Evidence Based Music Therapy

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Abstract

Evidence Based Music Therapy is a method in which the music therapist, in each decision he or she makes, tries to integrate best available scientific evidence with his or her own experience, combined with the values, expectations and wishes of his or her patient. Evidence Based Music Therapy is based on the principles of Evidence Based Medicine. A Systematic Review is a summary of the medical (or Music Therapy) literature that uses explicit methods to perform a thorough literature search and critical appraisal of individual studies and that uses appropriate statistical techniques to combine these valid studies.

Introduction

(The following paper was presented at the 2002 WFMT Conference in Oxford, UK.)
In this paper we will try to explain the principles of Evidence Based Music Therapy (EBMT). We will discuss criticisms that Evidence Based Medicine (EBM) has evoked. We will distinguish criticisms based on misunderstandings from those based on limitations of EBM. Our goal is to introduce EBMT as a music therapeutic method, set out the prerequisites for practising EBMT and highlight the role of systematic reviews in EBMT.

A Cochrane review is a systematic review in which relevant best practice research is summarized. The central topic of this paper will be to explain what a systematic review is and what the possible benefits are for music therapy practice, in line with current ideas of Evidence Based Medicine. At the moment, we are both involved in writing a Cochrane review about the effects of music therapy with demented elderly: “Music Therapy in the care of people with dementia”, together with Dr. R. Scholten of the Dutch Cochrane Collaboration. We will not focus on the contents of this review in-depth, as these results will be presented through the web later this year. Rather, we would like to use this review in this paper as an example to help you understand what a systematic review is and what benefits it may hold for you in evaluating research.

We will look back, what the past has taught us. Typical for the music therapy past is that we tended to theorize on our own. In terms of establishing music therapy evidence, we tended to ground our methods by referring to the Bonny method or the Priestley method. Most research and descriptive articles tended to be reflective of a way working of a particular therapist.

We also want to take a closer look in the here-and-now of music therapy: the necessity that we need to establish an evidence-based way of work-
Inherent to human being, we also want to know what the future may hold for us.

Therefore, we would like to elaborate with you some new ideas of evidence-based music therapy, which Manon Brusima has developed based on practice implementations. Some of you may have already read about evidence-based medicine, for instance in the special congress edition of the *British Journal of Music Therapy*. The number of articles in general healthcare that discusses the value of Evidence Based Medicine is accumulating rapidly. In the second section of this paper, we want to discuss examples of the implementation of EBM-principles in music therapy practice.

**Music Therapy Timeline**

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But first, let us go back in the past on the music therapy time line, or in some cases regretfully, still the present day situation. As a music therapist you are faced with the question of demonstrating the effectiveness of music therapy. First of all, to yourself, to evaluate your own way of working, but also there is the necessity to demonstrate the effectiveness to others. How did or in some cases still do we do this?

We read in our scarce time research reports, but we often do not have the time nor the knowledge to understand them in-depth. Tony Wigram pointed out during the congress: music therapists are not paid to be researchers nor do they have to be.

To help colleagues understand the value of music therapy, we often organize workshops for our co-workers and discuss a lot with other colleagues: all with the purpose of explaining and demonstrating the
effectiveness of music therapy. Luckily, other music therapists understand the topic. But, then there still is the struggle to explain it to other healthcare disciplines what music therapy is all about. This often takes years. In most cases, the value of music therapy in a certain facility tends to correlate strongly with the years of working experience. You were the person that demonstrated music therapy effectiveness. Times are changing fast and also healthcare does, which raises new demands for being a music therapy practitioner.

To end the past: we all know THAT music therapy works from our own experiences with single patients or groups in our own practice. But…how can we provide adequate ‘evidence’ for music therapy, also to other disciplines and policy makers? This question is typical for the present day situation.

If we would describe the music therapy timeline further, then a classifying characteristic would be for the present day situation that treatment should be evidence based: we need to demonstrate the effectiveness of our therapy. Not anymore by talking about music therapy’s effectiveness, but by referring to existent research materials.

Luckily, with the arrival of the Internet both patients and therapists have easy access to millions of pages concerning both general healthcare and music therapy, whereas music therapy books were generally hard to find in the past in the local libraries.

But as a music therapist how can I demonstrate effectiveness, I do not have the time nor the knowledge? This is in essence how the Cochrane review, also known as a systematic review, can be used as a helpful tool to keep your knowledge up-to-date. In a nutshell, the Cochrane review screens all good quality researches, selects the best and summarizes its
results, which you can implement in practice. Since 1993 the Cochrane Collaboration has invested in gathering knowledge how to combine conducted researches worldwide, involving the same topic.

Going through the music therapy literature, already many literature reviews have been published. Many books contain reviews about research outcomes relevant for music therapy. You might want to refer to these reviews, but in terms of establishing evidence these reviews are often not useful. If we look more carefully at the current literature reviews, we often see that an expert has been invited to write about a certain topic, which might have biased the review. A specific research question is often absent or subjective, which might again bias the conclusions derived in the review. Often the criteria are not outlined in the review why and how the discussed research studies were included. Or what methods did the author use to judge the quality of the included research studies? Often we see that there are many possible sources of bias, which makes it difficult to fully comprehend the conclusions presented in the review. The conclusions may be subjective and might be reflective of the author’s personal interest or theoretical background and also cultural factors may have influenced the nature of the conclusion. Working in the field of music therapy, I know for myself as a fact how easily you can be driven towards subjective descriptions. Especially, in the field of music therapy you tend to take an offensive point of view in your writings. This was also the case when I wrote the first protocol versions of the dementia review. I was rightfully corrected by the Cochrane editorial board, that I introduced bias by stating that music therapy IS effective instead of MIGHT be effective, until research shows otherwise… Objectiveness should be our critical guide in evaluating, conducting and interpreting research. But how to go about? The great amount of subjectivity in eval-
uating research was exactly the purpose that Archie Cochrane mentioned in 1979 that:

“It is surely a great criticism of our profession that we have not organised a critical summary, by specialty or subspecialty, adapted periodically, of all relevant randomised controlled trials.”

Following Archie Cochrane, the building blocks of a good systematic review should be the comparison of randomised controlled trials (RCT) in relation to a certain area of interest. Currently, in the context of healthcare interventions also clinical controlled trials (CCT) may be included.

Why RCT or CCT studies? RCT and CCT are commonly regarded as the most reliable research designs. Due to the design properties they allow for statistical comparisons between studies, with the influence of bias kept at a minimum. The results of separate research study outcomes can be analysed to one overall outcome measure indicating the overall effectiveness of a certain type of treatment.

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<th>RANDOMISED CONTROLLED TRIAL</th>
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<td>• Two or more interventions are compared in terms of effectiveness. One is the treatment intervention which is compared to an alternative form of treatment, no treatment or placebo</td>
<td>• Two or more interventions are compared in terms of effectiveness. One is the treatment intervention which is compared to an alternative treatment, no treatment or placebo</td>
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<td>• Adequate method of randomisation: patients are assigned in random order to one of the interventions</td>
<td>• No method of randomisation: random assignment of patients is often not possible in or across healthcare settings.</td>
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since 1993, the Cochrane collaboration has been started as an international non-profit organisation which prepares, maintains and promotes the accessibility of systematic reviews. By now the number of Cochrane Centres is rapidly increasing throughout the world, like an epidemic. The scientific literature is generally dominated by American and European research. With the start of non-western Cochrane associations, also research studies conducted for instance on the African continent, may become more easily accessible.

All the reviews that are conducted worldwide are accessible through the internet via the Cochrane library, for instance on www.cochrane.de. In any good medical library you may find access to the Cochrane databases. You might also want to search the internet to see if there any free trials through which you can search the Cochrane Library. Several databases are included in The Cochrane Library. One of them, The Cochrane Database of Systematic Reviews, contains Cochrane reviews and another, The Cochrane Controlled Trials Register, is a bibliographic database of controlled trials. The Database of Abstracts of Reviews of Effectiveness (DARE) includes structured abstracts of systematic reviews which have
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been critically appraised by reviewers at the NHS Centre for Reviews and Dissemination in York (UK) and by other people, e.g. from the American College of Physicians' Journal Club and the journal Evidence-Based Medicine. The Cochrane Methodology Register is a bibliography of articles on the science of research synthesis. Also included in The Cochrane Library is a Reviewers’ Handbook on the science of reviewing research; a Glossary of methodological terms and Cochrane jargon; and contact details for review groups and other groupings in the Cochrane Collaboration.

But why should I search for systematic reviews in the Cochrane library, you might ask. When you have a patient with Alzheimer’s disease for example, you can search what are current insights of best practice medicine with this client group. Regretfully, that are not many music therapy reviews available yet, but also the information of other reviews might be helpful in developing your treatment goals, as later in the paper will be described.

As there are clear guidelines, which have been developed over the years by the Cochrane Collaboration about combining and evaluating research, the advantages over the Cochrane review are clear. The process is transparent, controllable and replicable. The Cochrane review is a scientific based instead of a subjective summary of the literature and the reviews are easily retrievable through the Internet. The reviews are written comprehensively and music therapists do not have to have the skills and the time to digest all the research studies themselves.

WHAT THEN IS A SYSTEMATIC REVIEW?

A systematic review is a review that strives comprehensively to identify and synthesise all the literature on a given topic. The Cochrane review is a systematic review with includes the procedure of meta-analysis. Meta-analysis is a statistical technique for assembling the results of several
studies in a review into a single numerical estimate. Many reviews are not systematic but are still valuable and helpful as long as the reader is aware of the procedure. However, a meta-analysis that is not a systematic review is likely to be highly biased and should be used with extreme caution (Light, 2002). The Cochrane Collaboration focuses particularly on systematic reviews of randomised controlled trials (RCTs) because they are likely to provide more reliable information than other sources of evidence.

A systematic review following the Cochrane principles consists of the following steps:

1. Formulating the problem or research question (PICO)
2. A comprehensive literature search: locating and selecting studies - Objective inclusion criteria for retrieved studies - A critical appraisal of the methodological quality - Objective data-extraction by ≥2 reviewers - Meta-analysis
3. Structured method of reporting the results
4. Improving and updating the reviews

The starting point of the Cochrane review is a good research question, which is also known as ‘PICO’. A certain client population (P) follows a certain type of treatment (I) which is compared to an alternative form of treatment (C) which results in a treatment outcome (O). An example of the PICO-question translated to music therapy is for instance: Do demented elderly (P) benefit more from music therapy (I) than from comparative treatment modalities (C) in reducing problems in the cognitive, social, emotional and behavioural domain (O)? After formulating the research question, the following step is a comprehensive literature search to find all the relevant literature that may be included in the review. Recommended sources for literature searches are Medline, Embase, PsychIndex etc, which all can be found on the Internet. A clinical librarian can assist in formulating the right search-strategy. A comprehensive, unbi-
Based search is one of the key differences between a systematic review and a traditional review. While electronic databases such as Medline are powerful tools for locating studies, only 30 - 80% of all known published randomized controlled trials are identifiable using Medline (Clarke et al., 2001). Databases such as Medline do not include all available music therapy references. It is advisable to search also for music therapy literature in specific databases such as made available through the University of Witten-Herdecke on www.musictherapyworld.net or to conduct hand-searches.

There are many helpful tools available by which you can manage the retrieved references such as ENDNOTE or REFERENCE MANAGER. Through these programmes you can access for instance the Medline database and you can import the retrieved references directly into Endnote or Reference Manager.

**FIGURE 2.**

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See also: http://cebmjr2.ox.ac.uk/docs/levels.html

After finding references and ordering the hard copy’s, then the next step in the Cochrane review is selecting the best and excluding the worst designs. Not every retrieved study is included in the Cochrane review.
Only RCT’s or CCT’s are allowed to be included, in order to conduct a proper analysis. In general, the following order is used to evaluate research. The highest level of evidence is derived from a systematic review that is based on RCT’s, followed by RCT or CCT studies. Generally excluded in the Cochrane review are the patient-series with or without controls and case studies. The lowest level of evidence is formed by expert opinions. Qualitative research is generally also excluded in the Cochrane review. At the moment a Qualitative research group has been started at the Cochrane Collaboration that is looking at the merits of qualitative research. In current music therapy research patient series, case studies and qualitative research dominate. Relatively little systematic researches have been conducted.

In the table on the left, evidence from step 1 is the strongest and from Expert Opinions the weakest. The strength of evidence is related to the degree to which bias and confounding factors are controlled for. By definition this means that quantitative study designs provide the strongest evidence because they provide the best means of controlling for bias, but only if the sample size is large enough and appropriate to control for random effects. This does not mean that weaker types of evidence are not reliable, but simply that it is more difficult to control for bias. Studies that show dramatic effects require less control for bias than those which only show small effects (Light, 2002).
For the Cochrane review on dementia we have retrieved a total of 354 references. Most of them were descriptive or anecdotal reports concerning the topic of music therapy and dementia. After excluding these references, a total of 102 remained which were possible research studies. Of those titles, we ordered all the hardcopies and examined if they were suitable studies to be included in the review. As we can see from the graph, about 90% of the retrieved studies consisted of case studies and patient-series designs which were excluded from the review. A total of 10 studies was adequate for inclusion. The last step of the Cochrane review is the “meta-analysis”: the combination of the results of separate, comparable studies to an overall measure, indicative for an overall conclusion about the treatment effectiveness. The Cochrane Collaboration has developed a special program for this purpose: RevMan 4. All data that has been gathered is presented in the Cochrane review and can be checked on the Internet. All the included reviews in the Cochrane Library are written following the same standard.

- a 'cover sheet', a structured abstract
• a structured report of the review: objectives; methods; the results and discussion of the results of the analysis, list of excluded studies; judgments about the implications for practice and research
• tables of the characteristics of the studies included in the review, including information relevant to an assessment of the methodological quality of each of the studies included tables and graphs of the results of the review, with presentation of the statistical syntheses (meta-analyses)

To summarize, in this section of the paper has been described what a systematic review is. The purpose has been to demonstrate how (Cochrane) reviews are written and according to which standards, in order to understand them more thoroughly. In the next section of this paper will be discussed how they can be implemented in music therapy practice.

Edwards (2002) points out that it has been useful to outline the position of music therapy in relation to the Cochrane library when discussing music therapy employment proposals in medical contexts. In time, we will have more reviews which will also include music therapy interventions. At the time of writing, two Cochrane reviews are in process which concern the effects of music therapy. The dementia review as described before and Anna Marathos Tooth and Christian Gold work on a review about music therapy and depression (see reference section). The Universities of Witten-Herdecke, Aalborg and Melbourne are also writing systematic reviews about the effect of music therapy with a variety of client populations. At the time of writing, luckily these reviews are all written by skilled researchers.

The popularity of Evidence Based Medicine has become immense. This may also have it pitfalls as the term already has been misused on numerous occasions, which in time may lead to Evidence Biased Medicine. Edwards (2002) describes aptly that music therapists need to continue to discuss and debate their view as what constitutes knowledge, expertise
and ‘evidence’ in our profession. But the question is to what endresult will this discussion lead. Do we continue on our own and advocate music therapy effectiveness within our own ‘church’ and will we be establishing guidelines on our own of what ‘evidence’ is? Or will we be able to bring some of our knowledge across? Some authors have underlined that a RCT is not a suitable design to adequately describe music therapy’s process for all sorts of arguments. We should both work on establishing evidence to ourselves and to others. This may take different strategies.

For developing our own profession, study designs such as the qualitative design might enable us to gain more insight into its processes for our own professional development. On the other hand, we should not neglect the fact that we also should establish evidence to other professions. In terms of the current levels of evidence: music therapy does not do well in establishing a sound argument to others than ourselves. We should come up with evidence on all sorts of levels. We do well in terms of case studies and patient series but there are few randomised trials conducted in music therapy. Music therapy should also prove its value across people and across therapists in a randomised trial. In the Netherlands, multidisciplinary guidelines are being developed in which psychotherapeutic ‘evidence’ is given in line with evidence from other modalities such as music therapy. Not without reason, music therapy as an intervention in the treatment of depression has ended up at the last pages. Simply because we cannot come up with similar arguments of which I am sure that we are able to provide in time. Does it have to do with levels of evidence or with the current level of music therapy research? I do not know. Tony Wigram pointed out correctly that music therapists in their profession should not have to be researchers nor are they paid for it. We lack in general research studies, as is the case in the Netherlands where we do not have university support or adequate supervision for research in the field of music therapy.

In the current line of reviewing evidence of conducted trials, we have to
conduct similar but different research strategies. Not only to conduct music therapy research in purpose to demonstrate effectiveness. I hope to read at some time about a study which did not work at all: this is also evidence which we should allow ourselves to happen to further music therapy development.

In the second part of this paper we will look at Evidence Based Music Therapy from the therapists’ point of view.

Evidence Based Practice

The phrase ‘Evidence Based’ first caught my attention in the beginning of the year 2000, in a medical bookstore. There I bought the book: ‘Evidence Based Medicine: How to practice and teach EBM’ by David Sackett and colleague. I read it and in the following weeks noticed the phrase ‘Evidence Based’ popping up in newspaper articles. These concerned changes in health care policy and demands from consumer organisations. The words were used in various contexts and seemed to have a lot of different meanings. Apart from misuse of the phrase ‘Evidence Based’ there are in fact several understandings of Evidence Based Practice (EBP). They can be summed up by three levels in which health care professionals practising EBP operate. (Mace et al., 2001)
At the first level ‘best evidence’ is used in making decisions in our everyday work. At the second level the five steps of Evidence Based Medicine are used to solve problems arising from everyday clinical work. These five steps are followed through even if no satisfying evidence is found to support them. At the third level EBP concerns the theories about what we do and what is effective. It stands a bit apart from everyday practice but has wide implications for our daily work. Writing Cochrane systematic reviews and conducting a controlled trial in the workplace are examples of EBP on this level.
As with all new ideas and practices that spread rapidly through health care world wide, the phrase ‘Evidence Based’ is and has been misused. Some policy makers for instance, use the words to propagate EBP as a form of health care in which only therapies of which the effect has been proven are funded. In this approach ‘effect’ reigns, and theory is ignored. The problem with this ‘effect-based’ medicine is that it assumes that diagnosis is equal to the patients problem for which he/she seeks help. In regular medical medicine this can be done with relatively little serious consequences. In psychological settings however, this approach has major negative consequences. This is because diagnostic classifications, as used in psychiatry, are still a set of hypothesises about what is wrong with clients. They have been formed to make it possible for clinicians and researchers to make diagnoses, communicate about them, treat the various psychological disturbances and to research them. (American Psychiatric Association, 1994) Thus they cannot be used to practice the cookbook medicine or ‘effect based’ medicine without losing its scientific basis.
On the other side of the spectrum we find the ‘all evidence included based practice’. In this approach individual health care workers or their professional organisations do not distinguish qualitative research (patient series and case studies) from quantitative research. It will not be surprising that this approach is often used by individuals that want to meet the demand for evidence, but worry about the amount of good conducted controlled trials in their area of specialisation. The problem here is obvious; it lacks the scientific standard that is widely appreciated, and which enables communication with other disciplines.

EBP is in essence a sincere effort to combine the best scientific evidence according to scientific standards with the best patient –centered care. This is the EBM Sackett and colleagues introduced, and that is advocated by the Cochrane Collaboration, as pointed out in the first part of this paper.

The definition of Evidence Based Music Therapy is:

Combining the best available scientific evidence with the clinical expertise of the therapist and client values and wishes in the treatment of clients.
Similar to the steps in writing a systematic review the five steps of EBMT are:

1. formulating an answerable question (using the PICO-elements)
2. searching for evidence (in this paper the evidence will come only from Cochrane Systematic Review)
3. critically appraising the evidence
4. application of the evidence to your patient
5. evaluation of the previous steps

I will demonstrate what EBMT looks like by introducing an example from my own clinical work as a music therapist in a day-care clinic for adult psychiatric patients.

John, a 20-year-old man suffering from psychotic episodes was taking part in a Psychotic Vulnerability Training –program for young adults with schizophrenia related conditions. He was not responding well to the treatment, had difficulties in making contact and showed signs of depression. One session the patients played different parts of a round, Father Jacob, on different instruments, and by focusing attention entirely on each part, the song sounded right. John turned to me at the end of the session with delight and said: “This really works for me, by concentrating
entirely on my part I get grip on myself. That is something I miss most of the time”. Intrigued by his comment, I wondered if there existed a Cochrane Review on the subject of attention training and its benefits for patients with schizophrenia related conditions. If so, maybe the intervention should be included in the sessions for all the patients of the Psychotic Vulnerability Training. I went about it in an evidence based way. I formulated a question:

**FIGURE 7.**

Step 1: formulating an answerable question

Do musical concentration exercises (I) improve cognitive skills (O) in schizophrenic patients (P) compared to no musical concentration exercise (C)?

As you can see, all the PICO-elements are there, patient, intervention, comparison and outcome. Then I searched for evidence and turned to the Cochrane Library. With the search phrases ‘music, concentration, schizophrenia’ there were no results. I restricted the search to the phrase: schizophrenia. About 150 references were retrieved, most of which were on pharmacological treatments. I luckily had the time to go through the remaining abstracts, and found one on ‘Cognitive Rehabilitation for people with schizophrenia and related conditions’. The reviewers conclusion was that cognitive regabilitation, when used, should be presented to the client as ‘experimental in nature’, because no evidence was found that
cognitive rehabilitation improved cognitive skills in psychotic patients. The cognitive rehabilitation consisted of attention training on a computer.

So I had my evidence, trusted its quality (because the review has been accepted for the Cochrane library) and thus could skip step 3: critically appraising the evidence.

Moving on to step 4 had to see if the evidence could be applied on my patient. The following questions and notes arose:

- Are there reasons to believe the intervention would not work with our patient (-group)?
- Age, culture, sex, geographical origin are levelled out in Cochrane systematic reviews
- Comorbidity has to be considered!
- Qualitative research can play an important role in determining how to apply the evidence
- Do I possess the expertise? What are the costs?
- What are the wishes of my patient?

To apply the evidence to John's case we take a look at the inclusion criteria for the review, costs, expertise needed and patient wishes. Would John have been accepted for the experimental group? Does he have the same age, does he have any additional diagnoses? Does he come from the same cultural background? If not, do I have a reason to believe the different cultural background would not make the intervention described work? Does a different sex play a role?

Qualitative research can supply answers to the question: are there reasons to believe the intervention would not work with our client? Cochrane has a group focused on the application and standardisation of qualitative research.

Note: In this case I did not have access to evidence from a review on music therapy and schizophrenia. In future, this will hopefully change, as
more music therapists are starting to write Cochrane Reviews. At the moment Cochrane Reviews on Music Therapy are being prepared, for instance Kristian Gold and Anne Marathos Tooth’s protocol on MT and depression.

Carrying on with step 4 in the case of John, two problems in applying the evidence from the review appeared:

**FIGURE 8.**

Step 4: Applying the evidence to John’s case
- Is attention training on a computer comparable to attention training in music therapy?
- What does John want?
- Do I have the skills to give the therapy (in case there is a positive conclusion)?

When used as attention training, the music therapeutical intervention of playing a round contains similarities to the attention training on the computer, because of its similar goal.

Following the reviewers conclusion, I concluded that it would be unethical to present the exercise done in the MT session as beneficial for John’s cognitive skills. John himself seemed to hold the experience of getting a grip on himself as the most important aspect of the intervention. It seemed I could not offer him an evidence based intervention which would help him get a grip on himself. Instead I decided to pay more attention to his fear of disintegrating and mourning over his illness.
Summed up in the slide are the consequences for the treatment of John from the evidence I found:

**FIGURE 9.**

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**Step 4 continued**

- No psycho-educational explanation or encouragement was given to John about exercising his concentration by playing music.
- He was encouraged to enjoy himself in his own way.
- Special attention was given to his fear of ‘losing track’ of himself.

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In step 5 steps 1 –4 are evaluated. I decided to include special attention for mourning for all patients in the ‘Training Psychotic Vulnerability’.

Other examples of evaluations in step 5 are:

- working on your internet skills
- getting access to the Cochrane Library
- ordering a new drumset for aggression-regulation training

As we come to the end of this presentation we will sum up the characteristics of Evidence Based Music Therapy in this slide:
To summarize, in this paper we have described the possible benefits of evidence based working in music therapy.

We hope more music therapists will participate in the writing of Cochrane Reviews on Music Therapy or will find assistance in their work by using systematic reviews as an easy accessible source of information to retrieve current insights in research.

Usefull websites:
www.cochrane.org
www.cochrane.de
www.ebmt.info

References:


**Contact**

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