

From healing rituals to music therapy: bridging the cultural divide between therapist and young Sudanese refugees

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In music therapy literature and popular culture alike, music is often hailed as a universal language. It is appropriate then that music therapy is included within the services offered at a high school catering specifically to non-English-speaking students. The music therapy program described in this paper encourages students to explore and express their feelings by playing instruments, singing, writing songs, listening to music and talking about song lyrics. The school is state-run (but federally funded) and provides English language, high school preparation and settlement services to high school aged youth who have recently arrived in Australia from non-English-speaking countries. There are currently 22 nationalities represented amongst the student population, with most students staying no longer than six months before being integrated into mainstream schools with English as a Second Language (ESL) support. While some of the students' families are business migrants, some 60% of students have arrived in Australia as refugees. An increasing proportion (currently 41.6%) originated from The Republic of the Sudan in northern Africa.

Sudan is the largest nation in Africa. Located in the northeast of the continent, it is bordered by the Red Sea and nine other nations. It consists largely of flat, non-arable plains and deserts, but is also dominated by the Nile River and its tributaries. Despite this, the dry and arid northern areas and a lack of potable water render the country threatened by dust storms, desertification and drought. The people of Sudan reflect the country's proximity to both African and Middle-Eastern nations. With 52% indigenous and 39% Arabic ethnicity, there are 134 living languages in Sudan and over 500 tribal dialects (Ethnologue.com, 2003). However, since its independence from the United Kingdom in 1956, the ruling military regimes have sought to create a Muslim-dominated state. Arabic is the official language of Sudan and 70% of Sudanese (mostly in the north) are Sunni Muslims. This situation has fuelled the civil war in the non-Muslim, non-Arab southern areas of Sudan, where religious beliefs are largely indigenous or Christian. Most Sudanese live on or below the poverty line and the combined effects of famine and civil war have led to more than two million deaths and over four million displaced people in the last 20 years (unless noted, all facts taken from CIA, 2003). There is currently hope that the long running civil war is ending, with the extension of a recent ceasefire and agreement expected soon for an interim autonomy period for the south. (*Government, Darfur Rebels Extend Ceasefire for One Month*, 2003; *Support for Sudan More Critical Than Ever, Says UN Humanitarian Update*, 2003).

The young Sudanese refugees involved in the music therapy program are experiencing distressing circumstance. While the migration experience in itself is stressful, by definition refugees have fled their home country to escape persecution, having witnessed or experienced brutality and the deprivation of basic human rights (Bashir, 2000). Some of the students in this program have lost one or both of their parents. In addition to these

traumatic experiences, their accommodation and acculturation to Australian society is complicated by a lack of English language skills and often, a lack of literacy in their first language. For some, attendance at this school is their first experience of formal education. For adolescents, there is also a dilemma in adapting their self-identity within their new host society. While there are great pressures from the family to maintain cultural traditions, there is equally great pressure from their peer group to adopt new patterns of behaviour. These pressures can create enormous conflict within the family, and often leave the adolescent feeling alienated from both cultures (Bashir, 2000). Societal issues of racism, discrimination and cultural insensitivity further contribute to a mix of factors which result in heightened levels of depressive disorders, psychosomatic complaints and behavioural and learning difficulties (Bashir, 2000; Cassaniti & Sozomenou, 2000). However, while the needs of this population are many, the focus of this paper is centred on bridging the cultural divide between therapist and Sudanese youth, rather than their clinical needs and outcomes.

While music is often cited as a ‘universal language’, studies reveal that people’s perception of the emotional qualities within music is associated more with cultural tradition than the elements of the music itself (Bright, 1993; Gregory & Varney, 1996). If this is true, then music therapists should be developing greater awareness of the musical traditions of their clients. Moreno (1988) stressed this view in a unique article that introduces the basic musical materials of African, Indian and Indonesian music. He argued that becoming familiar with basic musical techniques from a range of ethnic backgrounds could provide new channels of communication with a wide variety of clients. Bradt (1997) further developed Moreno’s ideas, but emphasised the ethical concerns that arise when an uninformed music therapist works with a client from a different culture. In particular he asked how a music therapist could be aware of possible ethical issues when their training does not include a focus on cultural diversity. Indeed, when most music therapists are reporting that they gain their ‘multicultural knowledge’ by experience (Darrow & Molloy, 1998), one begins to question the ethnocentricity of the profession as a whole. Having said this, it is not always easy to be informed and aware of your client’s cultural traditions and there is inherent risk in making assumptions based on generalisations (Stige, 2002; Wheeler, 2002). Thus, this paper represents an opportunity to learn more about the Sudanese music traditions and the Sudanese population who are living as refugees in Australia.

Health, healing, music and music therapy

In Australia, the concept of health is one of normalcy, with ill health viewed as a deviation from the norm. Health is defined as a condition in which there is an “absence of disease or other abnormal condition” (Anderson, Keith, Novak, & Elliot, 2002, p. 783). Physical disease is usually attributed to genetics, infection, diet and other environmental factors (Anderson et al., 2002), while mental disorders share these causes in addition to the effects of physical injury, life experiences and the social environment (Oltmanns & Emery, 2001). Health care in Australia might be described as largely scientific, mechanistic, and individualistic. Scientific because we hypothesise the cause of an ailment, then apply a treatment and observe its effects. Mechanistic, because it usually

addresses the malfunctioning part of the body, and individualistic, because the focus is usually on the individual rather than the broader social contexts (White, 1999). What becomes apparent in the Australian view of health care is that ill health is caused largely by outside influences that are considered beyond the individual's control. Further, the causes and cures are usually scientifically explored before being widely accepted.

As social constructs, these concepts of health underpin the education of all, and the belief systems of many Australian music therapists. This is not to ignore the more holistic and socially modelled components of music therapy training, but simply to highlight that the prevailing medical culture permeates our fundamental assumptions of health, ill health and health care. The process of music therapy, as it is defined within the profession, makes the distinction that music therapy takes place over time; that a series of repeated sessions characterize the therapeutic process rather than a single event producing a therapeutic effect (Bruscia, 1998). The application of music therapy in Australia varies greatly, and therapists work with many different client populations. Techniques such as improvising, song-writing, re-creating and listening to music are selected to address the identified needs of the client. Many different theoretical explanations of music therapy exist, ranging from physiological responses, psychoacoustics and neuropsychology to the many varied psychotherapies. Nevertheless, most models are founded on humanistic principles wherein the client–therapist relationship is an encounter that is central to the client's growth and development (Wigram, Pedersen, & Bonde, 2002). Some also argue that benefits arise from unique qualities within the music. For example, the sound-centred nature of music provides unique channels for expression, exploration and experiencing self and others. The beauty-centeredness motivates an inherent search for meaning and wholeness that beauty brings to life, and the creativity at the heart of music provides opportunities for problem solving that parallel those found in life generally (Bruscia, 1998).

In contrast to the Australian concepts of health and healing, the Sudanese approach is more holistic and spiritual. While ill health is still considered to be a deviation from normal living, causes are attributed to the mind, the spirit, relationships and supernatural causes (Ball, personal communication, 2003; Mereni, 1996; Nzewi, 2002). To better understand the Sudanese perspective, literature on the role of music in traditional African health care (Mereni, 1996, 1997; Nzewi, 2002) were synthesised with the transcript of a personal interview conducted with Mr. Ball, a respected member of the Sudanese community residing in Brisbane, Australia (Ball, personal communication, 2003). While the literature relating to traditional African practices is comprehensive, Africa is a large and diverse continent, and even within Sudan there exist many varied practices. It is necessary then to be cautious of generalisations and to seek clarification from clients whenever practical.

The concept of health in southern Sudan must be understood in relation to spirituality. Most southern Sudanese believe there to be a 'master' God—a creator—who is capable of punishing or rewarding both the living and the dead. They also believe there to be lesser gods who direct their powers toward the living. When a person is suffering, the relevant god is called upon through special healing rituals to identify both the cause of

and cure for the condition (Ball, personal communication, 2003). The cause may be attributed to a person's unconfessed sins, or unresolved arguments, and the diagnosis may not identify malfunctioning body parts even if the sickness is located within a specific area of the body (Ball, personal communication, 2003; Nzewi, 2002). Importantly, the focus of health care is centred both on the healing of the psyche or spirit, and the physiological condition (Nzewi, 2002). Through a special healing ritual, a person acting as the 'agent' of communication with the God/gods will interpret the messages of the God/gods and direct the sick person as to the potential cure. Typically these might include animal sacrifice, pleas and prayers, confession of sins and actions of reconciliation with others (Ball, personal communication, 2003). In contrast to the Australian health care system, the Sudanese concept of health care requires belief in the spirits and God/gods, has a focus on the 'whole person' both physical and spiritual, as well as interpersonal relationships. Health care in Sudan is a community-based practice.

Although music is used extensively in health care throughout the African continent, there is no African equivalent to the Western concept of the word 'music' (Kigunda, 2003; Mereni, 1996, 1997). A discussion of such concepts can be found in Mereni (1996). The closest conceptualisation might be that of 'song' (Ball, personal communication, 2003). Mr. Ball's description of how the Sudanese express meaning in song illustrates their multi-modal concept. They sing the meaning through the words; they play the meaning physically through dance and play it through the instruments (Ball, personal communication, 2003). All components are necessary in the Sudanese understanding of music/song. The role of song in Sudanese health care appears to be more limited than that described in other African nations. During the healing rituals, song is used as the medium of communication with the God/gods, with the purpose of diagnosis and identification of the cure (Ball, personal communication, 2003). This is because music is considered to be the language of the God/gods (Ball, personal communication, 2003; Mereni, 1996, 1997). Each tribe has its own healing song and different uses of music within the ritual. For example, the Dinka tribe has a song calling the God to come forward and not burden them. They sing until the 'agent' is possessed by the spirit God and communicates the cause and cure of the condition. In contrast, the Luer tribe uses shakers as a means of communication. The song calls upon the God/gods and names those who are already deceased. At the end of the song voices of the God/gods are heard in the shakers and the healing 'agent' can understand these voices (Ball, personal communication, 2003). Notably, in Sudan, song is not a cure in itself but rather sets the conditions and provides the vehicle for communication of health care advice.

The other common use of music in Sudan is to effect social change. Unlike the Australian applications of song for expression of emotion, aesthetics or entertainment, song in Sudan functions as a type of community discourse. Improvised songs provide a medium for communication between individuals, resolution of disputes between social groups and the maintenance of tribal values (Ball, personal communication, 2003). Messages range from bitter disputes and romantic cries of despair, through to social judgements. The protagonists (who are often the best singers in the clan) sing/dance/play the song, while others begin to listen, catch on and join in. Gradually the song spreads through the village and the message makes its way to the intended recipient. Songs are communicated back

and forth by disputing parties and in this way social and relationship issues are worked through. In the meantime, the whole community has been hearing and communicating the meaning of the songs. The social implications are noteworthy. Children are the main transmitters of these social songs and the effects on children are both beneficial and harmful (Ball, personal communication, 2003). The use of song to resolve disputes avoids the need for physical fighting, and the fear of public humiliation prevents individuals from engaging in activities that are considered inappropriate or immoral. Yet on the other hand the children readily acquire judgements of people that are not based on personal experiences and it is easy to ridicule a person in public with unsubstantiated claims. Even though the person may vigorously respond, the derogatory song along with its message has already been spread through the village.

Several authors have argued the parallels between traditional African healing practices and modern music therapy (Kigunda, 2003; Mereni, 1997; Moreno, 1995). However, the divide is clearly wide. A recent article about the perception of music therapy in Kenya (a country bordering Sudan) found that Kenyan musicians were uncomfortable with the terms 'music therapy' and that they preferred to think of it as 'spiritual healing' (Kigunda, 2003). This sentiment seems to epitomize the divide between Australian music therapists and their Sudanese clients. While one draws upon the physiological, emotional and aesthetic properties of music and the client–therapist relationship to effect change in a person's well-being, the other considers music to be a form of communication to divine diagnoses and cures and effecting social change. While health care in Australia requires a systematic form of scientifically based treatment, health care in Sudan is based on advice from the spiritual world.

Creating musical bridges

A striking feature of the Sudanese students is their rhythmic expression and enthusiastic response to music. As in any population their abilities and preferences vary, however, the pervasive use of song in Sudan and the importance of rhythm in particular, have created a population who are naturally expressive through and responsive to music. Akombo (2002) has made similar observations about his work with children in Kenyan refugee camps. He observed that even though they could not understand the words of the songs, they would respond to the familiar, syncopated rhythms. Moreno (1988) argued the need to utilise musical elements that are familiar to clients, if effective communication and rapport is to be achieved. In working with the Sudanese youth, the use of a strong and clear pulse with syncopated rhythms, stimulated the greatest responses in sessions, along with an emphasis on the off-beats or second and fourth beats of the bar. It was not until these features were integrated into the music therapist's playing that the differences between their musical influences were understood. Prior to this point, clients were difficult to engage. One student in particular was very expressive on a range of instruments (although with no formal training) and had a terrific 'ear', however, each time the sessions were reviewed his playing seemed to be self-directed and not at all related to the music therapist's. It was as though the music therapist and the client were two individuals playing in parallel, sharing the same tempo and nothing more. Once the

music therapist had integrated more ‘African’ feel into her playing, the music making became more communicative.

During the initial sessions at the school, Bruscia’s (1987) ‘Techniques of Empathy’ were employed to build rapport with the students. Reflections post-session revealed that some of these techniques were limiting and at times, inappropriate. In particular, imitation and synchrony were more detrimental to the process than helpful. In fact, to align with the cultural roles of playing music within the Sudanese culture, the therapist must actually play a different but complementary rhythm. In African music, independent rhythms interlock and create an overall texture with implicit pulse (Moreno, 1988; Temperley, 2000). For example, if the student played a busy rhythm, successful contact was made when the therapist played a sparser rhythm and vice versa. This complementary style of playing was effective in promoting musical expression. With it, the students seemed to relax and become more expressive in their playing. Individual rhythms would ebb and flow in what felt like the auditory equivalent of a dance. Far from an avoidance of musical connection, it felt very connected as each player responded so spontaneously to the changes of the other. There was also another benefit of this playing: by accepting different and independent roles within the music, the music therapist no longer felt the need to compete with these students’ exceptional rhythmic skills.

When working cross-culturally, we must always review the way in which we apply our existing techniques and theories. In this case, Bruscia’s (1987) techniques of empathy could not fully articulate the technique described above, which was used to build rapport and communication. Students appeared uncomfortable with imitation and synchronisation. While techniques of incorporating, pacing and rhythmic grounding were adopted, they still only partially depict the therapist’s role during improvisations. Pavlicevic’s (1997) technique labelled matching goes some way to meeting our definitional needs. Here, the therapist mirrors some but not all the rhythmic components. Pavlicevic suggests the use of this clinical tool for a client who’s playing is rigidly repetitive; however, in this case, the technique was effective in building rapport and communication. However, even Pavlicevic’s (1997) definition of matching is insufficient as it does not embrace the contrasting musical ideas of both players. Perhaps the word complementing defined as “that which completes or makes perfect” or “either of two parts . . . needed to complete the whole” (Macquarie Dictionary and Thesaurus, 1991), is more appropriate here. It captures the essence of the technique used to quickly build rapport and communicate musically with the Sudanese students. Fig. 1 provides an illustration of how complementing might be conceived.



Fig 1: Sample of proposed complementing technique

Body movement or dance is implicitly part of the African concept of music/song. Movement cannot be separated from their music and indeed movement is music even without its aural component (Mereni, 1996, 1997; Pavlicevic, 1997, p. 44). Thus, one application of cross-cultural music therapy with the Sudanese is to incorporate movement as a fundamental aspect of making music. The following case vignette highlights its potential to enhance musical response.

Case vignette 1

Badiel was 13 years old and had arrived in Australia from Sudan one month earlier. He had no English speaking skills, and suffered from regular tonic-clonic seizures. School staff reported that he wandered aimlessly around the school ground. In the classroom Badiel was not learning and appeared to have trouble concentrating. His teacher reported that he did not respond to her attempts to interact with him and that interactions with classmates were unsuccessful as Badiel would often continue to talk as his classmates spoke to him. It appeared that Badiel was in the process of withdrawing from human contact.

When Badiel arrived for individual music therapy sessions, it was immediately apparent that he was capable of responding to the musical environment, however, the therapist had difficulty communicating her intentions. While he was fully engaged during drum improvisation and maintained eye contact with the therapist, attempts to instigate call and response activities were unsuccessful. The pivotal moment came when the therapist imitated the body movements he made while playing the drum. Once the therapist incorporated the physical movement into the call and response activity, Badiel was able to quickly recognise the therapist's intentions and he soon delighted in leading the multi-sensory calls. There was a noticeable deepening of the musical connection between Badiel and the therapist from this point forward.

Badiel had demonstrated that he was very capable of interacting with others and understanding what was required of him—the right mode of communication was all that was needed. After six sessions, Badiel was directing the improvisations using “stop” and “go” and was sharing songs and discussions on a variety of topics (via an interpreter). During the final session he was saying “hello”, “good”, “thank you”, “goodbye”, “What is your name?” and “My name is Badiel”. While the therapist's use of body movement did not directly effect Badiel's acquisition of the English language, it is suggested that it did raise Badiel's awareness of the therapist's communicative intent and facilitated connection in a more conscious manner. Body movement was essential for creating the right client–therapist relationship with Badiel, and it laid the foundations for his improvements.

From traditional song to hip-hop

The use of song as a social messenger is fundamental for tribal people of southern Sudan (Ball, personal communication, 2003; Ismail, 1972). Songs provide a medium for communication between individuals, resolution of disputes between social groups and the

upholding of tribal values. Within the music therapy program this was witnessed through the students' enthusiasm for singing and group music making, their desire to share songs between cultural groups and their strong attraction to rap artists. One group program with five Sudanese males considered to be amongst the most 'at risk' students in the school highlighted the potential for the use of song with this population.

Case vignette 2

The five boys were all around 12 years of age and had been referred for disruptive behaviours such as fighting, aggression and poor impulse control. Earlier music therapy sessions with these boys had been unpredictable, with some of the boys unwilling to attend to task or engage in verbal communication. There was a history of fighting between the boys and the tension both within and between individuals was tangible. During the first session their music making was recorded and played back to them. They immediately focussed, began taking turns to play solo, accompanied one another on guitar and drums, sang songs together, and translated the meaning of the songs for the therapists. These students shared so freely and joyfully in song, even given their different tribal backgrounds and their history of fighting. In later sessions, the boys began to explore free rapping to a techno beat. Although a little self-conscious, they were keen to contribute and share the microphone with each other in free-rap conversation.

Most of the Sudanese boys at the school are highly attracted to contemporary hip-hop artists including 50 Cent, 2 Pac, Nelly and JA Rule. It seems then that rap music may represent an effective medium for working with Sudanese youth. Not only was it their preferred style of music (in most cases), but it seemed to parallel the traditional use of song within Sudanese society and would ultimately draw upon their skills of vocal improvisation. Although it has not been systematically explored, a recent social work study argued that rap music could be used to engage youth and facilitate greater therapeutic outcomes, as the youth appreciated the respect afforded "their" music (Tyson, 2002). Given that the Sudanese derive social meaning from songs in their traditional culture, rap music could be used: (a) to promote insight, (b) as a vehicle for verbal processing of experiences and feelings and (c) to develop understanding of the social values of their new community. Sung choruses could be composed by the therapist (or by the students) to express a central theme. Students could then free rap their ideas about or responses to the theme. In this way, the activity is similar in intent to song sharing and discussion, however, it embraces a medium that is widely accepted by them and provides opportunity for developing a sense of mastery and self-worth, in addition to the specific goals addressed in the songs.

Questioning our assessments, interpretations and expectations

One of the important roles of music therapists working in a multicultural context is to continually question their interpretations and expectations of clients. Clinicians need to consider their own cultural conditioning and how it influences their goal setting, musical contributions, personal interactions, observations and interpretations. As Bradt (1997) highlighted, how can a therapist accommodate what they do not know about a person? As

described in case vignette 2, boys who joyously made music together, had been fighting just a day earlier. Music brought the students together as though nothing had happened. In hindsight, however, nothing really had happened. In some Sudanese tribes, fighting is an acceptable way to establish one's leadership. While fighting is a violent and often disturbing behaviour in Western culture, Sudanese males could be fighting one moment and walking away best of friends in the next (Ball, personal communication, 2003).

Similarly Badiel would not join with the therapist in singing simple songs. After involvement with an interpreter, he enthusiastically demonstrated his singing. It was a deep-throated, devil-like sound (complete with fierce facial expressions) and he called it the "voice of the hyena". He explained that in his country, people give him money when he sings. His ability to sing like a hyena was a skill that others did not possess, and so they would pay him to perform (Ball, personal communication, 2003). In subsequent sessions Badiel sang church songs freely, however, he never sang together with the therapist. To Badiel, who was from one of the smallest tribes in Sudan, singing seemed to be associated with the church or his special performances. The social role of singing—reflected in so many of the other Sudanese students—seemed less familiar to Badiel, thus raising other questions. What is the role of the church in Badiel's life and how might this be related to his epilepsy? Badiel once explained that the more he prays, the longer his seizures abate. Could the singing of church songs hold the same promise for Badiel? This example highlights the limits of our interpretations and that caution should be exercised when applying culturally specific knowledge to a population.

Interpretation of client responses and evaluation of change are fundamental to the music therapy process (Bruscia, 1998). Yet if techniques and tools designed within a mono-cultural model are employed, there is a risk that the work with Sudanese students is both unethical and clinically unsound (Corey, 1996). For example, presenting behaviours of Sudanese students within the music therapy program were usually very different to that detailed on their referral forms, especially during individual sessions. In many cases, students who were referred as disruptive or aggressive would present to sessions as cooperative and creative young people. Students who were withdrawn would immediately become interactive within music. Although experiencing clients in a different light to how they have been described is not uncommon to music therapists, it does lead to difficulties in identifying their most immediate needs, in setting goals and in measuring change. There also appears to be no assessment tools that have been developed or tested for cross-cultural or multi-cultural work. Yet, given the universality of music, surely it would be possible to ascertain elements that could be measured, even interpreted, cross-culturally. Bruscia's (1987) Improvisational Assessment Profiles (IAPs) stand out as an assessment tool with the potential for use cross-culturally. With its 6 profiles compiled from 74 subscales, it may be comprehensive enough to capture the essence of an individual's playing irrespective of culture. Future research might seek to examine which profiles and subscales could be used in this way.

Many other issues arose as a result of cultural differences. Although the scope of this paper does not allow the thorough identification and discussion of them all, it seems important to at least raise those that derive from the differing uses of music and healing.

For example, in the Luer tribe, a female healing 'agent' uses shakers as a medium for communication with the spirits (Ball, personal communication, 2003). How then would a Luer client respond to or feel about being offered maracas during a session? How would they respond to a female therapist using the maracas? Similarly, in the Dinka tribe, the 'agent' of communication is a man who becomes possessed by the spirits. What then are the young people's expectations of music making with a male therapist? Is it possible to practice client-centred therapy when their beliefs about healing practices are so removed from Western practices adopted in Australia? Clearly there are no easy answers to these questions, and future research with this population would do well to explore some of these issues. While music therapists cannot and should not duplicate traditions of others, familiarity with multicultural concepts of health, healing and music will assist clinicians in identifying their influence within the clinical setting.

Conclusions and recommendations

Music therapy work with young Sudanese refugees is new to Australia. This paper represents a unique opportunity to learn more about the cultural differences and to explore possible solutions for bridging that divide. The Republic of the Sudan is a large and diverse African nation influenced both by indigenous and Arabic practices. The effects of a long-running civil war have led to many displaced Sudanese arriving as refugees in Australia. Their youth are required to adapt to the Australian school system which for some is their first experience of formal schooling. The music therapy program aims to enhance the well-being of these young people by encouraging students to express and explore feelings through a variety of musical activities. However, the differences in our understanding of health, healing, music and music therapy are wide. While in Australia music therapists draw upon the physiological, emotional and aesthetic properties of music to enhance a person's well-being, the Sudanese use music as a vehicle for communication with the spiritual world, to divine diagnoses and cures. They also use improvised song to effect social change.

In considering the clinical implications of these cultural divides, it seems that the pervasive, communal use of music within Sudanese society has led to youth with well-developed rhythmic and improvisational skills. Several techniques have been highlighted as important for successful engagement of the young Sudanese in music therapy. The first is the use of syncopation and strong, clear rhythms. The second is the importance of players maintaining individual parts when making music together—that the music is really created by the interlocking of independent parts—and new terminology is proposed for this technique, namely 'complementing'. Thirdly, the use of body movement is suggested to be an essential element of music when working with this population. Each of these three musical ideas is important for building rapport and communication with the Sudanese youth.

The use of song as a social messenger, the natural improvisational skills of the Sudanese youth, and their attraction to Western hip-hop artists indicates the potential of rap music as a therapeutic intervention with this population. It is proposed that rap music might be used to promote insight, and as a vehicle for both the verbal processing of feelings and

the internalising of new societal values. This intervention would be familiar to the young Sudanese, and promote a sense of mastery and self-worth in addition to specific therapeutic goals. Finally, some interpretation and assessment issues were addressed in this paper. It seems that the more knowledge gained about a population, the more accurate reflections are of client behaviour. Despite the insights presented here, clinicians need to be aware that with five hundred tribal dialects, no assumptions can really be made. What is important here is to be aware of how the success of practice might be influenced by cultural difference. At this stage there appears a distinct lack of cross-cultural techniques and tools available within the profession, however, with future research and exploration, a well-recognised tool such as the Improvisational Assessment Profiles (Bruscia, 1987) might be reliably applied within multicultural settings. Many other issues were raised during this paper. It was not within the scope of this paper to either identify or answer all of them. Instead, this paper should be viewed as the beginning of a journey in documenting the benefits of music therapy programs for young Sudanese refugees in Australia. Further research needs to be undertaken in the area of assessment, and greater demarcation made between the issues of being Sudanese, being a refugee and being an adolescent. Perhaps it is also time that some of the more established assessment tools of music therapy be reviewed to reflect the newly emerging global (and therefore multicultural) community. The main issue at this point is in developing appropriate definitions to explain the techniques employed and their corresponding effects.

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