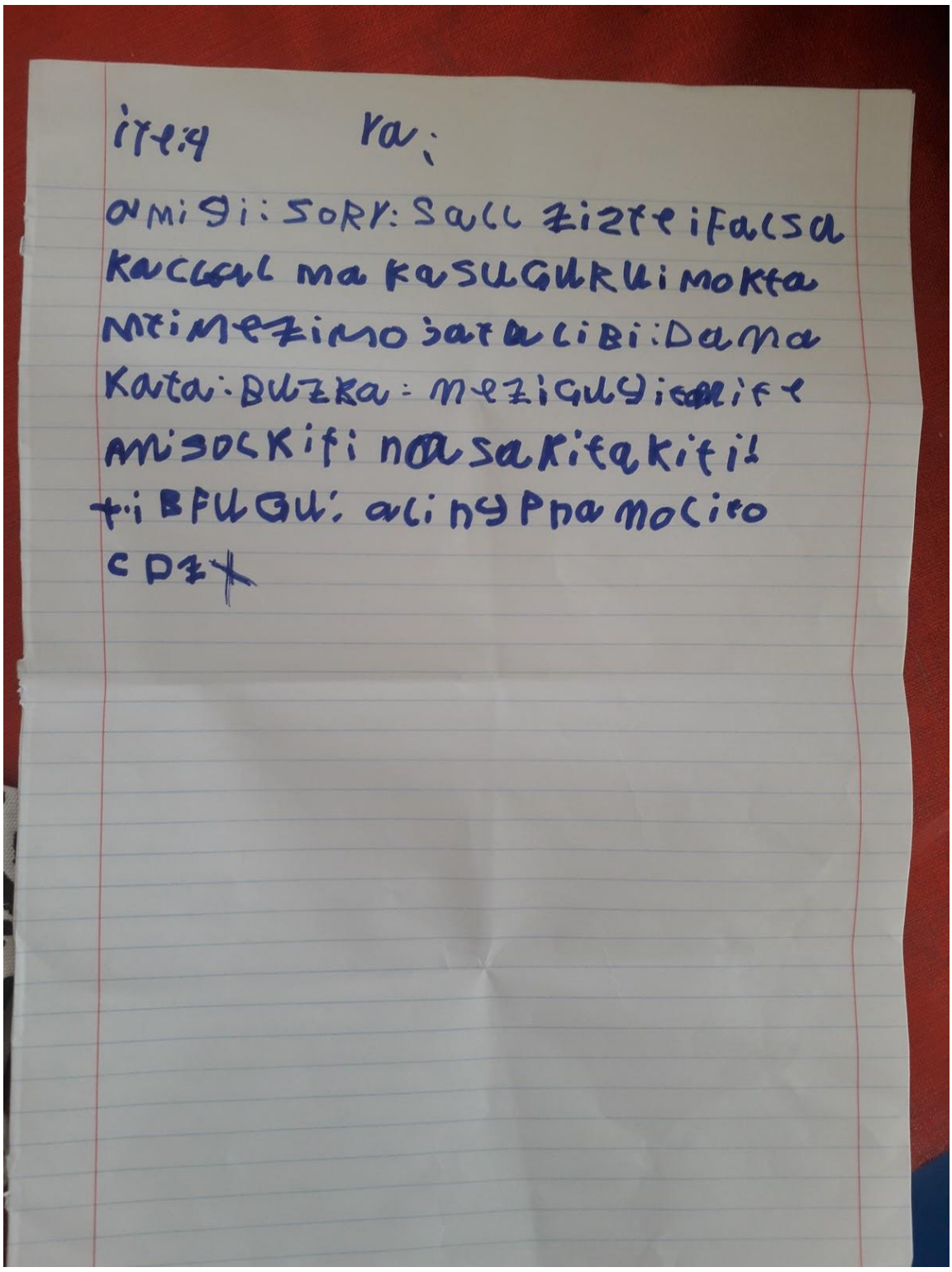
Appendix G

Photo of wall display



Appendix H

Lyrics written in creole by I.S.S.



Appendix I

Session outdoors with group of volunteers

Appendix J

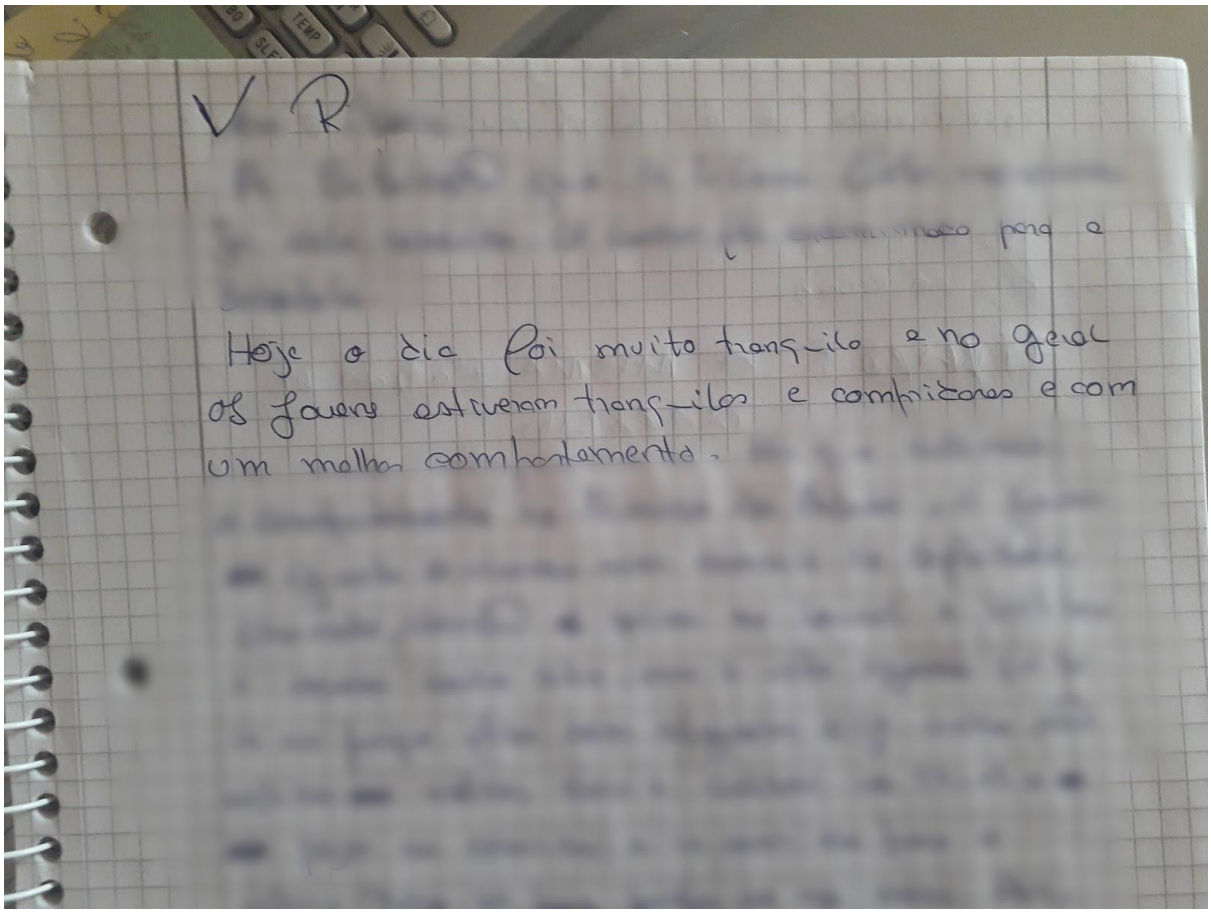
Photo of group art session in outside space

Appendix K

Photos from djembe making session 24/06/2020

Appendix L

Comment from staff logbook 24/06/2020



Appendix M

Checklist of sounds to record (N.M.)

07/07/2020 - Estufa Fria, Parque Eduardo VII, Lisboa

18/08/2020 – Parque das Nações, Lisboa

Lista dos sons para gravar

Tenta identificar e gravar:

- um som curto
- um som longo
- um som que te lembra da tua casa
- um som natural
- um som mecânico
- um som chato
- um som que tu gostas
- um som engraçado