The Foundations of Music Therapy: Interaction Between Universal Mechanisms and Sociocultural Learning

Yuchen (Albert) Hu
yuchen_hu@ridleycollege.com

ABSTRACT

As music therapy becomes increasingly popular globally, some Western assumptions including humanistic methods, egalitarian approaches and free form improvisation may be translated directly to other cultures without careful considerations. This review evaluates whether the efficacy of it is affected by universal biological mechanisms or culturally learned meanings. While neuroimaging and physiological data demonstrate commonalities across cultures, psychological research suggests that emotional interpretations of musical structures, such as major versus minor modalities, are substantially shaped by social experiences. Consequently, a possible structural mismatch may occur when Western improvisation methods meet some collectivist cultures that value structured instructions and professionalism. Without careful considerations on relational values described in Chinese clinical settings, such as guanxi and mianzi, the Western methods could possibly evoke feelings of anxiety in some Chinese patients. Synthesizing literature identified through the search process described in the Methods section, this article argues that Western assumptions should be adapted toward culturally responsive, hybridized methods, which include "mixture music" that may be more engaging for people with diverse backgrounds. Much of the supporting evidence is qualitative, theoretical, or indirect rather than clinical-outcome data, so the conclusions are offered as a conceptual argument and not as proof that one approach is more effective than another. Therefore, this paper concludes that while sound interacts with universal human bodies, culture shapes how music is interpreted and used in therapy, which highlights the necessity for adaptive frameworks for diverse global populations.

METHODS

This paper is a narrative literature review.

Databases searched: Google Scholar, JSTOR, PubMed

Search dates: June 20, 2026 to August 10, 2026

Search terms: "music therapy" AND (culture OR cross-cultural OR China); improvisation AND "music therapy"

Inclusion criteria: peer-reviewed scholarly articles in English that include biological response to music therapy methods, explain cultural influence on the methods, or introduce clinical accounts for music therapy. Two sources that are not journal articles were also included because they were the most relevant

available accounts of their topics: an unpublished ethnographic study of Western-trained music therapists in China (Donley, 2018) and a book chapter on cultural diversity in music therapy (Kim & Whitehead-Pleaux, 2015).

Exclusion criteria: non-scholarly sources; sources unrelated to the effects of music.

Selection process: The titles were first evaluated to determine whether they could contribute to the research. If the title included key terminologies such as "music therapy" or "culture," the abstract was looked over to understand the full content of the article. If it was confirmed to be beneficial to developing the research, the study was added and examined later. Findings by Penfield and by Opler and Singer are cited as reported in Robertson-DeCarbo (1974) and were not reviewed directly.

The sources found were then sorted according to the type of information they provided. Direct clinical and practice sources included the review of music interventions for older adults (Rose et al., 2020), the study of Western-trained therapists in China (Donley, 2018), the study of veteran rehabilitation (Dhokai, 2017), the guidance on music therapy (Kim & Whitehead-Pleaux, 2015), and two Cochrane reviews of clinical outcomes (Geretsegger et al., 2022; van der Steen et al., 2018).

Indirect sources included research on infant preference (Crowder et al., 1991) and adult musical-emotion perception (Midya et al., 2019), cross-cultural analyses of song and pitch perception (Mehr et al., 2019; Savage et al., 2015; Jacoby et al., 2019), music education for students with autism (Du et al., 2025), ethnomusicological and cultural theory (Robertson-DeCarbo, 1974; Mastnak, 1993; Mahoney, 2015), and community music research (O'Connell, 2011; Swijghuisen Reigersberg, 2017).

INTRODUCTION

Music therapy has become a widely recognized non-pharmacological treatment for conditions ranging from memory loss and pain to psychiatric symptoms. It is a therapeutic intervention where a trained music therapist systematically uses music experience such as listening and performing along with the therapeutic relationship to achieve individualized goals. It is often applied within a structured clinical treatment to maximize its efficiency in promoting health and wellbeing. As the method becomes increasingly popular globally, some Western assumptions including humanistic methods, egalitarian approaches and free form improvisation may be translated directly to other cultures without careful considerations. This assumption has been questioned in research and clinical reports from some non-Western settings.

Specifically, a central point of discussion in the literature is whether music's therapeutic functions are driven by universal biological mechanisms or by learned sociocultural norms (Crowder et al., 1991). The evidence reviewed here suggests that the two interact rather than compete. Neuroimaging techniques demonstrate similar patterns when music activates certain brain regions, supporting the biological explanation. However, anthropological research shows that emotional interpretation and definitions of mental illness are culturally constructed (Robertson-DeCarbo, 1974). The answer to this question is significant – if the connotations of music are learned in society, applying Western standards in other cultural contexts may reduce the benefits for participants or cause them discomfort, a possibility that requires direct clinical testing.

This tension may appear when Western-trained therapists work in some collectivist East Asian contexts. A specific example is Chinese culture. The Western method that primarily uses improvisation that allows patients to explore freely may be interpreted as a sign of unprofessionalism in settings that expect clear instructions. Relational norms described in Chinese clinical settings also shape the dynamics significantly, making it difficult to apply the Western standards unchanged.

A promising approach, supported mainly by qualitative accounts, uses "mixture music"—blending local and global genres—to reflect clients' actual lived experience, serving as a bridge for cognitive, emotional, and even community-level healing (Donley, 2018).

Ultimately, the sources suggest that developing culture specific music therapy methods is more likely to benefit patients effectively compared to implementing Western improvisation only. This means that understanding key concepts in different cultures, such as *guānxi* and *miànzi* in Chinese settings, and integrating research on biological versus cultural impacts on physiological response are both crucial.

I. THE CORE DEBATE: SHARED BIOLOGICAL MECHANISMS AND CULTURALLY LEARNED INTERPRETATION ACROSS CULTURES

Music therapy and music interventions have become more and more popular globally as non-pharmacological treatment options for memory loss, pain management as well as reduction of behavioral and psychological symptoms (Rose et al., 2020). As a relatively new method developed to assist with treatment of mental disorders, it has evoked rising interest among researchers. For instance, Rose's review of literature analyzes the music interventions for older adults across the globe to better understand the methods. The knowledge on multiethnic interventions is especially important for culturally diverse countries like the U.S. to ensure functionality for all patients. Using 449 studies that included 48 countries, they concluded that best practices are being developed worldwide in the field of music therapy, and the specific information exchange is beneficial in multicultural countries. Reviews of controlled trials likewise report benefits of music-based interventions for people with dementia, although the certainty of the evidence varies across outcomes (van der Steen et al., 2018).

Since the method and thus effectiveness of treatment varies significantly among different individuals, the factors influencing it are widely discussed and debated among experts in the field. The Diagnostic and Statistical Manual of Mental Disorders (1968 revision) of the American Psychiatric Association divides the triggers into two main categories: Organic brain syndrome and functional disorders (Robertson-DeCarbo, 1974). They represent the two main perspectives involved in this core debate. The first group of researchers believe that the efficacy of the therapeutic process depends largely on the universal biomechanisms in the human body. The same review by Rose et al. (2020) summarizes that physiological outcome measures have shown benefits gained from music interventions particularly for older adults across the cultural and ethnic groups studied. Neuroimaging measurements also support the clinically derived notion that music can address needs of people with dementia. More recent cross-cultural work supports shared features alongside variation. Analyses of song recordings from societies around the world found that songs share recognizable behavioral functions and acoustic regularities while also varying considerably (Mehr et al., 2019; Savage et al., 2015), and a study of singing across cultures found

both universal and culture-specific features of pitch perception (Jacoby et al., 2019). Robertson-DeCarbo (1974) supports the biological explanation by introducing the schemata theory. It states that our brains store information in a way that easy cognition of associations could be made rapidly when we encounter similar stimulus. The Gestalt school mentioned in her research explains those sequences in terms of schemata stored in the brain as a result of learning. Earlier theorists proposed that schemata operate as an unconscious process and may have a nesting structure, containing both deep structures that are abstract and unrestricted along with superficial structures that are more concrete and similar to reality. On the other hand, neural tissue is active by nature (Mastnak, 1993).

Multiple tools could be applied to aid the measurement of these activities, such as electroencephalography for infants as well as measuring radiant energy of particular wavelengths. Wilder Penfield's research shows that electrical stimulation of the temporal lobe evokes responses from mental patients, usually in reference to past experiences (as cited in Robertson-DeCarbo, 1974). This is consistent with the biological argument of music therapy, suggesting that specific regions in the brain are in charge of auditory recall and memory related functions that the music may universally target. Similarly, Robertson-DeCarbo's (1974) discussion of Washburn's research suggests that the cortex controls autonomic function, becoming consciously so in times of crisis and anger. Music interventions might also target this region to make therapeutic processes more efficient. Specifically, Western clinical observations report that music is often an effective stimulus for many psychotic patients, helping them restore basic functions such as eating, speaking, or even opening their eyes. These observations are older and descriptive, and newer controlled studies would be needed to confirm them.

However, Robertson-DeCarbo (1974) reinforces the crucial point that neither symptoms, treatment, nor hospitalization are valid indicators of mental illnesses across cultures. This is because anthropological definitions of mental illnesses rely heavily on observation of abnormal behavioral patterns, which are determined by social orders that differ heavily between cultures. She criticizes the dominant model in culture and personality theory, and argues that the importance of cognition and motivation is underestimated in the previous theory. While the biological processes are confirmed as essential for music therapy, she states that common understanding of learned meanings is an important contributor to successful music interventions. For example, she describes some southeastern Asian cultures as focusing on sudden physical assault on other people that cause actual damage, whereas some cultures in colder climates are described as focusing more on behaviors that demonstrate excitement rather than aggressiveness.

This observation of patterns is important – it suggests that culture, which is shaped by multiple factors including location and climate, affects the perspectives and standards utilized to determine mental illnesses. Those different beliefs influence how doctors treat patients differently in different cultural contexts. Moreover, the symptom patterns vary by ethnicity even within the Western societies. Opler and Singer found in New York City that Irish male schizophrenics tend to be quiet and withdrawn, yet Italian male schizophrenics tend to be noisy and aggressive (Opler & Singer, as cited in Robertson-DeCarbo, 1974). This evidence suggests that culture and previous experiences shape a patient's behavior even if the biological factors inducing those symptoms are the same. This divergence of behaviors extends directly into how humans perceive the same structural components of music, which serves as a critical point of

focus for the current debate on universal biological mechanisms and learned sociocultural influences. To evaluate whether the effects of music are expressed universally across cultures and ages or internalized through cultural immersion, developmental research has focused on the instinctual responses of young infants. In a study published in the Bulletin of the Psychonomic Society, researchers Robert G. Crowder, J. Steven Reznick, and Stacey L. Rosenkrantz explored how six-month-old infants demonstrated their musical preferences between music pieces with various harmonics (Crowder et al., 1991). Using a contingent head-turning preparation to track directional gaze times, the researchers discovered that infants overall did not show significant preference when choosing between a major chord and a minor chord. The average looking times were 2.67 seconds and 2.60 seconds respectively, which is not a convincing amount of evidence that there is a strong desire. Crucially, the researchers corroborated that the lack of difference is not due to an insensitive group of participants by demonstrating the infants' significant preference for consonant harmonies when given choices between consonant and blatantly dissonant chords produced. Combined with previous research results indicating that children as young as three years old can understand the uplifting and sad connotations of major and minor modes, the negative results gained in infants suggest that while certain acoustic preferences may be inherently biological, specific emotional meanings such as our cultural association of major keys with positive emotions and minor keys with negative ones are likely acquired through sociocultural learning and exposure during early childhood. Because this study measured infant listening preference rather than therapeutic outcomes, it informs the conceptual argument only indirectly.

This complex interaction between innate biological processing and cultural conditioning is further illuminated by exploring how adults decode the complex inner meanings of music produced. As documented in a study published in PLOS ONE, Vishal Midya et al. (2019) investigated how Indian listeners who are familiar with the culture behaved differently compared to those non-Indian listeners when given a piece of Hindustani classical ragas. The stimuli consisted of twelve distinct ragas, each presented in both a slow, improvised way and a fast, rhythm-strict way, allowing the researchers to isolate the independent emotional influences of tonality and rhythm. When comparing the emotional ratings across eight distinct dimensions, the authors discovered a significant cross-cultural agreement on the emotions expressed. Out of 192 between-group comparisons, intensity ratings differed in only 9% of instances, suggesting that perception of musical emotion could be universal even across entirely different cultures. However, robust regression and machine learning analyses (Random Forest and XGBoost) revealed a distinction in how these universal emotional endpoints were reached. Enculturated Indian participants relied mainly on tonality (defined as the pitch frequencies and interval relationships between notes) to decode the emotional meaning of the ragas. Conversely, non-enculturated listeners primarily utilized rhythmic cues—such as tempo, and note spacing to understand emotional context when navigating an unfamiliar tonal system. Taken together, the research points toward an integrated resolution of the core debate: while certain acoustic features leading to emotional understanding in music exhibit substantial cross-cultural universality, the cognitive reliance on specific acoustic cues appears to be shaped by an individual's unique cultural background and history. Biological mechanisms and cultural learning therefore appear to interact rather than compete. As with the infant study, this work concerns emotion perception rather than therapeutic effect, and it should be read as contextual evidence.

II. POSSIBLE STRUCTURAL MISMATCH: IMPROVISATION-CENTERED WESTERN APPROACHES VS. STRUCTURED APPROACHES IN SOME EAST ASIAN SETTINGS

While the interactions in cultures are highly complex and can vary due to various random factors, there are noticeable patterns in the values. Donley (2018) defines Western and Eastern cultures primarily based on the locations: Western countries include the United States, Canada, Western Europe, and Australia while Eastern countries are geographically defined as countries in South East Asia, South Asia, and North East Asia, such as Japan, Thailand, Vietnam, India, Bangladesh, and especially China, which is heavily discussed in the articles. These categories are broad simplifications that group highly heterogeneous populations, and they are used here only as shorthand for patterns reported in the cited sources. Beyond the geographical locations, Donley describes Western cultures as generally individualistic while Eastern cultures as generally collectivist. Individuals within every society vary, and the studies discussed below describe specific populations and settings, such as Western-trained therapists working in Chinese hospitals and one school in Fuzhou, rather than all of "the East."

The attempts to translate various methods of music therapy globally may face methodological friction, particularly due to the difference in basic structures of music – Western fluid improvisation and structured, programmed routines. In Western culture, particularly under modern knowledge frameworks, improvising to produce music is viewed as a central therapeutic technique for patients because it involves autonomous thinking and concepts like "breaking the order". Conversely, collectivist values, which are emphasized in many East Asian societies, may influence beliefs in therapeutic operations, as reported in some settings where music is used in stricter forms, follows social norms, and helps with "hiding the emotions" cognitively. This section examines the differences between those two frameworks, arguing that the Western reliance on unstructured, client-led improvisation may not be a universal therapeutic good. However, the improvisation technique could be beneficial to patients even in collectivist cultures, with proper remediation that addresses the core conflicts in concepts. Reviews of randomized trials in autism, which include improvisational approaches, report generally favorable but variable results (Geretsegger et al., 2022).

As Mahoney (2015) articulates in her critique of multicultural and anti-oppressive practices, some strands of Western music therapy tend to disagree with the traditional view on patients—a model that states that clients' body or mind has gone "wrong" and is in need of fixing. Within this central idea, influenced heavily by feminist and disability rights activism, the patients and therapists are heading towards a more and more equal relationship. The therapist is no longer the "expert" in the conversation – he or she becomes the co-creator of the improvisation piece of the patient, which allows the clients to express themselves more freely without having to concern about social norms or expectations.

Furthermore, the music therapy method that Mahoney advocates for emphasizes that interpersonal relationships must be egalitarian, empowering clients to challenge restrictions on ways of being "human." In this context, the music improvisation is not solely limited to a music exercise, but is also a tool for self reflection and liberation. It allows the individuals that feel suppressed to finally express their thoughts freely without the social limitations they experience. By engaging in those types of activities, the clients

may eventually gain their "true identity". The value of this framework, as Mahoney describes it, lies in removing boundaries set by traditional cultural values that can feel like psychological constraints, allowing clients to express themselves and potentially heal from trauma (Mahoney, 2015).

However, when this Western, humanistic method gets translated to some collectivist East Asian cultures, the positive effects of liberation and relaxation may not appear. Instead, practitioners have described clients in those contexts as experiencing nervousness, and even anxiety (Kim & Whitehead-Pleaux, 2015). These accounts come from clinical commentary rather than controlled outcome studies. Kim and Whitehead-Pleaux (2015) raise a useful question about this potential clash: "How uncomfortable would it be for a client, raised within a structured society, to be asked to make something up freely in music?" In many collectivist cultures, including China as described in these sources, members of the society value defined roles and respect for people in higher hierarchies to maintain harmony in society. In such environments, a client may expect the therapist to display "full command and supply comprehensive instruction" (Kim & Whitehead-Pleaux, 2015). When a Western therapist invites the patient to create music freely without any clear instructions, some clients may not perceive it as an egalitarian statement. They may interpret it as a lack of responsibility and preparedness, which could undermine the trust between patients and doctors and potentially reduce the benefit of therapy.

This challenge is also highly relevant to the mechanics of the music itself. Kim and Whitehead-Pleaux note that many Westerners are more familiar with diatonic scales, harmonic structures and instruments with physical layouts similar to the piano. Consequently, asking a patient who is not familiar with Western culture to improvise on a piano may not be a helpful act; rather, it may force the patient to step out of their comfort zone. Furthermore, in many collectivist-oriented societies, the individual is deeply bonded to their community and social relationships. Key figures in the family, often elders and seniors, traditionally assume and accept their role of guiding. Discussing or exploring emotional events outside of the family circle is often regarded as embarrassing. Therefore, the demand of the Western therapists for young people to express themselves and their vulnerabilities may go against some cultural norms. The unstructured nature of the improvisation may make some patients feel unsafe and anxious. Improvisation may fail when the therapist fails to address the cultural concerns of the patients in the context.

Therapists have to address the issue to support productive results in therapy. The qualitative observations from the Xing Yu School in Fuzhou, China, detailed by Du et al. (2025), provide contextual evidence on how music-based instruction may be adapted for one group of Chinese students. This study concerns music education rather than music therapy, and it does not test improvisation directly. In their study of music education for high school students with Autism Spectrum Disorder (ASD), Du et al. reported that growth in multiple areas including cognition and emotion was associated with "structured teaching" and "programmed arrangements." By using structured lessons and detailed instructions, educators at Xing Yu deliberately created highly organized learning environments that the authors describe as beneficial for the students' learning.

Crucially, the "stratified teaching" model used in Xing Yu categorizes students into groups of "A, B and C level" and has various tasks that are suitable for students at different levels—ranging from singing entire songs to executing simple rhythmic movements. This highly organized structure allows the teachers to

play the role of the authority in the school and give clear instructions, which contrasts with the Western "blank slate" improvisational therapist described by Mahoney (2015). For students with ASD, who frequently experience sensory differences and anxiety, unpredictable activities may be difficult and structure may be especially helpful. This is a hypothesis rather than a finding, because Du et al. did not compare structured with improvisational methods. Du et al. (2025) report that reduced ambiguity through structured routines appeared to help students process information better, regulate their emotions, and engage more socially. The intentional physical arrangements at the school, such as including specific percussion instruments and visual cue cards, further reflect an emphasis on external, programmed stability over internal, spontaneous generation. In this setting, the authors present these actions of the instructor as signs of professionalism rather than as oppressive.

The methodological friction between these two approaches may reflect different emphases in how "healing" and "growth" are conceptualized across cultures. Mahoney's (2015) Western framework views structural boundaries and limits on routines as restrictions that undermine human potential; thus, fluid improvisation is presented as an antidote to control. Conversely, Du et al.'s (2025) findings in the Chinese context suggest that for some populations, particularly those with developmental disorders, structural boundaries can be beneficial for learning and emotional regulation. When a Western therapist attempts to apply Mahoney's method of improvisation in a context described by Du et al., the result could be a structural mismatch. The therapist may believe they are offering freedom and empowerment, while the client may experience uncertainty and doubt about the therapist's preparedness.

Moreover, applying Western theories of improvisation without adaptation in some collectivist settings may raise ethical concerns in addition to practical ones. It could represent a form of cultural imposition in which a dominant culture's definition of wellbeing, characterized by individuation and high emotional release, is applied to a community that may place more value on social order and "hiding emotions." To address this concern globally, therapists should examine the assumption that Western methods of music therapy work universally. They may find that for many clients, psychological safety is supported by the reliable, programmed architecture of structured routines, although direct clinical comparison is still needed. Ultimately, this mismatch underscores that the Western method of fluid improvisation should be critically re-evaluated as a culturally specific intervention, rather than a universal clinical standard, to reduce the risk of poor fit in culturally diverse contexts.

III. CLINICAL ADAPTATION: NAVIGATING TRUST (GUĀNXI), REPUTATION (MIÀNZI), AND TRADITIONAL FRAMEWORKS IN CHINESE SETTINGS

If the structural difference in type of music interventions may represent a difference in approaches emphasized in Western versus some East Asian contexts, the specific dynamics in interpersonal reactions may highlight this variance even more. In models based on Western cultures which are humanistic, therapists often focus on egalitarianism and the uncovering of repressed emotional truths. However, when Western-trained music therapists enter Chinese clinical spaces, they may encounter a socio-relational architecture governed by different norms. As Donley's (2018) ethnographic research reports, according to the Western-trained therapists interviewed, clinical efficacy in China may depend less on individual

psychological exploration and more on the therapist's ability to successfully navigate the complex system of "guānxi" (relational trust). In Western clinical terminologies, "rapport" is generally defined as a mutual, empathetic relationship between patients and therapists by active listening and unconditional positive regard. However, as Donley describes, in Chinese culture trust is often mediated by guānxi, which is described as an intricate social networking system, consisting of reciprocal obligation (rénqíng), and emotional depth (gǎnqíng). Since restraining emotional expressions is valued in many Chinese social settings, some patients may not be willing to share the emotional struggles. Consequently, the Western method of asking deep, open ended questions often faces polite refusal. To overcome this methodological challenge, Donley suggests using indirect communication, using words like "maybe" or "try" to provide hope without making certain promises that could damage the relationship in the clinics. Furthermore, therapists should use narrative storytelling voices rather than professional clinical terms when communicating with the patients. When verbal communication is obstructed by cultural norms, the music itself can become an important tool for building guānxi. For example, therapists use instruments like acoustic guitars to build rapport through shared musical enjoyment. However, these findings come from a qualitative study of Western-trained therapists in China and cannot be generalized to all Chinese or East Asian clients.

Adjustments to accommodate the concept of "miànzi", or "social face", which is the preservation of one's dignity and reputation, are equally as important. In some collectivist contexts, mental illness can be not merely an individual burden, but also a source of emotional shame. A client seeking therapy may risk losing *miànzi*, as it can be seen as an individual's failure to play the role properly within a family to maintain harmony. This cultural reality creates a significant barrier to entry, as some clients may be wary of any clinical interaction that might expose their vulnerabilities or highlight their deficits. Here, the Western ideal of the "co-creator" or "facilitator" may conflict with some expectations of the healer in China. In settings with high power distance, clients may expect the therapist to possess substantial authority, comprehensive knowledge, and the ability to provide direct, rapid solutions. Donley (2018) notes that if a Western therapist takes a "blurry" stance and expects the patients to take initiative in the treatments, the Chinese client may not view this as empowering, but as professional incompetence, which could lead to loss of trust and withdrawal from treatment. To preserve the client's *miànzi* and establish a healthy *guānxi*, therapists in Donley's study described actively showcasing their expertise. As one of Donley's participants explicitly noted, she had to "pretend I know everything" in the initial stages of therapy to provide the authority her clients required. Some therapists therefore acted as a more directive guide, which they felt reduced client anxiety. Moreover, maintaining *miànzi* extends beyond the client. To secure the trust of hospital administrators and physicians, music therapists often found it necessary to supplement qualitative, humanistic narratives with quantitative, behavioral data. By presenting measurable metrics, the therapist can help protect the professional "face" of the music therapy department, demonstrating its utility to the dominant medical establishment.

Beyond interpersonal dynamics, the Western therapists may also need to adapt the Western frameworks to align with the traditional conceptualizations of health in Chinese culture, which are often described as somatic as well as psychological. Music therapy is frequently used to overcome trauma in the West. In China, however, health is often viewed through the lens of Traditional Chinese Medicine (TCM) and the

Five-Element Theory. Wellbeing is described in terms of *qì* (bodily energy) and the balance of opposing forces (Yin and Yang). Within this framework, music can be understood as a form of medicine. The pentatonic scales of traditional Chinese music are traditionally associated with the five elements (wood, fire, earth, metal, water) and their corresponding internal organs. Donley's (2018) data indicate that some Chinese clients and medical professionals appeared receptive to music therapy since it is viewed as a "natural way of healing". In a context where some individuals are reported to tolerate physical pain because of concern about the side effects of drugs, music therapy may align well with these needs. This alignment with traditional frameworks may encourage the Western therapist to reframe their clinical objectives. Instead of asking a client to verbally articulate the root cause of their depression—a question that may induce shame and violate the cultural norm of *hánxù* (emotional reserve)—the therapist can use music to "balance" the client's physiological state. This necessity for cultural reframing is perhaps most clearly visible in the linguistic adaptations required for end-of-life care. Donley highlights a methodological friction regarding the introduction of hospice music therapy. The direct Western translation of hospice care (*lin zhong guan huai*) is reported to carry an aggressive, frightening finality that clashes with a cultural avoidance of discussing death in some Chinese families, leading some patients and families to refuse services to protect their psychological and spiritual well-being. To address this issue, therapists came up with a more indirect way of translating (*huan he yi liao*, or soothing/easing medical care). This appears to be an important clinical adaptation that honors the traditional framework of spiritual preservation, allowing patients to accept therapeutic support without the stigma of confronting imminent mortality.

Ultimately, the ethnographic evidence provided by Donley (2018) suggests that successful integration of music therapy in China may require a substantial decentring of Western psychological individualism. The therapist may need to transition from an egalitarian facilitator to an authoritative architect of social harmony. By protecting *miànzi* through the projection of clinical expertise and framing interventions within the traditional, somatic paradigms of energy balancing and natural healing, the therapist can help bridge the gap between Western clinical science and Chinese cultural traditions. Without such adaptations, music therapy may feel unfamiliar to some clients and may be less accepted. Whether these adaptations improve clinical outcomes remains to be tested directly.

IV. STRATEGIC APPLICATION: "MIXTURE MUSIC" AND GENRE-SHARING AS THERAPEUTIC BRIDGES

Once the structural barriers of improvisation and the dynamics of guānxi and miànzi are successfully addressed, therapists must carefully select the specific music used for the intervention. When Western therapists attempt to incorporate the patient's culture into consideration, biases can emerge: the assumption that clients from non-Western backgrounds solely prefer music that is "purely traditional" may be inaccurate. Donley's ethnographic research in Chinese clinical settings explores this methodological friction in detail, suggesting that false assumptions made by the therapists could undermine the treatments. Donley observed that hospital administrators at some sites frequently purchased traditional Chinese instruments such as erhu or guzheng, based on the assumption that patients are more familiar with those instruments and thus resonate more. In reality, those artifacts often remained unused in storage boxes because some patients found them "useless". Therapists reported that effective sessions often relied on application of "mixture music", which blends Western pop, regional Chinese pop in the 1980s and 1990s, salsa or African drumming as well as contemporary film tracks. This preference of diversified music suggests the effect globalization may have on the identities of some Chinese populations. By overemphasizing ancient traditions and treating the music as an exhibit, the Western therapists risk overlooking the client's real lived experiences in a modern world. Therefore, a successful application may benefit from moving away from the pursuit of pure traditionalism and toward the "mixture" that reflects the real life scenario better.

To navigate this complex intersection of globalized tastes and personal history systematically, Kim and Whitehead-Pleaux (2015) proposed the framework of Culturally Informed Music Therapy. The core tenet is the rigorous rejection of cultural stereotyping, which can lead to bias and poorer care. For example, assuming a client of Latin American heritage will automatically connect with salsa, or an Asian client will prefer pentatonic cultural music. To overcome these biases, their assessment strategy maps the patient's identity across five cultural dimensions: the culture of heritage, religion, generation, location, and personal identity. This multidimensional mapping is important because a client's musical preferences are often shaped more by their personal experiences rather than purely ethnic heritage. A Honduran teenager, for example, might find traditional ranchera music entirely alienating and favor Michael Jackson or Justin Bieber instead (Kim & Whitehead-Pleaux, 2015). Similarly, it is possible for a Chinese elder to connect more deeply with the revolutionary songs of their youth or even emotional Western songs than with Beijing opera. By evaluating those five dimensions, the therapist can shift from the position of making unsupported assumptions to better understanding the patient's multifaceted identity and improve the accuracy of assessment.

This use of genre-sharing extends beyond patient preference and may function as a psychological bridge that can foster connectivity and cognitive rehabilitation, particularly when verbal processing is blocked by trauma or neurological injury. Dhokai's (2017) research with traumatic brain injury veterans suggests this mechanism. Recognizing that traditional clinical interactions often intensify the feelings of suffering from memory, Dhokai utilized the sharing of localized, contemporary genres, from Queen to Lil' Wayne, as the primary model. In this context, therapists only play the secondary role of guiding the participants and

allow them to explore the music they prefer. Discussing their opinions on rap, rock, or country music appeared to help them engage in conversations about past experiences despite their cognitive deficits. This may build confidence among participants who might otherwise struggle due to their injuries. The shared music experiences may become a safe, structured space where patients can reclaim confidence and identity, suggesting that respecting the patients' music taste could bring meaningful benefits, although this qualitative work does not measure clinical outcomes.

Furthermore, the strategic application of the shared musical experiences may extend beyond the micro-level of individual rehabilitation to the macro-level of community healing and avoiding conflicts. As O'Connell (2011) emphasizes in the review of music's role in war and peace, music functions as a "double-edged sword" that can either act as a "poison to excite hostility" or a "potion to foster friendship". In contexts related to deep societal trauma, division, or recovery, the localized musical genres can serve as an educational tool for peacebuilding. When the therapists actively attempt to utilize hybridized music to aid communities facing challenges, they may be engaging in acts of cultural restitution. O'Connell's analysis suggests that shared musical experiences can bridge entrenched societal divides, offering a contested space where dissent can be safely conveyed and communal assent can be rebuilt. By embracing the "mixture music" of a post-conflict or marginalized society, the music therapist may facilitate a localized form of conflict resolution. Music can act as an educational medium that may teach empathy across divided groups, allowing communities to process collective trauma and reconstruct a shared, peaceful identity through a widely accessible, yet deeply personal, sonic landscape. This community-level evidence comes from music and peacebuilding scholarship rather than clinical music therapy trials, and it is best treated as contextual.

Ultimately, the strategic application of "mixture music" and genre-sharing represents a promising paradigm shift in cross-cultural music therapy. It suggests that therapists should avoid both the rigid imposition of Western classical frameworks and the patronizing overemphasis on "pure" ethnic traditions. By employing the CIMT framework to map the intricate dimensions of a client's identity, and by utilizing contemporary genre-sharing as a bridge for cognitive and interpersonal connectivity, therapists can foster a more culturally responsive clinical environment. This approach may draw on the sociocultural power of music to support healing and community transformation.

CONCLUSION AND LIMITATIONS

Together, the evidence reviewed here supports an integrated position: shared biological mechanisms and culturally learned interpretation have a dynamic relationship in explaining music therapy. The argument is conceptual, and the direct clinical evidence for specific culturally adapted methods remains limited.

This review has several limitations. First, since it is a narrative review, relevant studies may have been missed. Second, a large amount of the evidence was gained from smaller quantitative studies mostly focused on China, and the results cannot be generalized to all East Asian or collectivist populations. Third, several sources are related to topics such as infant preference and community music, and therefore provide indirect rather than clinical evidence. Fourth, some foundational sources are decades old (Robertson-DeCarbo, 1974; Crowder et al., 1991; Mastnak, 1993), undermining the ecological validity.

Finally, the challenges of collaborative cross-cultural music and health research (Swijghuisen Reigersberg, 2017) mean that existing studies may not capture the full diversity of clients' experiences. Future research should directly compare structured and improvisational approaches in culturally diverse clinical samples, using outcome measures such as anxiety and therapeutic alliance.

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