

ESSAY | PEER REVIEWED

Navigating an Internship at a Residential Education and Medical Centre in Rural Kenya: Reflections of a Music Therapy Student

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Abstract

Little has been written from the perspective of a Kenyan student completing a music therapy internship at a mental rehabilitation institution in rural Kenya. At the time of writing this essay, music therapy was still not recognized as a profession in Kenya. This observation inspired me to fill a knowledge gap, encourage students to share their own experiences, and in the process, encourage aspiring music therapist students pioneering in other parts of Africa. I have divided my learnings into five themes based on my reflexive notes: (1) Mindset: Something out of nothing, (2) A staggered internship, (3) Transferring theory to practice, (4) Navigating workplace culture, and (5) Cultural sensitivity and musical multicultural competence. I advise the reader to take into consideration that these are my thoughts as a student undergoing a transformation. The essay not only describes my journey as an intern, but also provides me with a template for further reflections in my work as a music therapist. Compiling this essay has taught me that words on paper carry significant weight and have the ability to bring resolution to a problem or propagate it further. Through the internship, I came to learn that it is the role of music therapists to see beyond adversity; ignite hope where there is despair, and hold on to a future of possibilities.

Keywords: music therapy; internship; mental health; rural Kenya

Introduction

The use of music intervention is not a new concept in Kenya. Music has been used for its healing powers among various ethnic groups, particularly in ritual practices. The Digo tribe from the coastal region used the large *Mabumbumbu* drums and voice for healing purposes (Akombo, 2001). All-night *isukuti* drumming is still practiced today during burial ceremonies by the Luhya tribe in Western Kenya to announce the death as well as to numb the pain of losing a family member. The guttural drone vocals in the traditional music of the Maasai Moran in Southern Kenya and Northern Tanzania produced the desired trance-like effect in their rituals. This instilled courage before a hunt. This music is still performed, although hunting is no longer practiced as a rite of passage. For years there have been many individuals who continue to provide music interventions within community settings, fostering hope in refugee camps through after-school programmes for children (Akombo, 2001), in prisons (NaroFilm, 2019), and hospital wards (NTV Kenya, 2018).

More recently, like El Sistema in Venezuela, learning and performance of Western Classical Music was introduced to economically marginalized youth in one of the slum dwellings in Nairobi. Ghetto Classics is a project of The Art of Music Foundation, created in 2009, to mentor children and teens of Korogocho slums through Western Classical Music, steering them from a life of crime and destitution (Artofmusic, n.d.). Performing Classical Music is a key social activity bringing change to that community. This type of social activism through music is in many ways how we describe Community Music Therapy. Pavlicevic (2010) added that it “is part of a complex social web and is thoroughly engaged with the social issues of its time and place” (p. 223).

At the time of writing this essay, I could not find anything written from the perspective of a music therapy intern based in rural Kenya. Music therapy was not recognized as a profession in Kenya and, at the time of writing this essay, was not offered as an undergraduate or graduate field of study in any of the universities in this country. It took a while to develop an awareness of my inner self, break the cycle of negative thoughts, and observe my feelings. Through my practicum supervision,¹ I embraced the journey and learnt to integrate into my internship community, not only as the bearer of music therapy but also as the beneficiary. I decided to write this reflection and testimonial on my experiences at Matumaini Rehabilitation Centre to fill a knowledge gap, encourage fellow students to share their own experiences, and in the process, encourage aspiring music therapists taking the unbeaten path.

Background Information

After graduating with a Bachelor of Music degree, I was a Piano and Flute peripatetic tutor in Kenya for 20 years. I developed an interest in music therapy when I saw how my nephew, who has Down Syndrome, responds to music. Looking for a postgraduate course, I enrolled at ArtEZ University of the Arts, which offered a long-distance bachelor's equivalency programme, with four on-campus sessions through one academic year. During this period, students are required to find an internship that will run concurrently with the lectures for a total of 560 hours. Along with having a music therapist mentor to steer the practical learning process, students are required to undergo a total of ten hours of supervision to help cope with any psychological challenges that may arise. At the time of my music therapy studies, I was the only Kenyan enrolled in this programme.

Little has been written on the internship experiences of a pre-professional music therapist (Clements-Cortes, 2015). The student music therapist goes on an academic, and indeed, a holistic journey during the internship period when new self-perceptions and discoveries are made. Furness et al. (2020), have looked at the viewpoints of Australian allied health students and graduates on the value of rural clinical experiences in develop-

ing one's capacity for professional thought, feeling, and behaviour. Some valuable experiences included exposure to a broad spectrum of caseloads as well as opportunities to learn and support each other as students.

Matumaini Rehabilitation Centre

Matumaini Rehabilitation Centre (MRC) was established by Ruth Scott-Kellie in 1974, to provide education and medical care to children with disabilities in Molo, a rural district in Kenya (PEFA Matumaini, n.d.). At the time, the Kenya Ministry of Education (MoE) had not established educational policies for children with additional learning needs (Jenkins et al., 2010). Today, MRC is registered as a Charitable Children's Institution under the Ministry of Gender and Social Development. It consists of a hostel, a community-level medical dispensary, and a basic physiotherapy unit. Its once-active vocational training centre shut down in 2018 due to a lack of funding.

MRC sits on approximately five acres of well-utilized grounds. With a borehole providing a good water supply, the institution grew its own vegetables and ran a successful poultry project including a hatchery. A piggery had just been established and there were two milked cows, a ram, and a calf. The administration block, with a boardroom and two unused classrooms, stood at the entrance to the property, next to the community dispensary. The boys' dormitory was right behind the dispensary. Other buildings included staff housing, a defunct vocational training unit, a food storage room, a kitchen and dining room, and the girls' dormitory along with a TV room (doubling as the chapel) right next to the physiotherapy room. Grazing paddocks were interspersed along the periphery. The rest of the grounds had flower beds and well-trimmed grass where the clients spent hours of their day if they were not at school. Concrete paving had recently been laid to facilitate wheelchair access.

The population of over 70 students at MRC consists of children (and adults) aged between 5 and 33. About 85% have physical impairments mostly caused by poliomyelitis. Other conditions include Autism Spectrum Disorder, Down Syndrome, Cerebral Palsy, Attention-Deficit Hyperactivity Disorder, Traumatic Brain Injury, and Schizophrenia. Some individuals experience multiple conditions such as muscular dystrophy in addition to pre-existing undiagnosed disorders. Epilepsy is also a common disorder among clients.

I discovered MRC by chance. My internship was meant to be at a government-run special education school with a similar Swahili name, *Tumaini*, which in this context means *Hope*. Tumaini Integrated Primary School was originally an annex of Matumaini Rehabilitation Centre. After the founder returned to the United Kingdom, the school which had grown to over 250 mainly mainstream pupils, was left for the government to run and thus branched off from MRC. Due to the coronavirus pandemic, all educational facilities were closed. However, some children continued to stay at the centre through the pandemic and I was allowed to work with them in person.

Getting Started

My orientation to MRC included a brisk walk through the site with the administrator introducing me as the music teacher to the support staff and clients. Thus began my internship experience, with no music therapy room, no instruments, and no apparent vision. I spent my first three weeks interacting with the clients, desperate to gain their trust because so far, I was just a visitor, who came with no gifts. I would contemplate throughout my internship whether I should bring sweets as regular visitors did and finally did leave them with two packets of lollipops at the end of the internship period.

By observation, I felt that the economic situation at MRC looked dire. The centre was

understaffed and underfunded due to the unclear sponsorship mandate between the local government and a local church. Meanwhile, I had the task of finding a music therapy mentor as I simultaneously sourced instruments with my savings, while the imminent goal of starting music therapy sessions was beckoning. Remarkably, all things came together at the same time. A master's student at ArtEZ University of the Arts in the Netherlands offered to mentor me by video call (via Microsoft Teams), a set of instruments finally arrived at my location, and an unused classroom (doubling as mattress storage) was now also assigned for music therapy.

I officially began my clinical work four weeks into the internship. I looked through client files, trying to make sense of things. There was a lot of paperwork. Clients with physical disabilities had updated files. Those with mental health challenges as well as the neurodiverse were mostly undiagnosed or had outdated diagnoses. This was the case in most rural rehabilitation institutions in Kenya mainly because the government deployed a single social worker to cover a wide geographical area.² Some of the clients were admitted at MRC under court order. As I learnt about Trauma in my lectures, I realized it was prevalent among the clients at MRC. While music therapists are not mandated to work with a diagnosis, the unclear structure drew me deeper into uncertainty. For instance, between the administrator and the caregiver, the social worker and matron, it was unclear who I reported to, worked with, or discussed my clients.

Method

As part of the practicum, the pre-master music therapy students were required to keep a confidential daily log. Since I did my internship twice a week, I had two diary entries per week for the duration of 10 months. The daily journal was a detailed narrative of how my days unfolded as an intern. Everything was kept private. In addition to this, I also wrote reflexive notes after each supervision meeting.³ I had 10 supervision meetings, which translated into 10 entries. These were more introspective in nature.

Reflection Highlights

This reflection explores various themes that emerged as I underwent my music therapy internship at Matumaini Rehabilitation Centre. Quite early in my internship period, I was introduced to the book *Community Music Therapy* (Ansdell & Pavlicevic, 2004). Pavlicevic included a reflection on the role she played alongside three other art therapists on a 3-day project at Thembaletu, a non-governmental organization in South Africa. Feeling a little helpless, she examined her professional background and conventional music therapy practice apropos of the unfamiliar socio-cultural context she found herself in and derived both personal and professional themes. Following the framework presented by Pavlicevic, I referred to the two sets of notes and compiled the following five themes:

1. Mindset: Something out of nothing
2. A staggered internship
3. Transferring theory to practice
4. Navigating workplace culture
5. Cultural sensitivity and musical multicultural competence

Theme 1: Mindset: Something out of nothing

My first theme describes how I moved from a mindset of lack to one that saw possibilities and how that made an impact on myself and others at the centre. How does one create something out of nothing? Perhaps the best answer to this is that in every situation there

is always *something*. By seeing MRC through the lens of despair, I felt dejected and was further marginalizing the institution. In my supervision sessions, it emerged that I was harbouring thoughts of defeat, festering feelings that exuded pity. I struggled with a mindset that paralyzed my actions. And then one day, I made a conscious decision to make it work. This meant I would stop comparing my situation with that of my student peers in Europe who, I felt, were in a more privileged situation. I thought my colleagues in Europe had adequately staffed internship placements with clients that had all their basic needs met. I failed to believe that MRC would one day get there. It was a moment of reconciliation: “I am not in the Netherlands; I am in rural Kenya.”

In my reflexive notes, I began to list all the positive things about MRC, which far outweighed the negatives. It was only after I had this mind shift that I started to see how it was indeed possible to practice music therapy in this environment. And with a positive mindset, I developed positive emotions about the place. I began to see the beautiful grounds and flowers, the peaceful atmosphere, the clean air, and the twinkle in the little ones’ eyes. I visited the piggery and often checked on the calf. I was willing to endure the bumpy 30-minute ride on a motorcycle taxi deep into Kiambogo village every week for the duration of my internship. Month after month, my *something* grew to be stronger and more compelling.

The *something* I refer to here manifested in various ways. It was the connectedness I developed with my clients, who began to openly share their days’ accounts with me, both good and bad, so that I may address them on their behalf. It was the slow process of coming out of my shell in service of others. When one focused on the issues at hand, the ego disappears. It was seeing the power of music unfolding in unfathomable ways; the feeling of making eye contact for the very first time with a client with a disorder of consciousness was profound; a little boy who often played outside in solitude actively participated in the group sessions; an adult with aphasia who loved to sing looked forward to the songwriting sessions where he shared his story in the lyrics. I was no longer doing this for my studies, but for the impact it made at the centre and to me. This was a realization that something I was engaged in, was making a difference to someone or someplace. Through music therapy, a safe environment emerged for the client as well as for myself.

Theme 2: A staggered internship

This theme describes the logistical challenges I experienced with my mentor through the internship process and how we navigated them. In many internship placements,⁴ the music therapy student gets to observe a registered music therapist in action within a clinical music therapy setting. This mentor or coach in turn may assess the skills of the student music therapist throughout the duration of the internship until the student is more confident to lead individual and group sessions. This was easier said than done.

As mentioned earlier, throughout my internship process I was mentored through online correspondence, with me based in Kenya and my mentor based in the Netherlands. I was granted permission for my mentor to view videos of my work for study purposes, just as we could discuss videos of her own music therapy work. This is not a common practice but as an intern and given my unique circumstances, it was necessary for me to see how a music therapist works.

Unfortunately, this process lacked immediacy. Feedback had to wait for the meeting and the arising improvements had to wait to be implemented at the centre the following week. This differed from my peers, all of whom interned in institutions that had a resident registered music therapist and had the opportunity to observe the music therapist and be observed. After which, the music therapist would give them feedback in real time. Thus, developing competency as a music therapist student appeared to be a staggered process. On the other hand, I learnt to be independent right from the start. I watched and re-

watched my videos to see what needed improvement. I gained a “just-go-for-it” attitude to combat self-doubt and psychological as well as emotional challenges. My daily log indicated that I doubled my information intake by studying more so that I felt equipped when I was in the music therapy room. This included buying more books like *Therapy in Music for Handicapped Children* (Nordoff & Robbins, 2004), *Music Therapy Handbook* (Wheeler, 2015), and *The New Music Therapist’s Handbook* (Hanser, 2018). In the long term, the case examples in the books have helped me learn how to manoeuvre different working environments with varied types of clients.

This way of learning was coupled with additional challenges. Filming using a phone camera within everyone’s field of vision and reach was a high source of distraction. One particular client liked to tap the red button which stopped the recording, sometimes without my knowledge. Secondly, it was not possible to film all sessions due to storage space. Thirdly, the compiled version presented to my mentor was already edited into one long video. This removed real-time contextual information within the therapy sessions and thus compromised the quality of feedback I received from my mentor. Anderson and Proto (2016) have discussed ethical requirements and obligations in the use of video in qualitative research. While video is a powerful tool that offers opportunity for future observation and analysis, the critical dilemma of confidentiality and representation was an additional challenge I needed to address.

For instance, even though I was given full consent by MRC to share the filmed music therapy sessions with my mentor, supervisor and colleagues for study purposes, it was my responsibility to set boundaries as to how much I could share. I kept the clients’ personal details confidential, such as their medical records and family situation.

Through this experience, I have acquired a new appreciation for those that pioneered in this field in their countries. That said, I could use a further internship opportunity, working directly with a licensed music therapist, before or during my master's study.

Theme 3: Transferring theory to practice

My third theme shows how I tried to practice the learnt music therapy approaches and whether or not I succeeded. The whole point of a music therapy internship is to apply and integrate theoretical knowledge. The design of my university’s pre-master programme was such that the students logged into the lectures from different parts of the world. All students received the same course material which we converted into active learning at our respective internships. In theory, we learnt the same thing, while in practice at the internship, there were considerable differences. For instance, one peer interned at a rehabilitation centre for people with Wernicke-Korsakoff Syndrome in the Netherlands, another at a centre for elderly people with aphasia in Hungary, while my placement in Kenya comprised a population of children with physical challenges and additional learning needs, mostly under 16.

Clements-Cortes (2015) mentions more variables in terms of the size of the daily caseload, the number of individual and group sessions, the amount and frequency of supervision sessions, and the number of days or weeks prior to the interns leading their own music therapy sessions. My peers and I had unique internship experiences, yet our fear of facing this new experience was the same. A pilot study by Baker & Krout (2011), on collaborative songwriting as a tool for facilitating students’ reflections on their internship, revealed that despite their differences, one of the most common issues they shared was a lack of confidence in whether they were competent enough to work with clients in clinical practice.

On a survey studying Canadian students’ music therapy internship experiences, it was argued that students felt they were expected to grasp all the theory in order to react appropriately to all client situations (Clements-Cortes, 2015). Suffice it to say, chapter

thirty-seven, titled *Sixty-Four Clinical Techniques*, from *Improvitational Models of Music Therapy* (Bruscia, 1987), became my bible. In that chapter, Kenneth Bruscia has described the most common interactions therapists use to elicit responses from clients or direct the client's current experience.

While it was impossible and not a requirement to apply all clinical techniques such as the "*Elicitation Techniques*" and "*Redirection Techniques*," being able to fluidly incorporate them where needed remained a skill that would take beyond the duration of the internship to master. There were many occasions when the client did not acknowledge my presence in the room. On one occasion, a twelve-year-old boy had noticed the triangle for the first time. The boy was so fascinated by the ringing triangle that he went at it for minutes. He was completely in his world, hitting the triangle harder and harder so that my ears were beginning to ring. I did not know if he was sensory seeking or experiencing intense focus. The musicking was dangerously loud yet none of the Redirection Techniques like "*Introducing Change*," "*Calming*," or "*Intervening*" in Bruscia's book could redirect his aggressive playing. I felt completely helpless as I let him play on. By the end of the internship, my peers and I had spent hours poring over this chapter.

In addition to the lectures on *Improvitational Models of Music Therapy* learnt in my studies, Creative Music Therapy, Therapeutic Songwriting, and Neurologic Music Therapy became other areas of great interest for me. One of my older clients was a 28-year-old man with Traumatic Brain Injury (TBI). Having Broca's aphasia, the client had difficulty speaking fluently, although his language comprehension was slightly impacted. Broca's aphasia is caused by damage to speech and language areas on the left hemisphere of the brain (Aphasia, n.d.). Songwriting as well as Therapeutic Singing uplifted and empowered him despite his challenges. For that brief moment, there were no barriers as we made a human to human connection. Seeing how he engaged with music provided me with lessons on resilience, hope and happiness. No amount of theory could have prepared me for this experience. As my competency developed, I simultaneously became more aware of my working environment.

Theme 4: Navigating workplace culture

This theme takes a glance into how I developed as a professional within a quasi-informal workplace. Transferring theory to practice was a gradual process, as was both gaining competence and confidence. As weeks turned into months, I developed an acute awareness of the work environment and culture at the centre, which posed the question: "Would cultural differences arise for an African working among fellow Africans?" Workplace values and habits, institutional code of conduct, professionalism, and personal boundaries came into play when I looked at our cultural disparities at MRC. Yet, it is cultural sensitivity and multicultural musical competence (Hadley & Norris, 2015) that is often discussed in the music therapy academic arena. This will be discussed in the next theme.

I came to MRC as a music tutor who had taught for two decades within the school setting where punctuality, enforced with the ringing of a bell, was the norm and not the exception. I carried that mentality into music therapy with the expectation that sessions had to be time-bound, had a consistent scheduling structure so that the treatment plan was systematic, and that the duties of other staff members should not interfere with each other. Discussing the models of conventional modern music therapy, Stige (2004) argued that:

There are some general attitudes linked to looking at music therapy as a discipline and profession; there is a concurrent ethos that most music therapists subscribe to. Part of this is the value of working methodically, of using scientific theory, and of doing research. (p. 99)

Similarly, Pavlicevic (2004) argues that traditional music therapy practice ignored the socio-cultural environment and tended to preserve a culturally neutral stance which

included an enclosed music therapy space, music therapy techniques, scheduled sessions, followed by reporting, evaluations, and assessments. At MRC, following a strict timetable was impossible. Due to being time-conscious, I appeared to be strict in creating treatment plans and keeping my clients' notes updated. The other staff members were more flexible and did not engage too much in formalities, paperwork, or client evaluations. With time and experience I learnt to blend into the culture I found myself in and worked a flexible schedule within the context of that community. Music therapist Pavlicevic and her art therapy colleagues found themselves in a similar predicament with the *Thembaletu* women's group in South Africa. They looked beyond their conventional therapeutic territories as experts and became part of the women's group, which also meant conforming to the women's group's way of working (Pavlicevic, 2004).

An interesting observation at my internship was the extent to which the co-workers helped each other. Duties could and were expected to be shared. The high turnover of support staff looking for jobs that paid higher wages meant that duties often merged. As the year advanced, I would find myself assisting where possible. This helped me develop my extraversion and provided me with an in-depth view of the community I was in. The unwritten code of ethics at MRC was simple: Just show up and be there for the kids. In order to maintain ethical practice, I kept my work as a music therapy student separate, focusing on the task at hand. This was accurately exemplified by the dedicated MRC administrator who juggled his time between volunteering at the centre and his day job as a Physics and Maths teacher at a nearby secondary school.

Theme 5: Cultural sensitivity and musical multicultural competence

While the previous theme touched on organizational culture, this one describes my developing appreciation of the musical culture I found at the centre and the efforts I put into merging our cultural backgrounds. Kenya, where I spent my internship, is reported to have 42 tribal communities, which roughly translates to 42 spoken languages. My expectation was that the MRC children would be mainly from the two tribes within this locality, meaning I should probably immerse myself in the cultures of the Kikuyu and Kalenjin. That was the case with the employed staff, but not at all reflected among the clients, who represented a mix of various cultures, with no particular majority. How could I as a music therapy student respectfully integrate their musical cultures without diluting the context in which this music came? In many traditional African settings, music formed part and parcel of ritual ceremonies. As a music therapy student, Stige (2004) explained how he tried to integrate influences of the *ngoma* tradition in Tanzania into his music therapy thinking. He states that Music was not just about sound, but also body movement and storytelling. It was not about individuals but the broader community. And so when working with the children I learnt to create context by incorporating play and mutual learning into both individual and group therapy sessions, while making full use of the fairly large music therapy room.

Looking into the intricacies of cultural disparities, it was the very basic difference in language use, that presented my first challenge. The children called the drum *ndarama*, while I called it *ngoma*. Our greetings were dissimilar and the Swahili "goodbye" phrase, "*kwa heri*," was rather foreign to them, and yet in my Goodbye song we said, "*Kwa heri, kwa heri* [name of client], *kwa heri!*" Interaction outside the music therapy room helped us merge our 'dialects.' On many occasions, I kicked the ball with the children and pushed them on the swings. I did most of the talking even though it was impossible to hold coherent conversations with them. I was alert not to cross any ethical boundaries.

It would take the entire internship period for me to develop a broad musical language that served this multicultural environment. Through my upbringing, I had developed a wide repertoire of Swahili children's songs that the MRC children had never sung. I began

to merge my musical background with that of the clients. I picked a few of these songs and would insert the children's names in the songs. Similarly, I used songs familiar to the kids and substituted the lyrics to suit the context of our sessions and meet non-musical goals. In one instance, a fourteen-year-old boy with epilepsy who was rescued from the streets had been admitted at MRC as "*mlemavu wa akili*," the Swahili translation for "mentally handicapped." Due to his poor communication skills, the centre was unable to trace his family. Through singing and songwriting, the boy disclosed that his father was a fisherman. This provided a likely geographic location that could lead to his home. The boy was also very joyful when singing about his family members.

Hadley and Norris argued that there is more to musical cultural competency than simply singing music from the clients' ethnic cultures (Hadley & Norris, 2015). Indeed, I began to explore the musical cultures represented at MRC. Throughout my internship, we did a lot of drumming. Drumming is principal to most, if not all, traditional Kenyan music. Also common is an old tradition. Women do not engage in instrument playing together with men. In Oehrle et al. (2013), Akombo wrote:

In Luhya mythology, it is disrespectful for a woman to perform with male musicians on fiddles and percussion. Even though these instruments perform a "feminine" role in the dance ensemble by producing lyrical, feminine melodies over undulating male drum patterns, this prohibition is still in force. (p. 77)

As a key African instrument, the drum was going to play a major role in my music therapy internship. In order to be culturally neutral, I sourced drums that were non-specific to any local ethnic community. For example, I incorporated the *djembe*, which is a West African drum, often used in Kenya as a functional (rather than cultural) addition to drumming ensembles, especially in urban settings, much like the *conga*. The merging of our musical cultures and perceptions forged what would become the container of expression, the foundation of trust, and a medium for collaboration within the therapeutic relationship.

Development of Identity: Why am I here? Who am I, here?

I could easily answer the question "Why am I here?": To fulfill 560 hours of music therapy internship. This was a requirement of my studies institution, which I strived to pursue from the very first day I walked into the vicinity of Matumaini Rehabilitation Centre. However, the more profound question "Who am I here?" challenged me for the entire period of my internship. I was not confident of my answer and occasionally did not accept it either. Pavlicevic (2004) posed this question, "Who am I here?" (p. 37) as she navigated unfamiliar territory at *Thembaletu* in South Africa. The women in that community already knew how to use music to help their afflicted families cope with the stigmatising disease, AIDS. They also used music to shift their own mood as carers of these patients. This left Pavlicevic questioning her professional identity.

Studying music therapy was my goal, yet the journey increasingly unveiled a new outlook on what I was becoming. Early in this essay, I mention that I was desperate to gain the clients' trust. Why did I feel the need to be accepted? I found in my journal that this was really a projection of how I perceived my role within the context of the MRC community. Did I not trust the community I found myself in? Pavlicevic (2004) further contemplated:

Why 'read' the group at all? Is it not an imposition of conventional music therapy meaning and thinking frameworks on a context which does not invite - nor seem to want - this reading, while at the same time apparently operating within a frame that sees me as 'the music therapist'? (p. 39)

Relationships are built through time. I also came to learn that it would take a while to develop trust within the therapeutic alliance. Amir (2004) stated:

In my work with students and supervisees I became increasingly aware of their uneasy feelings when working with clients from different cultures. Jewish music therapists working with Arab clients, and non-religious students working with extremely religious children often experience strong feelings of inadequacy and confusion as to how to approach the other, how to build trust and make connections. (p. 249)

Indeed, with time, through musicking, a connection emerged between myself and the clients. It started in the music therapy room and slowly began to manifest itself in various ways beyond that setting. For instance, one of the kids liked to doodle abstract shapes in my notebook during our music therapy sessions. We would discuss his drawings and stick them on the wall to acknowledge his artwork. Today, this is how I would answer the second question “Who am I here?”: I am an agent of change that helps create an environment where the clients feel acknowledged and their feelings validated. This is so that they, too, can begin to see themselves differently. This is true of music therapists in diverse communities around the world.

As a music therapist within the context of MRC, I was also an observer, an activist, an artist, a visionary, a colleague, a teacher, a helper, a caregiver, a cleaner, a listener, a sister, and a friend. Through these lenses, I saw my strengths and weaknesses. A glaring weakness was my inability to recognize the available possibilities in such dire circumstances. At the start of my internship, all I could see was lack, suffering, and despair. Yet, it was my responsibility to look beyond that to see courage, resilience, and hope.

Conclusion

Internship was for me an internal process as much as it was an academic one, with both personal and professional outcomes. It was an emotional, spiritual, and intellectual transformation. Music therapy students often came out of their internships with a new outlook on life. One learnt to become comfortable with vulnerability, being unsure of the outcome but taking action nonetheless, testing one’s own theoretical knowledge with indefinite variables on the ground, allowing oneself to learn from their clients; fearing judgement but finding the courage to come out of one’s shell.

Since I could not find a music therapist locally, my experience included a long-distance, intercontinental mentorship with its fair share of challenges. Filming the music therapy sessions for study purposes was an innovative, albeit, limiting course of action to mitigate the dearth of music therapy expertise in my home country. Even with full consent, I maintained confidentiality and professionalism when sharing the videos. In the process of turning theory to practice, and in my transformation from music tutor to therapist, I learnt to be more flexible with both time and technique. While traversing the informal workplace at my internship, I somehow managed to negotiate between the various roles I played when I was not the music therapist and was often confronted by scenarios that tested professional and ethical boundaries. The rural setting also meant that there were slight language barriers, which turned into learning opportunities with music as the facilitator. With time, I learnt to fuse my formal training with the rich multicultural environment of MRC to paint new musical landscapes in spite of the underlying ethnic differences.

MRC provided me with a diverse community of client types and co-workers, a sound foundation for personal and professional growth. For music therapy to succeed, it is imperative to consider context with regards to the mutual physical, mental and social realities of all participants within the therapeutic relationship (Pavlicevic, 2004). As in many isolated parts of rural Kenya, the picture I painted here is not unique. While I

continue navigating this environment today, I keep in mind that music therapy has potential to thrive anywhere. In every situation, there are elements to build on, there is something to work with, and there are contributions from the community (or client) that enable us to integrate as music therapists and work together as facilitators of change.

About the Author

Mufu Luvai, is an alumnus of Maseno University in Kenya. She completed a pre-master in Music Therapy at ArteZ University of the Arts, the Netherlands. She is currently working as a music therapist in Kenyan schools, exploring music therapy within a multicultural environment. Her main interest is in the neurodiverse population as well as music therapy research within the African context.

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¹ As a requirement of the ArtEZ Pre-Master in Music Therapy programme, I held monthly online meetings with a competent professional to receive both professional and psychological support. Supervision was in many ways similar to psychotherapy. My supervisor was a practicing music therapist based in the Netherlands.

² By the end of my internship, MRC had employed a resident social worker.

³ My supervisor was also based in the Netherlands. Our meetings were done through Skype.

⁴ Not all institutions include a clinical practicum as part of their programme.