Vol 1(2), July 1, 2001
Voices1(2)Procter

Empowering and Enabling

Improvisational Music Therapy in Non-medical Mental Health Provision

By Simon Procter **|Author bio & contact info|**

photo not available

A Personal Introduction - Culture Clash

Between sessions, I look around at my environment. I work in a pleasant room, with plenty of light (although sometimes too much heat). I have a good array of instruments with which people can make all manner of music together. I think of the music-making I have been a part of here so far today: a listening and supportive group who have been together for over a year now and whose music is really developing; a startlingly beautiful Bangladeshi song sung by a woman with whom I have barely a word of language in common; and a rousing rendition of Frankie Vaughan's greatest hits from a would-be cabaret artist with me as his piano-playing sidekick.

A vast range within just three sessions. But what brings these people under the same roof is their choice to use non-medical mental health services.

Over lunch in the café downstairs, I chat with people who use the Centre. Some use music therapy, some don't. Our talking ranges over many subjects - inevitably the weather, but also politics and sport. There's a meeting this afternoon where users make decisions about day-to-day running issues, and the topics to be discussed get aired at the table too. As a sessional worker, not a user of the Centre's services, I won't be at the meeting.

One man explains to me why he uses the Centre. He describes himself as a "system survivor" - someone who has been subjected to the psychiatric system (against his will) and survived to tell the tale. He sees the Centre as an aid in "keeping out" of psychiatry and helping others to do the same. A woman who prefers the term "service user" tells me that she only came out of hospital last week - her fifth admission in as many years. It wasn't all bad, she says, and she plans to keep her outpatient appointments as she always has done, but the Centre gives her something to enjoy, something to get out of bed for.

My work seems to fit well here. As a musician, I know something of what making music, especially with others, can mean to people. I am happy to talk about this at the table.

But somehow, I feel less comfortable talking like this with my fellow music therapists. When they talk about mental health, they tend to mean psychiatry. When they talk about the people they make music with, they call them "patients" and focus on their problems, what they *can't* do. Yet for me, music-making has so much to do with building on people's experience of who they are and what they *can* do. There seems to be a clash of cultures here.

Am I just a maverick? Or hopelessly naïve? No doubt some readers will already have decided that I am both of these. But humour me, and let me address some of the issues that make me seem this way to you.

Music Therapy and Medicine

Music therapy in the UK has recently become a state registered profession overseen by the Council for Professions Supplementary to Medicine, making explicit a connection between our profession and that of medicine. Is music therapy then inevitably a part of the medical establishment? Or can we work outside it?

In the UK, music therapists working with people who have been labelled "mentally ill" generally do so in medical settings within multi-disciplinary teams. This is the norm, but it is not the only model of working. There is also an emergent and contrasting tradition of non-medical mental health provision, in which music therapy has tended to have minimal involvement. I am intrigued as to why this might be so, and what such an alternative ethos might have to offer us, our clients and our profession.

How Psychiatry can be Experienced as Disempowering

The medical approach to mental illness - otherwise known as psychiatry - is well-established. The psychiatric institutions within which we work often have long histories and are portrayed as having evolved from well-meaning benefaction in earlier days to providers of today's systematic, scientific interventions. Psychiatrists have considerable status not only within the institutions they oversee but in society as a whole. Professionals who work alongside the psychiatrist enjoy a measure of reflected respectability. Together they constitute the psychiatric system.

But this system is problematic. The status of medical professionals is largely due to the expert-patient dichotomy at the centre of the medical model. The patient has the problem; the doctor has the answer. The patient, characterised by need and ignorance, is thus in a position of dependent subjugation to the doctor, characterised by knowledge, experience and expertise.

This may not be a problem in physical medicine, but the nature of mental health problems has a great deal to do with people's perceptions of themselves and their experience of relationships with others. Yet the experience widely described by users of psychiatric services is one of disempowerment, of being put at a disadvantage to those "in the know". No other branch of medicine faces a comparable level of opposition from organised groups of current and former patients who criticise what they have experienced of its methods and attitudes at first hand.

Furthermore, as Williams (1999) points out, societal inequalities are clearly embedded within services and determine the nature of care provided to different social groups. Treatments most opposed by survivor groups - forcible treatment, drug treatment and electroconvulsive therapy (ECT) - are those most likely to be administered to older women and to people from minority ethnic groups, whilst the societally privileged have a greater opportunity of access to more favoured treatments, e.g. talking therapies. Social inequality is thus not only a major determinant of mental health but also an indicator of potentially disempowering approaches to addressing problems when they arise. This inequality is further institutionalised in terms of the differing provision on offer in different areas.

It is important to acknowledge here that many psychiatrists are aware of these problems and that some such as those engaged in the "postpsychiatry" movement (Bracken & Thomas 2001) - are actively attempting to address them within the system.

Towards Empowering: an Alternative to Psychiatry

The long tradition of rebellion against psychiatry gained new ground in the 1960s and 1970s as, in the spirit of the times, individual practitioners spoke out against what they saw as the abuses or misguidedness of their profession. So, for example, R D Laing, David Cooper, Thomas Szasz and Jan Foudraine endeavoured in various ways to change the way in which psychiatry viewed mental illness, the mentally ill and hence itself.

The movement that gathered strength in their wake has developed in a diversity of directions. One direction, starting with the work of groups like Survivors Speak Out in the 1980s (Campbell 2000), is the dialogue which has arisen in some areas between holders of statutory funding (such as health authorities and social services, rather than the psychiatric profession) and survivors or users of mental health services, particularly at local level. This has opened up new possibilities of using statutory funding to provide community-based mental health services which are explicitly non-psychiatric and, in some cases, user-led.

Services offered in such provision vary, but since the aim is empowerment by focusing on

people's ability and potential for wellness (rather than disability and illness), the emphasis tends to be on the practical (counselling, welfare and benefits advice, language / literacy classes etc) and the creative (musical, artistic, literary). Given this double emphasis on the practical and the creative, it seems odd that music therapy is rarely available.

Cultural Differences Between Medical and Non-medical Mental Health Provision

Medical and non-medical mental health provision do not differ simply in terms of opposing beliefs or practices. Rather, they represent contrasting cultural systems. Music therapists more used to a psychiatric setting will be struck - and perhaps disturbed - by clear differences in culture between medical and non-medical mental health settings. Nevertheless, cultural implications stem from philosophical differences, three of which I will now consider.

Diagnosis

From a medical standpoint, diagnosis is a pre-requisite for safe, effective treatment. Music therapists in psychiatric settings are expected to be aware of each patient's diagnosis, and may plan their intervention on the basis of it. In addition, the therapist's feedback may be sought as to whether the patient's presentation in music therapy seems consistent with the allocated diagnosis.

For most people, diagnosis is the gateway to services. Diagnosis can be a framework which helps to order someone's experience, and it can also relieve them of responsibility for their situation. But diagnosis can also be experienced negatively.

Diagnostic systems such as DSM (American Psychiatric Association 1994) are invested with immense authority. But it is an authority experienced as oppressive by many of those diagnosed. Sara Stanton (2001) writes of how diagnostic labels are "laden with psychiatric value" rather than descriptive of a person or their situation. In the first half of the last century Adolf Meyer warned that diagnosis could only be meaningful if it were secondary to the assessment of the patient as a person (Double 1991). It can "cover up as well as illuminate the reasons for our pain" (Bracken & Thomas 2000), thus obstructing the psychiatric system's view of the patient.

Although Bracken and Thomas regard psychiatric diagnosis as something interpretative, negotiated, tentative and partial, this is rarely the experience of patients: more often it is experienced as an attempt by an authority figure to represent a person's experience in pathological terms, which can be both disempowering and stigmatising. Furthermore, a psychiatric label can be the justification for the removal of rights others take for granted.

There is also the danger that professionals misdiagnose social non-conformity as mental disorder (Wiggins & Schwartz 1999). This is of particular concern given the correlation between allocation of diagnosis (and subsequent treatment) and social status, including race (Browne 1997, Littlewood & Lipsedge 1997). Diagnosis can thus be seen as perpetuating the very social oppression in which mental illness may have its origins.

Non-medical mental health services often strive to avoid making diagnosis the gateway to services. Because of restrictions imposed by funding agencies, however, this is rarely entirely possible: but at the very least, they can provide an environment where people, once through the gateway, do not come with diagnostic labels attached. Nobody comes to music therapy as a schizophrenic, but as a musician - with all their creativity and potential. In many cases, I know nothing of my fellow musicians' diagnoses until they tell me.

As music therapists, do we need diagnosis? Could we work without it?

Personal History

Medical settings keep records which act as a personal case history of the patient, both prior to and since being admitted to medical services. These are available for consultation by all relevant professionals. Thus a music therapist is able to read up on a patient before meeting him or her for the first time, and will document his or her account of interactions with the patient for other team members to be aware of.

In life generally, everyone expects a certain level of privacy. It is up to us if and to whom we wish to divulge personal information. But the patient in the psychiatric system loses much of this privacy - often discreditable information on social status and past behaviour is collected

and recorded so that any member of the psychiatric team can learn it. This is what Goffman, in his study of "total institutions" terms "a violation of one's informational preserve" (1961:32) and bears little resemblance to what most people understand by the term "confidentiality". Again, it puts the patient at a disadvantage to the expert who not only wields the authority of the DSM, but also knows intimate details of the patient's life. As Szasz points out (1974: 63-65), the only patients who may experience a higher degree of confidentiality are those in private treatment. Again the societally disprivileged are further disadvantaged by the psychiatric system.

The case history is generally authored not by the patient but by a professional who selects the "facts" that are recorded and rejects those that are "immaterial". In this way the whole exercise, far from holistic, can become one of "psychiatricking" the patient.

Thus minimal personal record-keeping is the norm in non-medical mental health provision. As music therapists, do we need the history? Could we work without it?

Hierarchy

Medical settings tend to be hierarchical with the consultant psychiatrist seen to be at the "top of the pile". Responsibility comes with authority. Those who constitute the multi-disciplinary team (including music therapists) carry some of this authority by proxy.

Another feature of Goffman's total institutions is the split between the large, managed group (the patients) and the small, supervisory staff:

> "Each grouping tends to conceive of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive and untrustworthy, while inmates often see staff as condescending, highhanded and mean. Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy, and guilty." (Goffman 1968: 18)

This split cannot make for the building of positive therapeutic relationships. Aware of the split, music therapists may try not to be identified as part of the day-to-day care staff, but as a semi-outside figure. Nevertheless, they remain part of the diagnosing, history-knowing staff. The consequences may be varied: I have certainly been aware in my work in hospital of people initially attending groups because they feel they earn "credit" for doing so and hence an earlier discharge. In this way the psychiatric system may be seen to replicate the social oppression which is a contributing factor to people's mental ill-health.

Thus in non-medical mental health there are conscious attempts to reduce this split. Professionals become "workers" - there to do a job rather than to occupy a position - and may be answerable to a management committee made up partly or even entirely of service users. Workers and users eat together, smoke together, talk together.

As music therapists, do we need hierarchy? Could we work without it?

Towards Enabling: Working Without

Ruud (1998:9-10) has written about the impact of anti-psychiatry and its legacy on his thinking. Yet, for the most part, and certainly in the UK, music therapy has not engaged with attempts to build publicly accessible non-medical mental health services. Perhaps this is due in part to suspicion amongst users that music therapists are irredeemably psychiatric. Perhaps, as a profession, music therapy desires to bask in the respectability of medicalism, hence choosing to concentrate on issues such as state registration at the expense of the breadth of services available to users. Or perhaps individual music therapists are simply reluctant to abandon the status and authority that medicalism confers upon them.

But there are good reasons for engagement. Ruud (1998:5) calls for music therapy to "align with those forces in society that work toward creating a space for human empowerment, self-insight, personal growth, solidarity, and social networking and with those that work toward alleviating structural forces blocking possibilities of action."

Non-medical mental health provision emphasises *personhood* (the idea that each of us is unique and deserving of recognition, respect and trust in relationships with others - a concept significantly most developed to date not in the psychiatric literature but in that on dementia care, e.g. Kitwood 1997), *empowerment* (which might be broadly described as acknowledging each person's ability and potential) and *enablement* (which might be broadly described as

promoting experience and development of that ability and potential).

Morgan (1996:118) points out that a focus on user-empowerment need not exclude professional skills. Rather, professionals need to be able to prioritise their skills differently or to use their skills in a different way. As music therapists, what are the skills we bring to our work with service users? How are we to prioritise them? Perhaps we can be guided by this definition of enablement drawn up by users of services in London:

> "Enablement is about helping the individual to achieve what is important to that person, and not necessarily about seeking normality or conformity. It is about helping people to respond to their circumstances; to assert their individuality and establish their goals. It is about establishing co-operative relationships. It is about removing barriers and creating opportunities which will help individuals to explore new areas, develop skills and gain mastery over their environment in keeping with their own aspirations." (Stewart 1994:248, quoted in Morgan 1996)

Which skills do we use to achieve this? The answer will inevitably depend on the theoretical framework and practical approach of the individual music therapist. For myself, identifying with the music-centred approach described by Ansdell (1995), the key skills are rather musical, and include the following (these skills of course presuppose a substantial musicianship, extensive musical experience and inter-personal awareness on the part of the therapist.):

- **listening**
- **hearing as music**
- **"musicking"** (after Small 1998) with the client so as to draw him into co-musicking (rather than simply using instruments together) with all the inter-personal and creative demands that this presents
- **considering and reflecting on** the nature of the co-musicking

These can be mapped onto the definition of enablement offered above. To enable people to achieve what is important to them, we need to *listen* to that person, both musically and non-musically.

We need not seek normality or conformity. There is no need to enforce anything or attain particular "standards". In order to help people to respond to their circumstances and assert their individuality, we need to hear *as music* the potential and the quality in their music-making with us.

Our co-operative relationship, at the centre of all we do, is that of *musicking* together, or *co-musicking*.

In order to remove barriers and create opportunities to explore new areas, we need to apply our musicianship in the broadest sense by *considering and reflecting* on our musicking together so as to make possible developments in the experience of co-musicking.

It is important to acknowledge that, as music therapists, we are not able to do this in every sphere of users' lives. However, in non-medical mental health provision we are likely to be working alongside others who will be aiming to enable users in other areas, perhaps in relation to work, housing, living skills, relationships and so on. This enables us to concentrate on offering our core skills - enabling people to discover their own potential in co-musicking.

Example

In the introduction, I described the "community resource centre for mental health" where I work in a socially deprived area of London. It employs no medical personnel, although its existence is dependent on annual grants from the local Health Authority and social services. There are no patients, just members. There are no experts, just workers. There are no files with members' case histories. There is no classification of members on the basis of diagnosis. Members are who they are as they are, not a personification of a history or diagnosis. Members become members and engage in activities here not because they are coerced into doing so but

because they have taken responsibility for doing so themselves.

The Centre receives its limited funding in order to provide services for people with severe and enduring mental illness. In general, psychiatrists would class its users as chronically rather than acutely ill. Many of them have been hospital inpatients and several are regularly in and out of hospital.

Users of the Centre are told about the various services on offer when they first visit and may choose which, if any, specific services they wish to engage with, or they may prefer simply to use it as a social meeting place. Thus some users may come with music therapy in mind from the start, whilst others may decide to try it after already being a user for some time.

Lana came to music therapy at a friend's suggestion. She had already joined a women's talking group at the Centre but, in her words, "they drove me nuts". She felt impatient with others' problems and said she preferred doing to talking.

Seeming confident, she was drawn to the percussion. She would play everything she could lay her hands on - quite literally. She never used sticks, brushes or beaters although these were readily available. She threw her whole body into playing with her hands. She demanded to be listened to. Nor was it difficult to hear what she was doing as music, for it was very musical. It was energetic, driving and dynamic.

Here is a description of part of our fifth session, together with some of my reflections:

> "Lana is at the congas, a hand on each. She doesn't look at me - she's completely engrossed in her own playing. She starts quietly and deliberately, but right from the start there's a sense of inevitable accelerando. At first she plays with deft wrist flicks but as the music grows, first her arms, then her upper body and eventually her entire torso is being flung at the drums. It seems she can't help getting faster and faster, louder and louder. At the piano, I try using musical devices to hold her back - halving my tempo, forcing ritenutos - but these work only temporarily or not at all. The improvisation culminates in an inevitable accelerando to a big climax, followed by a dramatic ritardando."

I enjoyed this kind of playing. It was exhilarating if at times exhausting. But it was also relentless. She always exclaimed how fantastic it was after each improvisation, but my hearing of her musically and my reflecting on our co-musicking suggested that this kind of playing was not entirely the result of choice on her part. Yet my attempts to offer her alternatives by pulling her back seemed to be little more than temporary frustrations. I wondered whether I shouldn't be pulling her back into my idea of a better way of playing - "seeking normality or conformity" - but rather "helping her to explore new areas", rather like Ruud's idea of "increasing possibilities for action".

In musical terms, a major barrier to the scope of our co-musicking seemed to be the way in which rhythmicity took her over bodily. She avoided tuned instruments and never had a chance to be part of any sense of musical line: maybe my role should be to enable her to experience being melodic?

> "I suggest Lana joins me at the piano - "just one finger at once if you want". Within seconds she is using all her fingers. But it's the way she uses them that strikes me. It's careful and almost painstakingly legato. Between the notes, there is far more space. All I have to do is underpin what she is doing - attend to her harmonically. At moments, accelerandi threaten to take over, but this time she doesn't need me to pull her back - she's doing it herself. This seems to enable her to hear what I'm doing too: I have a real sense that instead of hurtling after each other down a musical helter-skelter we are accompanying each other into new territory where unfamiliar features of the landscape include a sense of ongoing phrase, legato and even rubato. At the end of this, our longest-ever improvisation, she is silent for several seconds (also something new) before quietly observing, 'I didn't know I could do that.'"

This was a turning point in our work together. In subsequent sessions she might start on percussion, but then would move to melodic instruments. She clearly had more choices in how to music with me, and she used this to take more risks.

At the close of our work together, approximately 3 months later, I asked her what, if anything, she had gained from music therapy. She told me that other people described her as impatient and impulsive (though her psychiatrist called her manic). Despite this way of being resulting in considerable problems for her in life, she had never really accepted the idea. But in music therapy she had found that she could do things in more than one way. "I can be loud or I can be quiet."

In music therapy Lana experienced being listened to and heard in musical terms. This I regard as the way in which I, as a music therapist, can offer the people I music with opportunities for empowerment. Furthermore, both her potential and qualities and my skills and understanding were utilised in co-musicianship so as to remove barriers and explore new musical areas. This I regard as enablement.

I did not know Lana's diagnosis or history before we started, and I strove to avoid hierarchy. In hearing all she did as music, however, I was able to consider what I might have to offer of value to Lana, rendering a diagnosis less necessary. By co-musicking, we created our own shared musical history, not documented for others to pick over, but experienced by each of us in our own way.

This leads to an interesting consideration for me: whilst music therapy as I understand it in this setting is not part of a medical treatment model, neither is it really "just playing music". In my work with Lana, I subjected my experience of our co-musicking to reflection and consideration in order to offer intervention. By this I mean that I changed the ways I played and the suggestions I made in response to my musical observations of our co-musicking. Without these interventions, I could not have offered Lana the same opportunities for empowerment and enablement. Perhaps, then, I need to be careful not to under-represent what I am doing when talking with my more medicalised colleagues!

Assessment and Evaluation

In medical circles, there are increasing demands for assessment (of the "progress" of a client in a particular provision or their "suitability" for the provision) and evaluation (of the value of the service being provided).

Without diagnosis, history or hierarchy, can we assess? Indeed, is there any need to assess? In a sense, the continuous exercise of the skills identified above amounts to ongoing clinical assessment. However, assessment as documentation could be seen within the non-medical sphere as another repressive tool of medicalism, labelling people, violating their informational preserve and adding to the hierarchical gulf between practitioner and user.

Evaluation (of the value of the service being provided) is another matter. Funding agencies require evaluation of the way their money is being spent. At present where I work, this is done in terms of attendance statistics. If people turn up to sessions, this is taken as suggesting that they value what happens in the sessions and find it motivating enough to attend. However, whilst there is certainly some validity in this, it is not tremendously valuable for practitioners, as it does not address reasons why people do not attend - or, perhaps more importantly, why they do attend and hence what they value about it. The only source of this kind of information is the users themselves. Both non-medical mental health provision and post-psychiatry value "user-led" (or "emancipatory") research (Bracken & Thomas 2001), and it is perhaps through this kind of investigative process that meaningful evaluation of such services will be possible.

Reflections

Non-medical mental health provision has developed as a response to the experienced inadequacies of the psychiatric system. As a cultural system, it presents music therapists more accustomed to working in psychiatric culture with both challenges and opportunities. Many of its values can be seen to accord closely with those of improvisational music therapy. In particular, empowering and enabling are seen to relate closely to the concepts of listening and hearing as music (empowering) and offering opportunities for the development of experience in co-musicking (enabling).

Non-medical mental health provision offers us opportunities to focus on, and learn about, the essence of what we are about as music therapists. We need to be clear what it is we have to offer to users of our services, and to ensure that we are capable of offering this in practice.

But there is no reason why these lessons should remain confined to non-medical mental health. When working within psychiatry, we should be aware of the limitations both of the system of which we are part and of the fit between music therapy and the system.

As our profession matures and makes the transition from radical, outsider group to accepted, establishment group through processes such as state registration, we must be aware of the dangers of "professionalisation". Preoccupation with rising professional status or eagerness to adopt the assumptions of more established disciplines can compromise our ability to offer clients our distinctive skills.

Music has a role in health and social provision precisely because it is *not* like anything else. It is not psychometric, biomedical or verbal. Nor is it part of a vaguely generic "arts therapy". "Music therapy works in the way music works" (Ansdell 1995:x) Far from limiting us, as musicians this gives us the opportunity to bring the personal and social benefits of co-musicking to cultures and communities where it will be valued. Amongst these is non-medical mental health provision.

Music therapy has come from the outside, from radical musicianship. We must not merge entirely into a medicalised professional hierarchy: to empower and enable, wherever we work, we need hearing minds and radical hearts. And if that means being regarded as mavericks or naïve, then so be it.

Acknowledgements

This article is based on a presentation given at the Vth European Music Therapy Congress, Naples, Italy in April 2001.

The author would like to thank Rachel Verney for her help in formulating some of the ideas in this article.

References

American Psyciatric Association(1994). *Diagnostic and Statistical Manual of Mental Disorder* Fourth Edition. Washington DC: American Psychiatric Association.

Ansdell, G. (1995). *Music for life.* London: Jessica Kingsley Publishers.

Bracken, P. and Thomas, P. (2000) Postmodern diagnosis. *Open Mind 106, p. 19.*

Bracken, P. and Thomas, P. (2001) Postpsychiatry: a new direction for mental health. *British Medical Journal 322,* pp. 724-727 [available online at **http://www.bmj.com/cgi/content/full/322/7288/724**]

Browne, D. (1997) *Black people and 'sectioning'.* London: Little Rock Publishing.

Campbell, P. (2000) The history and philosophy of the survivor movement. *Southwark Mind Newsletter 24.*

Double, D.B. (1991) What would Adolf Meyer have thought of the neo-Kraepelinian approach? *Psychiatric Bulletin 14,* pp. 472-474.

Goffman, E. (1968) *Asylums.* London: Pelican.

Kitwood, T. (1997) *Dementia reconsidered: the person comes first.* Buckingham: Open University Press.

Littlewood, R. and Lipsedge, M. (1997) *Aliens and alienists: ethnic minorities and psychiatry (3rd edition).* London: Routledge.

Morgan, S. (1996) *Helping relationships in mental health.* London: Chapman and Hall.

Ruud, E. (1998) *Music therapy: improvisation, communication and culture.* Gilsum NH: Barcelona Publishers.

Small, C. (1998) *Musicking.* Hanover NH: Wesleyan University Press.

Stanton, S. (2001) I don't know what 'ill' is. It's just me. *Open Mind 108, pp. 24-25.*

Szasz, T. (1974) *The myth of mental illness.* New York: Harper.

Wiggins, O.P. & Schwartz, M.A. (1999) The crisis of present-day psychiatry: the loss of the personal. *Psychiatric Times 16(8)* [available online at **http://www.mhsource.com/pt/p990860.html**]

Williams, J. (1999) Social inequalities and mental health. In: *This is madness*, ed. C. Newnes, G. Holmes and C. Dunn. Ross-on-Wye: PCCS Books.

To cite this page:
Procter, Simon (2001). Empowering and Enabling: Improvisational Music Therapy in Non-medical Mental Health Provision. *Voices: A World Forum for Music Therapy*. Retrieved from http://www.voices.no/mainissues/Voices1(2)Procter.html

Moderated discussion

Add your comments and responses to this essay in our Moderated Discussions. Contributions should be e-mailed to either ***Barabara Wheeler*** *or* ***Thomas Wosch*** **Guidelines for discussions**

View contributions on this essay: [yet no contribution]