

‘Through music and into music’, through music and into well-being: Dalcroze eurhythmics as music therapy

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Abstract. There is a longstanding relationship between music therapy and Dalcroze Eurhythmics, an approach to music education that had its beginnings in the reform pedagogy movement of the European fin de siècle. Émile Jaques-Dalcroze (1865-1950), the founder of the approach, initially focused on educational aims, but was soon to include therapeutic ones as well. During the early twentieth century, Dalcroze teachers applied the approach to their work with disabled children. Such applications have continued to develop to the present day and have expanded to include palliative treatment in HIV/AIDS and gerontology.

There are many theoretical and technical similarities between Dalcroze Eurhythmics and improvisational music therapy, including communication through musical improvisation and attunement in playing for movement. However, many of these similarities remain to be discussed in relation to the literatures on music therapy and communicative musicality. To address this gap, this article takes a transdisciplinary approach, making conceptual connections between the theory and practice of both Dalcroze Eurhythmics and music therapy. Implications for future training, practice and research in Dalcroze Eurhythmics are discussed.

Keywords. Dalcroze Eurhythmics, improvisational music therapy, wellbeing, communicative musicality

Introduction

This article is about the relationship between music therapy and Dalcroze Eurhythmics. Dalcroze Eurhythmics is an approach to music education that had its beginnings in the reform pedagogy movement of the European fin de siècle. Émile Jaques-Dalcroze (1865-1950) founded the approach for the purposes of music education, but over time he also developed explicitly therapeutic aims. During the first decades of the twentieth century

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Dalcroze Eurhythmics teachers began to apply it to the education of those with disabilities. Joan Llongueras focused on blind children (Jaques-Dalcroze 1930; Mones i Mestre 2000) and Mimi Scheiblauser on those with hearing impairments and physical and learning disabilities (Brunner-Danuser 1984). These pioneers saw its therapeutic as well as educational benefits. Such applications of the Dalcroze work have continued to develop to the present day, most recently in the field of gerontology (Kressig et al 2005; Trombetti, Allali and Beauchet 2010) and in settings for people with HIV/AIDS (Frego 1995, 2009).

The twentieth century also saw the growth of music therapy as a practice and a profession. Some historians have argued that music therapy, in the USA at least, developed mainly as a response to World War II, when musicians often performed to large groups of wounded soldiers (Rorke 1996, Sullivan 2007). In the post-war era some of the most significant individuals who developed music's potential as a therapy include Juliette Alvin (Haneishi 2005), Ira Altshuler (Davis 2003), and Paul Nordoff and Clive Robbins (Aigen 1998, Kim 2004). In the UK, music therapists began to professionalise during the late 1950s (Barrington-Hill 2005), a decade or so after their American counterparts, and in many countries music therapy is now a registered allied health profession. Music therapy is used to foster the wellbeing of people with learning and physical disabilities, acquired brain injury, mental illness, trauma, and dementia (Bunt and Stige 2014). It has applications across the lifespan, from premature birth (Nöcker-Ribaupierre 2004) to end-of-life care (Lee 1995).

There are many theoretical and technical similarities between Dalcroze Eurhythmics and music therapy. Some of these, such as the primacy of rhythm in entraining the body have been pointed out (Skewes and Daveson 2002). Others, including communication through musical improvisation and attunement in playing for movement, remain to be discussed. At a time when music, health and wellbeing has established itself as a field of research in its own right (MacDonald, Kreutz and Mitchell 2012), it is important not only to honour the role that Dalcroze Eurhythmics plays in promoting health and wellbeing, but also to make use of current theories to enhance our understanding of how it does so.

The personal motivation for this research comes from my experience as a music therapist and trainee Dalcroze teacher.² My understanding of music's very nature and potential has been profoundly influenced by my work in both areas and I have become intrigued by the ways in which they overlap historically and in terms of current practice. Therefore, this article addresses the research question: how can we expand our understanding of Dalcroze Eurhythmics through the lens of music therapy? It is a comparative discussion that takes a transdisciplinary approach, drawing on the historical, qualitative and theoretical research into Dalcroze and music therapy, as well as my experiences in both fields. The article makes conceptual connections between the theory and practice of both Dalcroze and music therapy, and in so doing highlights similarities and differences.

The article addresses the research question in six sections: (1 and 2) a description of each practice; (3) the historical context of their relationship; (4) a literature review of Dalcroze used therapeutically; (5) a discussion of conceptual models that include music education and music therapy; (6) and a closer look at one particular topic: music as communication. Whilst I conclude with some implications for future training, practice and research in Dalcroze

² Dalcroze Eurhythmics is often shortened to Dalcroze. I will follow this convention and refer to Émile Jaques-Dalcroze by his full surname.

Eurhythmics, I hope that what follows will be useful to practitioners and researchers in music therapy as well.

1. Music therapy

Definitions of music therapy abound. One recent one is from Bunt and Stige (2014): ‘the use of sounds and music within an evolving relationship between patient/participant and therapist to support and encourage physical, mental, social, emotional and spiritual well-being’ (Bunt and Stige 2014: 18). The World Federation of Music Therapy defines it in similar, if more detailed, terms:

the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing (WFMT 2014).

In both cases, the intrinsically holistic nature of music therapy is implicit. It is important to note however that terms such as ‘therapy’, ‘health’ and ‘well-being’ are cultural constructs and this is as true of music therapy as any other practice (Boyce-Tillman 2000). Music therapy has – and still does – align itself with, and borrow concepts, terminology and practices from, many different fields: psychoanalysis, psychotherapy, behavioural therapy, neuroscience, developmental psychology, to name but a few. All of these discourses have their histories and assumptions. Furthermore, although music therapy as a profession is a relatively recent one, the relationship between music and wellbeing – music *as* wellbeing – is ancient and can be found the world over (Boyce-Tillman 2000; Gouk 2000). Music therapy is but one cultural manifestation of that relationship.³

This article focuses on improvisational music therapy (Bruscia 1987). This is an umbrella term for any approach to music therapy in which music is co-created by client and therapist in an ongoing relationship.⁴ Such methods include creative music therapy (Nordoff and Robbins 1977) and analytically oriented music therapy (AOM) (Priestley 1994).⁵ Improvisational music therapy approaches are used with a very wide variety of people, including those with learning disabilities, mental illness, and dementia.

Improvisational music therapy is fundamentally *expressive* and therefore different from practices such as Guided Imagery and Music (GIM) that are fundamentally *receptive* (Bonny 2002). In GIM there is very rarely improvisation between client and therapist, but recorded music is used instead to elicit feelings and memories as part of a primarily verbal process. In contrast, improvisational music therapy is based on shared, spontaneous music making with voices and/or instruments within the client-therapist relationship. However, even within this practice, there are important differences. In AOM, for example, whilst improvisation is also

³ It is all the more important to acknowledge this in the context of transdisciplinary research and, indeed, in writing for a journal based on the continent of Africa, with its many different traditions of musical healing (see, for example: Friedson 1996; Janzen 1992; Schumaker 2000).

⁴ For client, we could also substitute patient or service-user, depending on context.

⁵ Creative music therapy is the term originally used for the approach developed by Nordoff and Robbins (1977). However, the term is controversial, since it may imply that other forms of music therapy are not creative.

present, it is often based on a 'playing rule', agreed beforehand, that is used to explore a particular aspect of the client's experience. The improvisation, which may be recorded, listened to, and discussed in the session, is a precursor to verbal processing of a psychoanalytical nature. Therefore, 'Music making and verbal processing [have] equal weight' (Trondalen and Bonde 2012: 46).

In all improvisational music therapy, the therapist draws on empathy, a person-centred ethos, attunement and careful timing in improvised musical interactions, during which any sound may be accepted as music. The client is free to move and make music as they wish, or to remain silent. Whereas in AOM, the therapeutic relationship develops through music and verbal dialogue, in improvisational music therapy of the sort developed by Nordoff and Robbins (1977), the therapeutic relationship develops primarily in and through the music. It is sometimes called *music-centred* music therapy (Aigen 2005) and this is a central idea for this discussion. This music-centredness also differentiates this type of music therapy from those in which, for example, recordings are used to stimulate verbal conversation (GIM), or sounds are used as stimuli to help regain movement after a stroke (neurologic music therapy, see Thaut 2005). In these cases, there is music – or sound – but it is not improvisatory and it is not shaped co-creatively between two or more individuals.

Another way of putting this is that in music-centred improvisational music therapy, music is not merely used *in* therapy, but is used *as* therapy. It is the primary medium in which the relationship between client and therapist exists (although verbal process may also play a role). Over time, changes in the improvised music are generally interpreted as changes in the client's emotional state, preferences, and behavioural patterns. Most importantly, they can signify changes in the therapeutic relationship. Flexible musicking may be a sign of a healthy psychological state, whereas inflexibility could point to the opposite. For example, we can imagine the case of a traumatised child who is unable to take turns in musical interactions. Through music therapy, he or she could develop the ability to take turns and this musical change might not only be interpreted as the analogue of a psychological change (the ability to regain trust in others, for example), but might also extend to changes in interpersonal relations outside the boundaries of music therapy.

2. Dalcroze Eurhythmics

Jaques-Dalcroze was a pianist, composer, conductor, theatre director, and pedagogue. His approach to rhythmic education initially grew out of experiments he made whilst teaching harmony and solfège at the Geneva Conservatoire in the 1890s (Berchtold 2005). In his hands, and those of colleagues such as Nina Gorter (Odom 2004), the approach continued to develop at the Dalcroze training school in Hellerau, near Dresden, in Germany. This garden city community, of which Jaques-Dalcroze's school was the centerpiece, flourished in the years immediately prior to World War I. Students from many countries engaged with new ideas about music's relationship to movement and staged performances that drew prominent artistic figures from Europe, America and Russia (Odom 1998).

By the time of Hellerau, the 'methode Jaques-Dalcroze' (1906) had transformed into something with much wider implications than music education. Jaques-Dalcroze had come to see his approach as one that could restore and connect all the faculties of the person: the senses, the moving body, emotion, thought, imagination, and will. Important in this

transformation were Jaques-Dalcroze's experiences in music and theatre, and the combined influences of psychologists, teachers and artists. He intended his exercises to develop a sense of self and sociability as students worked alone, in pairs and groups (Jaques-Dalcroze 1920: 19-20, 38; Jaques-Dalcroze 1921: 32). The result of the liberation of innate responses to music and a growing sense of the creative power of the will would, he claimed, lead to feelings of freedom and joy (Jaques-Dalcroze 1915: 91-102) and transform not only education, but also society itself (Jaques-Dalcroze 1930: 57-58). Jaques-Dalcroze considered that music, when studied through his approach, had the power to make the body perfectly expressive. Music was not only the goal of study; it was the means to discovery, skillfulness, and personal transformation.

Dalcroze is made up of three interrelated branches:⁶

- *Rhythmics* works on time-space-energy relationships common to movement and music by means of exercises using movement, improvisation and highly focused listening;
- *Aural Training (solfège)* uses movement, improvisation and the voice to assist in aural development and understanding; and
- *Improvisation* of all kinds – vocal (using solfège, bruitages (vocalised sounds), and words or poems), instrumental and in movement – works on developing creative and spontaneous expression.

When one branch is the focus of a lesson, the others are also present. For example, in a solfège lesson the students will not only sing and vocalise, but also move in and around the space and, through rhythmic exercises and whole body movements, show and learn about the intervals, melodic shapes and harmonies in question. They will also improvise vocally to become familiar with the topic being studied. The learning is therefore active and somatic (Greenhead and Habron forthcoming; Urista 2001).

As a consequence of his pedagogical observations, Jaques-Dalcroze insisted: 'The whole method is based on the principle that theory should *follow* practice' (1967: 63).⁷ Therefore, he developed a philosophy of education, which in its holism echoes the definitions of music therapy given above (Bunt and Stige 1994, WFMT 2014). Furthermore, this philosophy rejected the mind-body split, the epistemological legacy of Descartes (Damasio 1994). Jaques-Dalcroze wrote: 'The object of education is to enable pupils to say at the end of their studies, not 'I know,' but 'I experience'' (Jaques-Dalcroze 1930: 58).

Jaques-Dalcroze therefore foreshadowed the philosophy of Dewey, who popularised the term body-mind (Dewey, 1958). Dewey's emphasis on bodily experience as the medium of knowing is well-rehearsed, not only in philosophy (Johnson 1987, Lakoff and Johnson 1999,

⁶ The name Dalcroze Eurhythmics is still used to distinguish it from other practices, such as Rudolf Steiner's Eurythmy. Originally, Jaques-Dalcroze's approach was known as 'rhythmic gymnastics' (Jaques-Dalcroze 1906), but sometime between December 1911 and the publication of *The Eurhythmics of Jaques-Dalcroze* (Jaques-Dalcroze 1912) John Harvey suggested that 'eurhythmics' better described the entirety of the approach (Ingham 1914). The appellation 'rhythmics' is also used in continental Europe as an umbrella term for various kinds of rhythmic education, which may have more or less in common with the Dalcroze practice. Dalcroze Eurhythmics has been carefully defined by Le Collège de L'Institut Jaques-Dalcroze (2011). Although the word 'method' is often used in relation to Dalcroze Eurhythmics, I have adopted the word 'approach' here to emphasise its flexibility and to avoid the implication that it sets out a fixed sequence of exercises.

⁷ All italics in quotations are in the original sources.

Merleau-Ponty 1962, Shusterman 2012), anthropology (Varela 1992), and neuroscience (Damasio 2000), but also in the philosophy of music education (Bowman 2004, Juntunen and Westerlund 2001). Jaques-Dalcroze influenced the development of somatic practices in the twentieth century (Eddy 2009; Batson 2009) and his ideas find support in contemporary theories that focus on the role of the body in cognition and emotion, including multiple intelligences (Aronoff 1988), flow (Custodero 2005, Frego 2009), forms of vitality (Stern 2010; see below), and shared affective motion experience (Overy and Molnar-Scakacs 2009; see below).

The Dalcroze approach is largely orally transmitted (Odom 1995) and has been developed and refined during more than a century of practice (Odom and Pope 2013). The principles that underpin Dalcroze (personal and aesthetic expression, awareness of self and others, flexibility and creativity, artistry, and self-mastery) transcend disciplinary boundaries and therefore the practice is associated with several fields (Habron 2013). Principally, these are: health and wellbeing (see Section 4), music and music education (Juntunen 2002, 2004; Mathieu 2010; Seitz 2005; Urista 2003), theatre (Lee 2003) and dance (Odom 1998).

3. Historical relationships and cultural context

Historically, Dalcroze and music therapy have much in common and, as mentioned above, the former has always had therapeutic potential. Bachmann writes: ‘At a very early date Dalcroze’s own followers could see what part Eurhythmics had to play in the then little-explored field of education, or re-education, for those...with mental, sensory, and motor handicaps’ (Bachmann 1991: 66). One of these followers was Angèle Porta, who in 1917 first began a Dalcroze class for ‘backward children’ (Dutoit 1971: 94). Another was Joan Llongueras, whose work with blind children began a year later (Dutoit 1971: 94). This early therapeutic application of Dalcroze is revealing, if compared to a recent definition of music therapy. In 1930, Llongueras wrote that the blind children attained:

‘A very sure and precise notion of the space in which they move, their movements become more definite and assured. Eurhythmics vivifies the personality, enriches their lives, develops their imagination, strengthens their will and clarifies their thinking processes. They have become bolder and more optimistic and have felt growing up within them the sense of expression, a feeling of pleasure and enthusiasm’ (cited in Jaques-Dalcroze 1930: 148).

This account was written 84 years before WFMT’s definition of music therapy, referred to above, and decades before the widespread establishment of the practice we know by that name today. However, in these three sentences all of the WFMT’s aspects of music therapy are present (Table 1). Thus, the therapeutic impact of this early Dalcroze work is clear.

Table 1: A comparison of Llongueras' account of teaching blind children and WFMT's definition of music therapy

WFMT's terms (2014)	Llongueras' observations (1930)
Physical	Very sure and precise notion of the space in which they move Their movements become more definite and assured
Social	They have become bolder
Communicative	Sense of expression
Emotional	More optimistic Pleasure Enthusiasm
Intellectual	Develops imagination Strengthens their will Clarifies their thinking processes
Spiritual	Pleasure ⁸

Also in 1930, Jaques-Dalcroze wrote: 'if nerve specialists would be good enough to study my experiments carefully, they would speedily recognise the therapeutic value of exercises that control muscular contraction and relaxation, in every shade of time, energy and space, for instruction thus given must inevitably stimulate intuition and endow the pupils with bodies perfectly organised, both mentally and physically' (Jaques-Dalcroze 1930: 105). Jaques-Dalcroze specifically uses the word therapeutic and offers a transdisciplinary invitation to medical practitioners to study his work. In the same essay he mentions giving lessons to large numbers of 'ultra-nervous' children (1930: 104) and curing 'abnormal children' (1930: 105). He claims: 'In many cases, my pupils have been cured of *idées fixes*, of special obsessions' (1930: 115). Thus, Jaques-Dalcroze was thinking outside a purely educational framework. As he admitted several years earlier, in 1914: 'The actual practice of individual rhythms...is more than a pedagogic system' (Jaques-Dalcroze 1914/1967: 63).⁹

Cowan (2008) contextualises Dalcroze Eurhythmics within a culture of will therapy, whose proponents identified the psychological problems of the modern subject as lack of will power, over-sensitivity, and nervousness. Often these were grouped together under the heading of neurasthenia, a medical term which Jaques-Dalcroze also used (Jaques-Dalcroze 1912: 20). For Jaques-Dalcroze, as with many of his likeminded contemporaries, one of the most influential factors on their reforms was industrialisation and how it changed subject-object

⁸ This is taken as a synonym for joy, which Van Der Merwe and Habron (forthcoming) identify as one of the aspects of spiritual experience in music education.

⁹ Jaques-Dalcroze wrote this in 1914, but it is anthologised in Jaques-Dalcroze (1967).

relations (Goeller 2005). There was a fear in the early years of the twentieth-century that humankind would be controlled by the machines it had created (Cowan 2005: 191).

This fear permeated many aspects of culture and was memorably and comically portrayed by Charlie Chaplin in the film *Modern Times* (Chaplin 1936/2003). Chaplin, as a factory worker, is reduced to a quivering wreck by mind-numbing and repetitive work; the machines swallow him and force him to work, and even eat, at inhuman speeds. Perhaps a return to a pre-industrial way of life is what Jaques-Dalcroze meant when he called for the uniting of the 'natural rhythms of body and mind' (Jaques-Dalcroze 1930: 14).

Cowan also claims that the work of 'armchair anthropologist' Karl Bücher was influential in Jaques-Dalcroze's circle in the years around 1910 (Cowan 2005: 189). Bücher looked to what he saw as 'primitive' cultures for examples of people for whom work and life had not been separated and for whom there was the possibility of "joyful" rhythmical activity' (Cowan 2005: 190). This adds to the most common narrative about the development of Dalcroze's thinking, which focuses on his time at the Geneva conservatoire, where he found the teaching methods too theoretical and disconnected from the students' emotions and sensations (Berchtold 2005). Although we have no reason to doubt the veracity of this narrative, it might not be the whole truth. The impact of contemporary psychological and anthropological theories about nervousness, rhythm, and work might have also played their part.

However, a more balanced summary than Cowan's is provided by Franco, who gives due regard to Jaques-Dalcroze's musical and pedagogical intentions. The approach had a 'twofold design...of artistic musical education and...the treatment and prevention of psychological and neurological malfunctioning' (Franco, no date).

4. Literature review

The writings of Llongueras and Jaques-Dalcroze can be considered alongside several later figures. Dutoit (1971) provides us with an account of Dalcroze-related music therapy, but there is little detail on techniques used, except for those of Scheiblaue, whose deaf pupils carried tambourines as 'portative ears' (Dutoit 1971: 72). Feldmann (1970), a neuropsychiatrist, collaborated with Dutoit to develop rhythmic exercises for the psychomotor assessment and rehabilitation of socio-culturally deprived children. Also in the 1970s, Swaiko (1974) wrote about Dalcroze as 'a resourceful and valuable aid in deaf education' (Swaiko 1974: 322). Habron (2014) discusses the writings of Priscilla Barclay, a British Dalcroze teacher and occupational therapist who was active as a music therapist during the 1950s-80s. Whilst these historical sources provide interesting perspectives on Dalcroze Eurhythmics as music therapy, they are insufficient evidence for the therapeutic effectiveness of the Dalcroze approach. More recent research, however, has been framed within qualitative and quantitative research paradigms and has greater methodological clarity.

Frego (1995, 2009) pioneered the therapeutic application of Dalcroze for those with HIV/AIDS. He notes that, when used therapeutically, the goal of Dalcroze 'is not only to give the immediate palliative care needed, but also to encourage the client to take responsibility for his/her own therapy' (Frego 1995: 22). An ethnographic study revealed increases in energy level, expression, self-esteem and benefits from 'non-verbal

communication through eye contact and physical touch' (Frego 1995: 24). *Dancing Inside: Dalcroze Eurhythmics in a Therapeutic Setting* (Frego 2009) is a single case study of Luke, whose experiences in a Dalcroze class include feeling more connected to his body and to others, a sense of physical health, and spiritual focus. In summarising his personal transformation, Luke says, 'I think that a eurhythmics class is a microcosm experience of moving from risk into trust... The sense of letting go of vulnerability and opening up to the experience was one of the most liberating moments of my life' (cited in Frego 2009: 322-323). Dalcroze provided him 'with the tools to be resilient' (Frego 2009: 327).

Habron-James (2013) carried out a qualitative observational study of four children with special educational needs over the course of six Dalcroze classes. The results, presented as Mind Maps (Buzan 1995), show eight themes: musical, physical, emotional, cognitive, behavioural, vocal, and social (Habron-James 2013: 15). It is noteworthy that these contain the four primary elements of Bunt's definition of music therapy: physical, mental (cognitive), social, and emotional (Bunt and Stige 2014: 18). The four case studies paint very detailed pictures of the children's responses. The Dalcroze approach had a beneficial impact on the children's wellbeing; 'moving to music, with others, and in a contained space, can bring a sense of freedom and contentment...engagement in music and movement activities develops the range of vocal communication of children with weak language acquisition' (Habron-James 2013: 61).

Two studies carried out in Switzerland provide quantitative evidence for the effectiveness of Dalcroze for older adults, not only in regulating gait (Kressig, Allali and Beauchet 2005; Trombetti et al 2010), but also improving balance and reducing the prevalence and risk of falls (Trombetti et al 2010). The 21 female participants (average age 79.6) in Kressig's experimental group each had 40 years' experience of Dalcroze. Under a dual task (walking whilst counting backwards from 50), there was no significant increase in stride time variability, whereas 'the healthy older subjects in the control group significantly increased their gait variability' (Kressig, Allali and Beauchet 2005: 729). Trombetti et al (2010) present the results of a randomised controlled trial that analysed the gait, balance, and functional performance of 134 older adults, without any prior experience of Dalcroze. Participants who had Dalcroze sessions for six months showed a statistically significant improvement to gait variability and balance as well as reduced rates of falling and the risk of falling.

The studies of the therapeutic or wellbeing outcomes of Dalcroze in recent decades tend to make research questions and outcomes clearer than the earlier writings, and this is helpful for future research. Frego (2009) and Habron-James (2013) stand out in the level of detail provided on the specific Dalcroze-based interventions used. This depth of description may prove vital in linking practice, process and outcomes in the ongoing relationship between Dalcroze and music therapy.

5. Conceptual models that include music education and music therapy

The idea that music education and the therapeutic use of music share common ground was current in Jaques-Dalcroze's time (Jaques-Dalcroze 1921, 1930) and is widely acknowledged today. Harland et al (2000) have shown that engagement in music enhanced students' wellbeing and that some participants spoke explicitly about music's therapeutic nature. Broh (2002) found that participation in music led to increases in self-esteem and social skills, whilst McQueen and Varvarigou (2010) have reviewed the benefits of music participation for people over 50, as well as for those in prisons and residential homes.

Two recent sources have visualised the relationships between the educational and therapeutic in musical activity. The first is MacDonald, Kreutz, and Mitchell's (2012) conceptualisation of music, health, and wellbeing, in which they include community music and everyday uses of music. All four domains have something in common with each other.

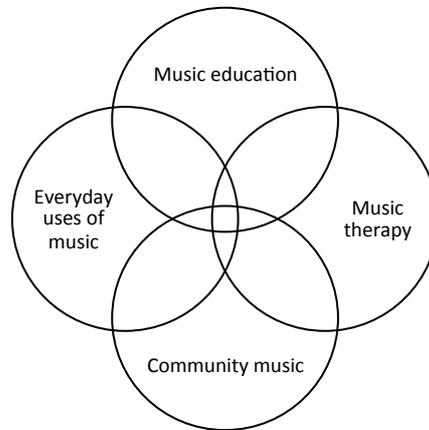


Fig.1 A conceptual framework for music, health and wellbeing. From MacDonald, Kreutz, and Mitchell (2012: 8)

The overlap between music education and therapy is clear. The authors note: ‘The purpose of a piano lesson is to improve piano skills; but there may be secondary benefits for participants relating to health and wellbeing and it is these psychological benefits of music education that overlap with music therapy’ (MacDonald, Kreutz, and Mitchell 2012: 7-8). The reverse is also true: a client in music therapy may benefit psychologically, but also learn about instrumental techniques and musical materials.

A second example comes from Ockelford (2008). Here, it is the intention of music therapy or music education that differs; on a fundamental level, the one intends to promote wellbeing and the other the development of skills and knowledge.

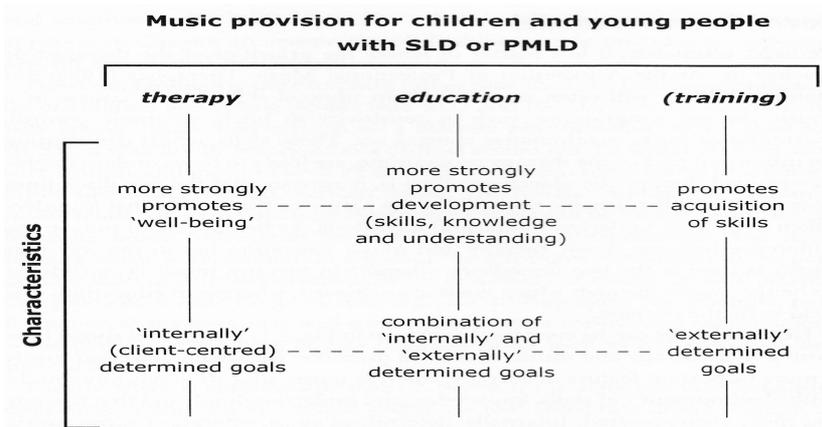


Fig.2 The characteristics of music education, therapy and training for children and young people with complex needs. From Ockelford (2008: 42)¹⁰

¹⁰ SLD = severe learning difficulties, PMLD = profound and multiple learning difficulties. Although Ockelford focuses on these groups, his model is still useful for my purposes.

Ockelford's picture includes the notion of goals and where these originate. For him, music therapeutic goals are more internally determined; the client's needs are uppermost. In education, by contrast, these internal goals are balanced with those of the curriculum, external goals. Ockelford connects the characteristics of therapy and education with dotted lines to show that there is not a division between the two. He also uses the comparative 'more' – 'music therapy more strongly promotes wellbeing' (Ockelford 2008: 42) – to highlight that the differences between music therapy and music education are questions of degree.

Ockelford paraphrases Bruhn (2000) as follows: 'the difference between music therapy and music education lies in the way that music is used in the two disciplines...in therapy, music is considered to be the *means* through which goals are achieved...in education, it is held to be the *purpose*' (Ockelford 2008: 41). However, in the case of Dalcroze this is not true, because music is not only the purpose, but also the means. In particular, expertly improvised music and the movement it incites, are the means to achieve music-pedagogical goals; the non-verbal media of music and movement are both means *and* purpose. Thus, verbal instructions may sometimes be minimal in a Dalcroze class.

As Bachmann, paraphrasing Jaques-Dalcroze, put it: it is an education through and into music (Bachmann 1991). If music is both the means and the purpose in Dalcroze, then this may be one of the most important features that marks it out from other music pedagogical approaches, and one that brings it nearer to music therapy. We could say, adopting the description from improvisational music therapy (Aigen 2005), that Dalcroze is a music-centred education. As Llongueres writes: 'Let us not forget that...we owe to Jaques-Dalcroze the very introduction of music into pedagogy' (Llongueres 1984: 131).¹¹

The area of overlap between therapy and education within the Dalcroze work has already been discussed in terms of the intentional use of Dalcroze as a therapeutic approach. However, there is evidence of wellbeing outcomes as by-products of engagement in Dalcroze, for those who regularly attend training courses. Participants in the *Moving into Composition* project (Habron, Jesuthasan, and Bourne 2012) were invited to take part in a short course of Dalcroze and compose in response to their experiences. An unexpected finding was that the students reported benefits to do with wellness. They spoke of enjoyment, relaxation, increased confidence, increased body awareness and even flow experiences, as well as impacts on their compositions and musical understanding (Habron, Jesuthasan, and Bourne 2012: 23). This happened in the context of higher education, not therapy.

Another recent study also investigated the experiences of university students in Dalcroze-inspired classes (Van Der Merwe 2014). Van Der Merwe found that, besides being beneficial for their musical understanding and speed of learning, the lessons were essentially joyful experiences and made the students feel more connected and socially integrated. These two studies indicate that there may be a wider prevalence of such impacts in educational, rather than therapeutic, contexts and that researchers could begin to theorise them in terms of wellbeing.

¹¹ My translation.

6. Communication through music

MacDonald, Kreutz, and Mitchell state that ‘The communicative potential of music is undoubtedly linked to its therapeutic potential’ (2012: 6). This communicative potential is now a field of study in its own right (Miell, MacDonald, and Hargreaves 2005; Malloch and Trevarthen (2009). In both improvisational music therapy and Dalcroze, music is the medium of communication for most of the time. They are music-centred practices. Trondalen and Bonde (2012) describe music therapy as triadic (see Fig.3). It is ‘relational and always involves the triad of music, client and therapist... In music therapy the music experience is always embedded in the therapeutic relationships that are both interpersonal and intermusical’ (Trondalen and Bonde 2012: 41).

MUSIC THERAPY

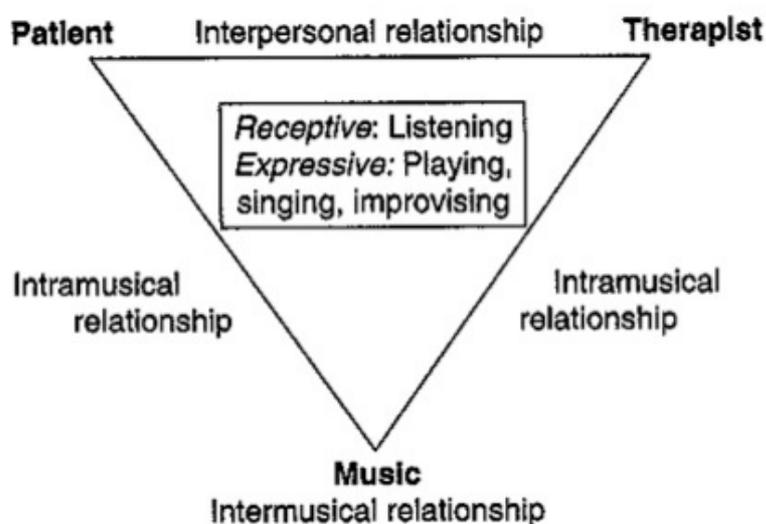


Fig.3 Elements and relationships in music therapy. From Trondalen and Bonde (2012: 42)

This model could also help to explain the relationships within a Dalcroze class, if we change therapist to teacher and patient to student; here, too, teacher and student have intramusical relationships, as well as a relationship between each other that exists in shared music making. However, the one element that may be problematic in transposing this model to Dalcroze is the interpersonal relationship between teacher and student. This is, for sure, present in a Dalcroze class and an important part of any educational process, but it might not be as close or allow for as much personal disclosure as in the case of music therapy. Furthermore, the model could be adapted to show that students in the Dalcroze class interact with each other intramusically, as do clients in a group music therapy session.

Trondalen and Bonde’s (2012) model highlights the social aspect of music making. Malloch and Trevarthen (2009) support this and show that human communication is itself made possible through innate musicality. In the very early stages of infancy the exchanges between a baby and its caregiver show a combined ability to imitate, reflect and synchronise with one

another in highly complex ways, which are musical and dance-like. Such ‘communicative musicality’, as Malloch and Trevarthen call it, adds to the argument that the propensity for musical communication is hardwired (Wallin, Merker and Brown 2000). As Cross puts it: ‘a predisposition to engage in music-like activities seems to be part of our biological heritage’ (2005: 38).

Music therapists use theories of communicative musicality to understand their work. For example, through attuning to the client in sound and gesture, music therapists model the to-and-fro of infant-carer interaction (Pavlicevic 1997, Stern 2010). Music therapists Ansdell and Pavlicevic (2005) state that human communication is developed through improvised, coordinated interaction in time. Music – an improvisational, interactional and time-based art – therefore provides readymade resources for communication and *music therapy* can be thought of as specialised communication work:

Music therapists are trained to understand the process of musical communication, and to use music as a medium and tool for initiating or enhancing interpersonal or social communication through developing musical companionship and musical community’ (Ansdell and Pavlicevic 2005: 193)

It may be that as early as 1925, Dalcroze himself had observed the phenomenon of what would become known as communicative musicality:

‘The child loves well that which he knows well. His first love is that of his mother, and this love develops in proportion as he learns to know her better, to value her unfailing affection, her tender solicitude. In her he loves the life that she passed on to him, the love that she awakens in him, and those throbbing rhythms that link together two organisms: he loves his mother because he knows her and recognises himself in her’ (1930: 127)¹²

These ‘throbbing rhythms’ may be the heartbeat and the breath heard and felt in the womb – we do not know – but they may well be the synchronous babbling and cooing, as well as the facial expressions and bodily movements, of infant and caregiver. What is important is that Dalcroze notices a rhythmic connection between the two parties, that this has to do with development (‘she awakens [love] in him’), and that there is a process of recognition of self and other.

The theory of communicative musicality may also help us to understand teaching and learning in a Dalcroze context. If, for example, the Dalcroze class is responding in movement to the teacher’s improvised music, there is a sort of dialogue. The class responds by showing with their bodies, and in their use of spatial and interpersonal relationships, rhythm, intensity, phrasing, harmonic tension or whatever the focus of the exercise is. An imaginary student’s experience might be:

...as these chords get louder, I step out into the space with more energy and intensity; as they move towards a cadence, I look for a partner so together we can make a gesture of resolution; we communicate our understanding of the music through our movements, our facial expressions, our eye contact; a moment of rest...

Likewise, the teacher may be inspired to modify his or her playing according to the students’ level of understanding or individual expression. An imagined episode might be:

¹² Jaques-Dalcroze wrote this in 1925, but it is anthologised in Jaques-Dalcroze (1930).

...I notice that the students are bunched up in the middle of the room, so I start to use more of the piano's full range and increase my dynamic level; they spread out; I change to skipping rhythms and I can see that the class has taken on the bouncing movement quality needed to express this rhythm; however, one of them skips in an idiosyncratic way and this inspires me to alter my touch on the keyboard...

These music-movement relationships also happen between the learners in pair and group work, when students improvise music to each other's movements. Furthermore, these interactions are inter-modal: the medium of music is projected in the medium of movement or vice versa. This process of transfer between modes is also fundamental to communicative musicality. It is seen, for example, when an infant's bodily movement is mirrored in a caregiver's vocal sound (Stern et al 1985). The typical Dalcroze lesson will contain music-movement attunement of a similar sort, albeit on a teacher-student or student-student level. The therapeutic potential of Dalcroze may therefore share its roots with communicative musicality.

A second vital component in communicative musicality is synchrony. The Dalcroze class often moves in concert and partakes of the same musical energies and dynamics simultaneously. Similarly, music therapists synchronise with the music (and therefore movements) of their clients. This is an essential means of making contact between client and therapist. Take, for example, a client who can only make the tiniest, silent tapping of a finger. The therapist will attune to that tapping and make sounds that reflect its pulse and quality, and a musical narrative will begin (Ansdell and Pavlicevic 2005).¹³ Such 'interactional synchrony' (Sawyer 2005) is powerful and the resulting rhythm can be an effective organiser (Skewes and Daveson 2002).

Dalcroze noted this aspect of rhythm's potential, but also noted that in shared rhythmic music or movement, the process is two-way and that rhythm can be altered in a process of attunement. He writes: 'Rhythm is life... And so rhythm creates order in the unconscious manifestations of the individual, whilst forcing metre to become supple, and to accompany all the rhythmic swing and flow of individual life' (Jaques-Dalcroze 1930: 133). The role that mirror neurons play in such experiences has been investigated by Overy and Molnar-Scakacs (2009), who put forward a theory of shared affective motion experience (SAME) to explain the social bonding and empathy that can result from such synchronised and interactive music making.

The final element to consider is improvisation, which is at the core of both improvisational music therapy and Dalcroze. Whilst recorded music plays a part in Dalcroze, piano improvisation is the norm. The Dalcroze teacher invites the class to move to music, sometimes in free, spontaneous ways, such as showing the phrasing of a piece, and sometimes in more fixed ways, such as stepping the rhythm of the bass or treble. As with communicative musicality, this process is two-way because the Dalcroze teacher should modify the improvisation in response to the class, if it is too fast for a particular student, for example. Changes in dynamic, register, harmony, and touch can all be used to make the intention clearer. We may therefore adapt the words of the music therapists Ansdell and Pavlicevic quoted above:

¹³ Ansdell and Pavlicevic use these three terms – pulse, quality and narrative – to understand musical communication in music therapy.

[Dalcroze teachers] are trained to understand the process of musical communication, and to use music as a medium and tool for initiating or enhancing interpersonal or social communication through developing musical companionship and musical community (adapted from Ansdell and Pavlicevic 2005: 193)

The notion of social integration experienced by the participants in Van Der Merwe's (2014) study would support the interpretation of a Dalcroze class as one of musical companionship and community.

Summary, implications and final words

This article set out to address the question: how can we expand our understanding of Dalcroze Eurhythmics through the lens of music therapy?

To summarise, we can say that Dalcroze and improvisational music therapy share music making as the primary means of working towards change. The notion of music *as* therapy finds an echo in Jaques-Dalcroze's idea of an education through and into music, music *as* education. It is also clearly present in the continuous thread of Dalcroze-based therapy that developed alongside Jaques-Dalcroze's educational aims.

In both music therapy and Dalcroze, musical interactions are communicative and improvisatory, and based on synchrony and attunement. Music is used dialogically or conversationally and, even if students sometimes move silently to music in a Dalcroze class, we can still understand the interaction as thoroughly musical, through Small's inclusive notion of musicking (Small 1998) and the theory of communicative musicality (Malloch and Trevarthen 2009). Jaques-Dalcroze seems to foreshadow the latter when he writes about mother-infant interaction and appears to understand the link between synchronous human interaction, attunement, and musicality on the one hand and the development of the self-in-representation on the other. Within his holistic vision of education, Jaques-Dalcroze, as with subsequent practitioners, does not separate the educative from the therapeutic; similarly, music therapists encourage and promote learning within therapeutic contexts and do not separate what, after all, are inextricably overlapping domains.

Some of the implications of this discussion for Dalcroze training, practice, and research are as follows: (1) Training programmes could develop Dalcroze teachers' understanding of their practice from wellbeing and therapeutic perspectives. This may include developing a vocabulary and theoretical framework with which to describe or interpret the experiences of learners in terms of wellbeing; (2) Practitioners could expand the current application of Dalcroze to a variety of other contexts, such as psychiatry, neuro-rehabilitation, or family therapy;¹⁴ (3) Researchers into Dalcroze could investigate the wellbeing impacts of Dalcroze in general music education contexts; they could also apply theoretical models – such as communicative musicality, interactional synchrony, and shared affective motion experience – to research how musical communication and interaction happen in the Dalcroze class and what this means for teachers and learners.

¹⁴ As far as I am aware, there is currently no provision of Dalcroze in any of these contexts, at least in the UK.

The title of this article is adapted from Bachmann's book *Dalcroze Today: an Education through and into Music* (1991). The re-wording of her title ('through music and into wellbeing') has helped us to think about the common ground as well as the differences between improvisational music therapy and Dalcroze. In Dalcroze lessons, even when not with a particular clinical population, wellbeing outcomes may be present. As Bachmann states:

For Dalcroze...what counts is Man himself, and the avowed aim of his work will be to enable that being to achieve fulfillment. No human faculty must be left hiding its light under a bushel: they are all capable of helping one another, of pulling together with a view to affirming that functional balance and harmony which is the source of all well-being. (Bachmann 1991: 11)

For Jaques-Dalcroze, his approach was always more than an education through and into music or a preparation for artistic work. Rather, it had wellbeing at its core and his vision was that individuals transformed through rhythmic movement would foster nothing less than 'a more beautiful humanity' (Jaques-Dalcroze 1912: 31). In 1925 he wrote:

Rhythmic gymnastics¹⁵...restores us to ourselves, in making us aware, not only of our own powers, but also those of others, those of humanity... It enables us...to create closer relations between body and mind, to unify the moral and physical forces of the individual, and to give a firmer foundation to the relations between men (1930: 57-58).¹⁶

This is a wellbeing or therapeutic programme in all but name, and 90 years after these words were written, the field of Dalcroze work is ripe for further development, both to nurture its therapeutic potential and capture its impacts on wellbeing.

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¹⁵ Here Jaques-Dalcroze, or perhaps his translator, inadvertently reverts to the earlier name for his approach.

¹⁶ Jaques-Dalcroze wrote this in 1925, but it is anthologised in Jaques-Dalcroze (1930).

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