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ARTICLE

Relaxation Music (RM), Mindfulness Meditation (MM) and Relaxation Techniques (RTs) in healthcare: A qualitative case study of practices in the UK and South Korea

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ABSTRACT

Relaxation Music (RM), Mindfulness Meditation (MM) and Relaxation Techniques (RTs) are widely used in healthcare contexts and these interventions have been investigated for integrated healthcare, psychotherapy treatment and collaborative and multidisciplinary approaches. However, the information exchange between healthcare practitioners in the UK and South Korea has so far been limited and cross-cultural comparisons of RM, MM and RTs within the healthcare context of the UK and Korea have previously been unexplored. The aim of this paper is to present a summary of the key aspects from an unpublished PhD study (Hwang, 2018). The focus of this paper is to explore the similarities and differences in understanding the use of RM, MM and RTs between practitioners in the UK and Korea. A qualitative case study methodology was used and data were collected through semi-structured interviews with six Korean and six UK healthcare practitioners in three professional areas: medical practice, meditation, and music therapy. Similarities (in outlooks and purposes, methods, interests and concerns, responses and approaches) and differences (in historical and traditional influences, behavioural patterns and particular emphases) were identified. The value of cross-cultural and multidisciplinary research is increasingly recognised and the use of RM, MM and RTs as mind-body-spirit interventions are considered to be useful integrated treatments. This paper contributes to cross-cultural qualitative research between South Korea and the UK and integrating theory and practice with respect to RM, MM and RTs.

KEYWORDS

relaxation music,
mindfulness meditation,
relaxation techniques,
healthcare,
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INTRODUCTION

The use of Relaxation Music (RM), Mindfulness Meditation (MM) and Relaxation Techniques (RTs) has been stimulated by the growing interest in the interactions between mind and body and these interventions are considered to be useful in psycho-physiological therapeutic processes (Davidson et al., 2003; Edwards, 2016; Hanh, 2008). In both East and West, MM, RTs and music have been demonstrated to be beneficial therapeutic mediators within health, education and social community settings (Crane & Kuyken, 2013; Grocke & Wigram, 2006; Kabat-Zinn, 2009). Existing evidence supports the effectiveness of music-assisted relaxation including listening to music, deep diaphragmatic breathing, progressive relaxation technique, imagery and breathing techniques (Bonny, 2001; Robb, 2000; Thaut & Davis, 1993; Wolfe et al., 2002).

There is an emerging evidence base to suggest that, under certain conditions at least, RM, MM and RTs can be of benefit to clients such as those dealing with anger management, stress management, depression, and anxiety, as well as cancer and hospice patients (Carlson et al., 2004; Dhungel et al., 2008; Hanser, 2014; Kavak et al., 2016; Smith, 2008). In both East and West, RM, MM and RTs have been used within an integrated treatment approach. Research has indicated that such an approach can help manage stress, promote well-being and self-care (Lesiuk, 2016; Liu et al., 2019). The effectiveness of techniques relating to RM, MM and RTs have been critically reviewed (Arias et al., 2006; Krisanaprakornkit et al., 2006) and diverse health benefits reported, such as reduced psychological distress, reductions in stress symptoms and negative emotions, maintaining positive feelings, emotion regulation, increased sense of spirituality and self-actualisation (Davidson et al., 2003; Edwards, 2016; Jacobs, 2001; Smith, 2008).

Throughout history music has been used as a healing force in both Eastern and Western cultures in their own way (Choi et al., 2008; Ruud, 2008). The use of music for health is increasing within the healthcare profession, including medical practitioners interested in the combination of music and medicine (Bernatzky et al., 2011; Bunt & Stige, 2014; Nilsson, 2003). Nilsson (2003) investigated the effects of music in surgical care through a systematic review. She found that music interventions had positive effects on reducing patients' anxiety and pain. Nilsson emphasised the inexpensive nature of music interventions and potential ability of music to reduce distress. Similarly, Evans (2002) conducted a systematic review in order to investigate the effectiveness of music interventions for hospital patients. This review concluded that the use of music is recommended as supporting treatment during normal care delivery.

RM, MM and RTs have been investigated in fields such as: music in health, music therapy, psychotherapy, complementary and alternative therapies, advanced nursing, mental health, hospice and palliative medicine (Dobkin, 2008; Klainin-Yobas et al., 2015; Kwekkeboom et al., 2010). Cochrane reviews testified the increasingly widespread use of music in health and show evidence of the benefits of music (Bradt et al., 2013; Kamioka et al., 2014). Bradt et al. (2013), for example, examined the efficacy of music interventions, particularly listening to music, on psychological and physiological responses of coronary heart disease patients. 26 trials with a total of 1369 participants

were included. In this study it was concluded that listening to music has a moderate effect in terms of both anxiety and pain reduction.

Research shows that music can be useful in nursing activities and there is a gradual recognition of the benefits of a systematic use of music in the production of relaxation responses as well as positive changes regarding patients' emotional and physical states and distress levels (Guzzetta, 1991). In the hospital environment, music can be used simply for relaxation or recreational purposes. Further, the use of music in clinical situations, following a specific systematic approach has distinctive health benefits (Guzzetta, 2000). The systematic therapeutic process of music therapy from assessment, treatment planning, therapeutic intervention, through to evaluation of each client can be used with particular therapeutic aims in medical settings in order to achieve better outcomes for individual patients. For example, Marconato et al. (2001) investigated the effects of receptive music therapy for cardiology patients. They reported that music did not cure effectively by itself, but when music was applied in a systematic professional way, there were significant therapeutic impacts.

The use of RTs (including meditational practices) has been developed in healthcare settings and benefits of RTs in health have been reported. Meditation has now become "one of the most enduring, widespread and researched of all psychotherapeutic methods" (Walsh & Shapiro, 2006, p. 227). In the area of mental health, various self-regulation interventions using RTs have been explored to treat mental disorders, emotional disorders, conduct disorder, hyperactivity, and Social, Emotional and Behavioural Difficulties (Gootjes et al., 2011; Mowat, 2010). RTs and meditation have also been used for stress reduction and as emotional support interventions dealing with negative emotions (Jorm & Wright, 2007; McNamara, 2000). Hence RTs can support clinical treatments as well as helping to relieve and manage emotional difficulties. Arias et al. (2006) systematically reviewed the treatment of illnesses through meditative techniques, covering 82 journal articles and 958 participants. The evidence of the effect of meditation on anxiety, depression, fears and mood disorder, menopausal symptoms, as well as on learning difficulties, was a constant theme in the literature (Beauchemin et al., 2008; Chen et al., 2012; Davidson,1976; Davidson et al., 2003; Lee et at., 2016; Toneatto & Nguyen, 2007).

Meditative practices are an ongoing subject of discussion among both Eastern and Western researchers (Hofmann et al., 2010; Weick & Putnam, 2006). Western healthcare practitioners and researchers have taken an interest in meditation techniques as self-regulation strategies and for clinical applications out of a desire to develop non-pharmacological solutions and non-drug treatments (Shapiro & Giber, 1978). They were impressed with the psychotherapeutic effects and benefits of RTs and meditative practice for stress-related illness, positive mental health and relaxation responses (Shapiro & Zifferblatt, 1976). In music therapy, RTs are sometimes associated with the induction stages of GIM (Guided Imagery and Music) or MI (Music Imagery). GIM is often used and is popular as a music-assisted therapy in South Korea and now increasingly recognised and developing as such in the UK. It frequently combines RTs, although other kinds of inductions are used, for example to energise the body before the listening part of the session. Besides GIM, a wide range of methods involving RTs have been used as therapeutic tools showing that a range of receptive approaches can work at different levels (Goldberg, 2013; Grocke & Wigram, 2006; Summer, 2011).

A variety of RTs have been recognised as achieving a relaxation response, for example, progressive relaxation technique, guided relaxation imagery, breathing techniques, mindfulness, Zen meditation, walking meditation, compassionate/loving-kindness/forgiving meditation, positive psychology technique (emotional freedom technique), autogenic training, meditative prayer, yoga and transcendental meditation (Chiesa & Serretti, 2009; Jorm & Wright, 2007; Mitchell, 2009; Robb et al., 1995; Thaut & Davis, 1993; Williams & Carey, 2003; Wilson, 2014).

There is a growing recognition of mindfulness-based practice, which is actively promoted in community settings and clinical practice (Greenland, 2015; Kim, 2004; Speca et al., 2000; Williams, 2008). Studies on mindfulness-based interventions published in the UK databases report that MM has general mental and physical health benefits including stress management (e.g., National Health Service (NHS) Evidence in Health and Social Care, NHS Healthcare databases advanced search (HDAS)). The National Institute for Clinical Excellence (NICE) and National Health Service (NHS) both regarded MM as evidence-based treatment and recommend mindfulness courses for patients living with various conditions.

MM is intentional mental practice, staying in the present moment and is performed without any judgmental attitudes. The technical Buddhist term for mindfulness (sati, 念), (念 in Chinese)' is comprised of two aspects, 'mind (心)' and 'in the present moment (今)' and originating from the Sanskrit for 'remembering'. MM is originally based on Buddhist meditative practice (Kabat-Zinn et al., 1985). Kabat-Zinn wrote that "[the] contribution of the Buddhist traditions has been in part to emphasize simple and effective ways to cultivate and refine this [mindfulness] capacity and bring it to all aspects of life" (Kabat-Zinn, 2003, p.146). However, he used 'mindfulness' as '(pure) awareness' regardless of religion roots or ideology.

Meditation has been practiced for more than 2500 years and there has been a long history of introducing the meditation/Zen practice to the western culture (Coleman, 2002; Weaver et al., 2008; West, 1979). For example, Suzuki (鈴木 俊隆, Shunryū Suzuki, 1904-1971) introduced Zen philosophy to the West and many educated Westerners began to recognise Zen Buddhism and mindfulness (念) concepts around 1950 (Suzuki, 1973). Mindfulness-based meditation became popularised into mainstream Western culture by Zen masters and meditation practitioners such as Thich Nhat Hanh and Kabat-Zinn (Hanh, 2008; Kang et al., 2009; Williams, 2008).

The research of Kabat-Zinn (2009) and Williams (2008) revealed that MBSR (Mindfulness-based stress reduction) can reduce anxiety, depression and change negative emotions to positive ones. Mindfulness has been found to be a wide-ranging and effective treatment, for example for cancer patients, sleep disturbances, improving health-related quality of life and the ability to concentrate in class (Krusche et al., 2012; Vøllestad et al., 2011; Winbush et al., 2007). MM is a well-known form of meditation and known by Korean practitioners as well as many Western practitioners to have scientific backing (Kabat-Zinn, 2009; Kang et al., 2009). MM is now being offered in a wide range of formats including workshops, short courses, eight-week intensive courses, meditation retreats, and online apps and webinars. One of the reasons why the MBSR programme has successfully been adapted in Western medicine is the fact that the standardised programme and systematic guidance make it easy for practitioners to follow and use.

In Korea, MM related to Zen meditation, is one of the fundamental traditional forms of meditation. Because of the long history and cultural influence of Buddhism, meditation has long

been studied and commonly recognised as part of Korean culture and meditative practices naturally utilised in the health context (Buswell, 1993; Pihl, 1995). In the UK, MM is increasingly used for health and well-being purposes, despite there not being a historic or religious tradition. In Korea, the use of meditation for health has evolved gradually over a long time, while in the UK it has developed more rapidly during a single decade. Nevertheless, today there is considerable public and academic interest in MM in healthcare both in Korea and the UK.

This literature review explored the ways in which RM, MM and RTs have been adapted for use in evidence-based practice and their therapeutic value and benefits; it outlined the rational use of RM, MM and RTs for health and well-being. This exploration of the literature will inform the discussion as to how RM, MM and RTs are applied, and will also give insights into the different cultural assumptions that underpin these practices. This literature review highlights the absence of discussion as to actual differences in practitioners' understanding or practice in Korea and the UK, which will be the focus of this paper.

METHOD

A qualitative case study methodology was used in this study and data were collected from the three sample groups, within the UK and Korea, of music therapists, medical practitioners and meditation experts. The context of health practitioners in the UK and Korea acts as the 'cases' in this study, and therefore the methodology aims at a comparative approach to case study methodology (Yin, 2003). This study used in-depth semi-structured qualitative interviews as the method. Preliminary findings from the pre-interview process were followed up by individual face-to-face in-depth interviews and the recordings of the interviews were transcribed in full. The general focus of the research was to explore the ways in which professionals understand and use specific kinds of interventions and thereby to seek to uncover cultural differences that might lie behind their thinking and choices.

The study was carried out in line with the ethics guidelines of the University of the West of England (UWE Bristol) and was approved by the Faculty Ethics Committee.

Fieldwork and interviews

Prior to the in-depth interviews, several steps were followed: (a) Arranging informal and internal practice interviews and supervisions with mentors and supervisors; (b) Preparing an acceptable consent form; (c) Preparing a detailed information sheet to send to interviewees and topic guide; (d) Arranging and conducting two informal practice interviews; (e) Feedback from the informal practice interviews to learn more about interview approaches, skills and types of questions which was discussed with the supervision team; (f) Submitting the ethics application to the University's Faculty Ethics Committee; (g) Sending invitations (pre-interview letter containing information sheet) to 12 interviewees explaining the aims of the research; (h) Fieldwork in South Korea and the UK following approved consent; and (i) Sending additional questions after the interview (where applicable). Before invitations were sent out contact was made with suitable participants so as to assess whether participants would be available for in-depth interviews. The invitation letter then explained the nature of the research study and invited participation in the project as well as providing an information sheet about the project.

Sampling, group size and participants' information

In order to achieve a basis for comparative analysis of participants' understanding and use of RM, MM and RTs in the UK and Korea, the main participants in the study were purposively sampled according to the three population groups across both countries - those professionally engaged in medical practice; in meditation; and in music therapy. The proposed number of subjects was 12, six from each country. Below are details of all the Korean and UK interviewees' professional areas: (a) Music therapists working in university and various settings (hospice, community, school) (n = 5); (b) Medical practitioners with an interest in MM, RTs and music in healthcare (n = 4); and (c) Meditation experts working in university and community settings (n = 3). All participants were professional experts from their respective three areas with a depth of understanding of RM, MM, other forms of meditation or RTs. The 12 participants were contacted by email or phone and asked whether they would be available for face-to-face in-depth interviews.

Participants interested in RM, MM and RTs were selected, with 7-25 years of work experience in teaching or healthcare in various settings. Of the 12 interviewees, six were university professors or senior lecturers, seven were therapists, eight routinely teach RTs or meditation or music therapy in university and community settings, eight were female and four were male. All participants were anonymised and had their names changed.

Data collection

Data were collected through an audio-taped interview with each of the 12 participants. The semi-structured interviews consisted of both direct and indirect questions and ranged from 70 to 90 minutes in length. The flexibility in semi-structured interviews allowed for exploration of new ideas, topics and points of cultural comparison. (Horton et al., 2004; Radnor, 1994). Initial interview topics were: (a) Personal background/experiences; (b) Personal understanding/ attitudes about RM, MM and RTs; (c) Current practice and constraints; (d) Combining and integrating RM, MM and RTs within healthcare; (e) Cultural considerations; and (f) Recommendations and advice.

Data analysis

Qualitative data were analysed using the thematic analysis approach devised by Braun and Clarke (2006). This enabled provision of a theoretical framework for qualitative analysis of in-depth interview data through the following six stages: (a) Familiarisation; (b) Coding; (c) Searching for themes among codes; (d) Reviewing themes; (e) Defining and naming themes; and (f) Producing the final report. Following the process, potential codes were identified, generating initial codes and, through organisation of these, potential broad themes and patterns were identified. Finally, the following selected main themes were defined and named: (a) Music and health; (b) RTs and MM and health; (c) RM, MM and RTs applications and responses; and (d) Cultural context (see Table 1). Hand-coding of the analysis of interview data was carried out rather than through using a software system. Data analysis by NVivo was tried, but there were times when important details of the interview data were lost or could not be found.

Main themes	Sub-themes
Music and health	• Music and music therapy approaches (e.g., criteria for choice of music, music genre and instruments) • Music, health and well-being (e.g., personal motivations, use of music in health contexts) • Qualities and abilities of the practitioners (e.g., level of competency and abilities of the practitioners)
RTs and MM and health	• RTs and MM approaches (e.g., purposes, types and adaptations of RTs and MM, personal motivations in using RTs and MM) • RTs and MM as healthcare interventions (e.g., understanding of RTs and MM for health and well-being) • Use of RTs and meditation in health contexts (e.g., MM, breathing techniques, imagery and visualisation, mandalas)
RM, MM and RTs applications and responses	• RM, MM and RTs, creativity and spirituality • RM, MM and RTs as stress management (e.g., practitioners and trainees) • Use of RM, MM and RTs for stress management, active and receptive methods for stress management • Practitioners' understanding of relaxation and relaxation responses • Stress responses and relaxation responses/responses to RM, MM and RTs
Cultural context	• Cultural factors/understanding and use of interventions (e.g., cultural factors, cultural background and responses to interventions, religious influence, cultural factors and sound instruments) • Similarities and Differences (e.g., similarities and differences between the UK and Korea, differing familiarity with the use of interventions, similarities and differences between the three groups of participants across the countries)

Table 1: Emergent themes and sub-themes

RESULTS

In the healthcare services of Korea and the UK, the practice of RM, MM and RTs have developed into their own unique approaches. By exploring the main themes and sub-themes, we have identified similarities and differences in perceptions, understanding and outlooks with regard to the use of RM, MM and RTs between Korea and the UK.

Similarities in practice between Korea and the UK

In both countries there are basic common underlying principles behind the understanding and use of RM, MM and RTs and similar types of practices were often used. Practitioners revealed their enthusiasm for RM, MM or RTs because of perceived health benefits; these practical benefits motivate and inspire them to continue and develop their use of RM, MM and RTs. The following similarities between Korean and UK practitioners were identified (see Table 2).

Common topics	Similarities between South Korea and the UK
A common awareness (of)	The health benefits of RM, MM and RTs The value of evidence-based practice (EBP) in clinical settings The benefits of integrated health, knowledge-sharing and collaborative work
Common themes and concerns among practitioners	Client-centeredness (how to cater for and adapt to the individual) Practitioners' qualities, qualifications and level of competency Factors regarding location and environment of practice settings Relevant hospital support services and levels of funding
Common purposes in using RM, MM and RTs	As a stress management strategy As an emotion management strategy As part of a rehabilitation programme As a pain management strategy As a personal transformation tool As a component of a spiritual development programme In activities for creativity In an integrated approach to health
Common interests among practitioners	Mind-body-spirit interventions Integrative health A personal and professional interest in RM, MM and RTs Expanding the practical resources for clients' mental, physical, emotional and spiritual care Maximising health benefit outcomes

Table 2: Similarities in practice between South Korea and the UK

Similarities in stress responses and relaxation responses

RM, MM and RTs can bring about a state of mental and physical rest and tranquillity. Participants from both countries use various approaches to RM, MM and RTs in order to elicit a relaxation response and similar relaxation responses and stress responses were described (see Table 3).

Responses	Reactions to RM, MM and RTs
Stress responses	Frustrated, nervous, depressed, unrelaxed, angry, upset, sad, fearful (having phobias), experiencing discomfort
Relaxation responses to MM, RTs	Peaceful, relaxed, happy, safe, confident, dreamy or awake, hopeful, comfortable, safe, experiencing love, kindness, inner strength, a healthy mind, freedom, trust or reassurance
Relaxation responses and reactions to music	Pleasant, relaxing, beautiful, feeling of lightness, stress reduction, feeling of change in the body sensation

Table 3: Stress responses, relaxation responses and reactions to the music

Similarities in types and approaches with respect to RM, MM and RTs between Korea and the UK

From the data analysis, it was possible to identify some common features across the three interventions: RM, MM and RTs (see Table 4). Additionally, further analysis indicated more active and more receptive activities and approaches within the three interventions (see Table 5).

	Similar types and approaches
RM	Listening to recorded music, listening to music through live performance or improvisation, singing, instrument playing, music and imagery, music and drawing (e.g., mandala, creating a drawing of the imagery experience), guided imagery and music (GIM), music imagery (MI), active involvement in music improvisation by means of playing instruments, stress-releasing rhythm-based music, music composition
MM	Mindful breathing, mindfulness movement (e.g., walking meditation), guided sitting meditation, lying down meditations, body scan, loving-kindness meditation, forgiving meditation, observing-thought meditation, mindfulness meditation for everyday life (e.g., mindful eating meditation)
RTs	Progressive relaxation technique, body scan, guided imagery, visualisation, guided meditation, yoga, breathing techniques (e.g., abdominal breathing, diaphragm-breathing exercises, breath-holding tech niques, alternate nostril breathing technique), autogenic therapy, Tai-Chi, mandalas

Table 4: Similar types/approaches of RM, MM and RTs

	Active activities and approaches	Receptive activities and approaches
Approaches of RM	Active involvement in music improvisation Stress-releasing rhythm-based music Music composition Music with movement and dance Singing Instrument playing	Listening to recorded music Listening to music through live Performance or improvisation Guided Imagery and Music (GIM) Music imagery (MI) Music and drawing (e.g., mandala, creating a drawing of the imagery experience)
Approaches of MM	Walking meditation Mindful movements Mindfulness meditation for everyday life (e.g., mindful eating meditation, mindful driving meditation)	Sitting meditation Mindful breathing techniques Guided mindful meditation Body scan Mindfulness guided imagery Zen meditation Meditative prayer Loving-kindness/Forgiving meditation
Approaches of RTs	Stretching, Physical exercise Yoga Tai Chi	Breathing techniques Progressive muscle relaxation Autogenic training Visualisation techniques Mandala

Table 5: Active and receptive activities and approaches

However, the categories of active and receptive approaches might also be distinguished according to how deeply the mind and body goes into a state of relaxation. For example, while listening to music, people can actively engage in exploring the self-image and spiritual aspects of themselves and through such musical experience they may reach a deep level of inner reflection and relaxation. Similarly, sitting meditation may appear to be a passive pursuit but it can actually actively engage participants in profound mindfulness, calmness and a process of self-reflection.

Therefore, if the state of relaxation is deep, this can be regarded as an active state of relaxation and depending on the degree of relaxation and level of engagement of the relaxation response, the meaning of receptive and active can be defined in a different way. However, generally, it would be taken for granted that walking meditation or drumming is an active form whereas sitting still or listening is passive and receptive. Depending on the practitioner's own interpretation or outlook, active and receptive RM, MM and RTs can be defined in different ways. Thus, the categorisation of specific practices into active or receptive, may not be a fixed one since the same activities can be performed both actively and receptively. This leaves open to doubt the validity of the distinction between active and receptive.

Differences in emphasis in practice between Korea and the UK

Differences were seen regarding perspectives, value systems and beliefs, tendencies, preferences, resistances and approaches in the use of RM, MM and RTs. Firstly, the concept of creativity was more referred to and discussed among UK practitioners:

> Music serves two purposes. It serves the purpose of keeping it calm and quiet, but also because we believe that music taps into the creative side of the brain. [UK]

> If I use it (music) in the creative sessions, it seems to allow that feeling of allowing their minds to open up, to be creative and when I do relaxation techniques with students, I will use music. [UK]

Secondly, in Korea emphases in schooling (for young people) and the role and use of music or meditation in relation to education were more often mentioned. By contrast, UK practitioners placed more emphasis on stress in general and the use of RM, MM and RTs to achieve a state of relaxation and a positive change of mind and body for everyone, not only students:

> I focus in my therapy on how concentration can be increased when using music. Students often say music (when they like it) can help their concentration, especially during the late evening study periods in school. [Korea]

> People are so busy […] it benefits them and just helps them to take those few minutes to get rid of all the worries from their head. [UK]

Thirdly, in the UK there was greater emphasis on practicability and the use of simplified practices (e.g., the 3-minute breathing space) and grounding aspects of the practices:

> Particularly if you're using shorter, […] these can help people to feel more grounded. So, if they're feeling flooded by overwhelming feelings, negative thoughts, if you're just doing very short practices, where they're just really feeling their feet on the ground, their body on the chair, it's helping them to ground themselves into the here and now. [UK]

In Korea, by contrast, there was greater familiarity with and interest in deeper states and longer periods of meditation. The Korean participants focused more on cultivating concentration and insight-focus practices, and also theory-based practice and the theoretical framework. However, in certain settings, particularly hospital settings, simplified techniques and short grounding practice were preferred by both Korean and UK practitioners:

> Simple guided meditation, diaphragmatic breathing, body scan and autogenic training are good examples to use with patients. [Korea]

So, despite different preferences in terms of deeper or longer periods of practice, there was an underlying common understanding and recognition of the importance of adopting more practicable (often simpler) approaches for individual clients and their health needs.

Different levels of familiarity with and responses to the meditational practices and receptive approaches within the respective healthcare organisation

The use of RTs and meditation is gradually being recognised in the context of mind-body-spirit therapies, complementary medicine and integrative health both in Korea and the UK (Hubbard et al., 2015; Klainin-Yobas et al., 2015). Nevertheless, there is a difference between Korea and the UK. In other words, receptive approaches and mediational practices in the Korea are familiar, but in the UK they are still less familiar:

> Receptive techniques and achieving deep relaxation through therapy is still a relatively limited area in the UK. [UK]

By contrast, one of the South Korean interviewees said:

> We have a long tradition of meditation and a high level of interest. So, the application of relaxation techniques and meditation within healthcare will be much more straightforward. [Korea]

It seems that between the UK and Korea there were differences in resistance and acceptance regarding the use of receptive approaches and meditational practices which may be caused by different traditions, history and a sense of national feeling and character. These cultural factors and

people's way of thinking can affect people's responses, familiarities as well as participants' professional work with regard to the use of RM, MM and RTs in UK and Korean healthcare organisations.

Differences in atmosphere and preferences during MM and meditational practice

Mindfulness practice in the UK appears to be more connected to a social event in which lively group discussions can take place, while in Korea the atmosphere is more one of silence and individual practice. In the UK, during meditation sessions, participants feel free to discuss and even converse freely with other participants (relating real life stories, personal difficulties and their preferred methods of practice). These differences in atmosphere and peoples' attitudes were observed during MM, RTs and meditation practice sessions and would seem to illustrate different cultural models of practice between the UK and Korea. Participants also referred to such differences:

> Occasionally I've had people who - their intentions are very good, they want to make cups of tea to help people, […] - but they start making the tea in the middle of the relaxation. [UK]

In Korea a more formal atmosphere is preferred and conversation is considered a distraction. Rather than talking, people prefer an atmosphere of quiet or else listening to systematic guidance from the expert. In the UK a comfortable position is preferred while doing meditation, while Koreans prefer to use the more standard meditation positions, as directed by tradition or an expert:

> Sit or lie in a comfy position, spine straight but at ease, shoulders relaxed, breathe in - and - breathe out, making the out-breath slightly longer than the in-breath. [UK]

Differences between the three groups of participants from Korea and the UK

Besides the general differences between Korea and the UK a number of differences were identified among the three practitioner groups.

The music therapists' group

Music therapists use music as a primary method of treatment and the way they plan and prepare focuses to some degree on musical qualities:

> It's a lovely tool. […] A Tibetan bowl will have maybe different musical tones in it, some of which are very close together, and this causes like a low beat frequency - and because of the frequency, the brain wants to match that. And so, the brainwave has to slow down to match it. It's what I would call entrainment. [UK]

By contrast, the other two groups (medical practitioners and meditation experts) tended to use relaxation music as a background to their main work or to support their own specialisations:

> I use music as background of (my work) just to make people calm. Normally when I start just doing relaxation, we just get calm, then talk about what happened this week. [UK]

Secondly, the music therapy group paid special attention to establishing good rapport with clients and the outcome of interventions. They were therefore concerned with how to develop and maintain rapport between practitioners and clients when using RTs and RM in combination:

> Once we have developed a rapport, clients often reveal their inner emotions and tell me their real feeling. Then they seem more accepting and with this rapport volunteer more about their feelings towards the music. [Korea]

The medical practitioners' group

In this group, practicalities, such as the portability of music-playing devices, were the greatest concern when using RM, MM and RTs to support a patient's treatment and for rehabilitation in hospital. Secondly, several cautions were commonly mentioned with respect to the hospital organisation, the need for evidence-based practice and careful preparations before embarking on therapeutic treatments (in particular, checking the clients' health condition). Thirdly, this group focused more on outcomes and clear or measurable health benefits:

> In my case, I choose music which gives comfort to me and I use it as background music for my relaxation sessions for my cancer patients or heart failure patients. By using the CD player, I play the music before or during my session and I sometimes use Tibetan small bells which are good to relax them. [Korea]

> As a medical doctor, I tried to find a way that I can help patients by using relaxation skills as well as medical treatments. I started study focus on mindfulness and Herbert Benson's Relaxation Response. I think these two methods have scientific backing[...] I think that these treatments are efficacious for some patients. [Korea]

The meditation experts' group

In the use of MM and meditation, this group is more theory-focused, inclined to explore the inner self in a deep way and they value achieving deep levels of meditation in practice (personally and professionally). However, depending on the client group and situation, they also create useful and simple tools just as the other practitioner groups do and can generally be practical and happiness-focused in their orientation:

> The first approach is a theoretical study […] and the second one is a practical study based on the theoretical study. I think future research will be conducted and continued in this way [practically as well as theoretically]. [Korea]

To conclude this section, cross-cultural perceptions with regard to RM, MM and RTs among the participants have thus been identified. The client and patient groups with whom the 12 practitioners work vary in terms of their medical conditions and individual preferences; the practitioners are concerned to expand the techniques available to them. In addition, practitioners generally share a positive attitude towards collaboration work in use of RM, MM and RTs. Various similarities and differences besides the differences between the three groups and the participants as a whole were found. In a more general way, however, Korea and the UK have different cultural models of care with noted differences in perceptions and attitudes. Such differences relate particularly to different cultural and historical background, educational culture and religious outlooks. These cultural factors and their relationship to the cross-cultural perspectives under consideration will now be discussed.

DISCUSSION

Between Korea and the UK, certain differences related to cultural factors were seen in the use of RM, MM and RTs. Such different cultural factors lead to different models of healthcare and differences in outlooks and attitudes among UK and Korean practitioners. This section will discuss what cultural factors may bring about or have a bearing on the differences and similarities in relation to the use of RM, MM and RTs between the UK and Korea.

Different historical background and development of use of music (particularly in music therapy) and MM and meditational practice

Music therapy has become established as a clinical discipline in both Korea and the UK. In April 2019 there were 1080 music therapists registered with the Health and Care Professions Council in the UK (British Association for Music Therapy, personal communication, October 23, 2019) and in Korea, more than 2500 certified Korean music therapists (graduates from 23 universities) are working in various fields (The Music Education News, 2019). However, in the UK music therapy has a longer history and has developed continuously for around 60 years (British Association for Music Therapy, 2019). In Korea music therapy is a relatively young profession and discipline but has been a fast-growing university subject for about 20 years (Goodman, 2015; Kim, 2014). Music therapy is Western in its origins and the way it is used in Korea broadly follows Western practice (e.g., Guided Imagery and Music, Music and Imagery, Improvisation activities).

The way music in combination with RTs has developed and been adopted in Western music therapy has influenced the development of music therapy in Korea. Many studies have also shown evidence of how music has been combined with RTs, such as progressive muscle relaxation (Thaut, 1989), diaphragmatic breathing techniques (Wolfe et al., 2002), music assisted relaxation (Robb et al.,1995) and guided imagery (Bonny, 2001). For example, Guided imagery is one of the types of RTs often used in Korea. Bonny says through music, people can experience new consciousness which is

an altered state of consciousness (the contemporary term being non-ordinary states of consciousness) and for this process, RTs can be helpful (Summer, 2002, 2015) (see above for reference to other more energising forms of induction). While listening to the music and creating imagery, the client can reach a deeply relaxed state in the 'here and now' and this can possibly expand our consciousness and lead to self-discovery. Through this process, the client can experience self-transformation. Bonny lists a number of RTs such as progressive relaxation technique, biofeedback, Zen meditation, music-chant, transcendental meditation and mind control (Bonny & Savary, 1990; Bonny, 2001). In this sense principles, values and approaches in use of RTs and music are shared in many ways, therefore in this study several similarities in practice (e.g., common purposes, theme, concerns, interest) were discussed. But nevertheless, cultural differences can be identified, such as the respective preferences and different emphases in practice in the UK and Korea.

On the other hand, meditation and mindfulness practice are Eastern in their origins and more cultural differences can be seen which may be connected with the differing traditions, even though they share basic common underlying principles and Meditation also exists in Western cultures such as Christian contemplative prayer (Paul & Ian, 2010). In the UK, mindfulness has recently attracted a large amount of publicity and the national media has shown a particularly strong interest in MM (BBC News, 2016, 2018). Following on from the public interest, a number of universities in the UK have started up degree courses in MM (Masters degrees (Mindfulness), 2016). Mindfulness (sati, 念) originates from Buddhist traditions such as Zen Buddhism (禪佛教) (Janesick, 2016; Speca et al., 2000). In South Korea, Zen meditation has been developed in the academic world, notably by Dongguk University (東國大學校) – where the University Kabat-Zinn's Zen master Seung Sahn(崇山) studied – and has been the subject of theoretical research; whereas in UK, MM and meditation have grown in public interest and have been adapted for general health purposes in the UK and out of this there has been interest among academics (Kang et al., 2009; Williams, 2008).

In the West, mindfulness is defined as "the practice of maintaining a non-judgmental state of heightened or complete awareness of one's thoughts, emotions, or experiences on a moment-to-moment basis" (Mindfulness, 2018). Many people use it for the more practical and general mental and physical health benefits such as stress management. Therefore, historical background and understanding of meditation has given rise to actual differences in practice between the UK and Korea participants, including different levels of emphasis regarding theory-based approaches versus more practical considerations, different degrees of familiarity with receptive approaches and differing levels of resistance and acceptance when integrating RTs and MM within practice.

Differences regarding attitudes towards the integration of meditational practices

There has been an increasing acceptance of the place and value of meditational practices within healthcare both within the UK and Korea (Williams, 2008). In Korea the health benefits of meditation have been widely recognised and its place within organised healthcare has gradually developed over

time (Kim, 2004); in the UK the trend has been more recent. However, within the healthcare systems of both countries we can identify a certain inbuilt resistance to meditational practices, but for different reasons. Buddhism in Korea dates back to the 4th century AD and became the recognised national religion. Many people associate meditational practice with Buddhist practice (Seth, 2010). As was evident in the interview process, the therapy sessions with some Christians in Korea, resulted in the use of meditation being regarded as a religious resource rather than spiritual practice. This can create potential resistance and can be particularly difficult then to develop a rapport with the client at an early stage. In the UK, such issues are much less likely to occur than in Korea, and Christians or people from other faiths would be less likely to associate breathing techniques and meditation with any particular religious practice.

In the UK, meditational practice tends to be seen in terms of its health benefits, as a self-development tool or for spiritual practice, but not necessarily bound up with religion. However, since meditation is still not as popular in the UK, it is possible that there is some association with people who hold certain sets of values or beliefs. Although the NHS now recognises MM and it is becoming more mainstream and even encouraged (Marx et al., 2015), in the public mind it is far from being mainstream and may be considered something of a luxury or a fringe interest in the UK (even amongst therapists). Consequently, the reasons for acceptance and for resistance to meditational practice within healthcare may be different between the two countries. In future this situation is likely to change. Within the UK, MM is becoming much more familiar and recognised; in Korea opposition to it among the younger generation of Christians is less. Some Christian churches in Korea have even introduced meditation classes (Suh, 2012). There is an increasing focus on health benefits rather than its place in religion. The value of holistic treatment and mind-body interventions, and as such of MM, are increasingly being recognised in both countries. Therefore, we may expect there to be a change in attitudes towards the integration of meditational practices in healthcare services.

Differences in purpose and use of RTs, meditation and music

Cultural considerations may inform our understanding of RM, MM and RTs and their development in East and West. In both the UK and Korea, a great many studies have demonstrated RTs, meditation and music to be valuable therapeutic mediators in healthcare, education and social community settings (Grocke & Wigram, 2006; Kabat-Zinn, 2009). However, as mentioned before, there are different levels of emphasis on the stresses faced in schooling by young people. School life is very different in Korea from the UK and problems relating to stress are very significant in Korea because of competition and pressure as a result of study. Many studies have shown that using music, RTs and meditation can help manage the pressures of learning and school life and help to revive minds to a bright and healthy state after students experience high levels of stress in school (Hong & Yeo, 2010; Kim, 2011). Compared to Korea, in the UK, there is greater emphasis on stress in general and the use of RM, MM and RTs for everyone. Therefore, there may be cultural differences related to the purposes of use of RM, MM and RTs.

Limitations

During the interviews, specific topics would be mentioned by practitioners from only one of the two countries, or else by one group of practitioners, that would otherwise have been valuable to analyse more fully. Some of the discussion therefore reflected the thoughts of one group in particular and this may be regarded as a limitation. Of course, if any practitioner was unwilling to talk about a specific question, it was inappropriate to pressure them into talking and so with some topics interview data needed to be analysed in a one-sided way. Examples of such topics include 'financial support and practice', and 'guidance and practice'.

CONCLUSIONS AND RECOMMENDATIONS

South Korea and the UK represent different cultural models of healthcare service and different approaches to interventions. Despite these different perspectives, beliefs, tendencies and religious influences, practitioners are commonly aware of the importance of knowledge sharing and benefits of integrating Eastern and Western practices in terms of their use of interventions and integrated medicine. For example, in its use of RM, MM and RTs, 'multidisciplinary integrated care' has become established in music therapy in both the UK and Korea. Like other professional practitioners, music therapists build relationships and networks and share across the worldwide community. As such RM, MM and RTs are clear examples of interventions that are currently and will increasingly be used in combination, drawing on practices in other countries. Therefore, by uncovering the ideas that underline UK and Korean practice, this study contributes towards both the body of research on multidisciplinary integrated care and cross-cultural healthcare research within this growing area. This paper shows the differences and similarities in use of RM, MM and RTs and how these can be affected by differing cultural and healthcare contexts.

To the first author's knowledge, this is the first qualitative and comparative case study of RM, MM and RTs within the specific context of South Korean and UK healthcare. This study is exploratory and broad in scope, an approach which is common in qualitative research where there is little existing research and where a key contribution made can be developing understanding and the meaning of particular social practices. The UK and South Korea have distinctive strengths in their use of mind-body-spirit interventions. In the future, through the growth of cross-cultural dialogue, the practitioner can learn from their respective strengths within their existing healthcare frameworks. In relation to cross-cultural points of comparison, there are various topics that can be taken up again and built on by future researchers such as cross-cultural qualitative research and integrating theory and practice.

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Ελληνική περίληψη | Greek abstract

Μουσική Χαλάρωσης (ΜΧ), Ενσυνείδητος Διαλογισμός (ΕΔ) και Τεχνικές Χαλάρωσης (ΤΧ) στην φροντίδα υγείας: Μία ποιοτική μελέτη περίπτωσης των πρακτικών που ακολουθούνται στο Ηνωμένο Βασίλειο και την Νότια Κορέα

Mi Hyang Hwang | Leslie Bunt

ΠΕΡΙΛΗΨΗ

Η Μουσική Χαλάρωσης (Relaxation Music - MX), ο Ενσυνείδητος Διαλογισμός (Mindfulness Meditation - ΕΔ) και οι Τεχνικές Χαλάρωσης (Relaxation Techniques - ΤΧ) χρησιμοποιούνται ευρέως σε πλαίσια υγειονομικής περίθαλψης και αυτές οι παρεμβάσεις έχουν διερευνηθεί στην ολοκληρωμένη υγειονομική περίθαλψη, στην ψυχοθεραπεία καθώς και σε συνεργατικές και διεπιστημονικές προσεγγίσεις. Ωστόσο, η ανταλλαγή

πληροφοριών ανάμεσα σε επαγγελματίες υγείας του Ηνωμένου Βασιλείου και της Νότιας Κορέας είναι έως τώρα περιορισμένη και οι διαπολιτισμικές συγκρίσεις των παρεμβάσεων ΜΧ, ΕΔ και ΤΧ στο πλαίσιο υγειονομικής περίθαλψης του Ηνωμένου Βασιλείου και της Κορέας δεν έχουν διερευνηθεί μέχρι σήμερα. Στόχος του παρόντος άρθρου είναι να παρουσιάσει συνοπτικά τις βασικές πτυχές μίας αδημοσίευτης διδακτορικής διατριβής (Hwang, 2018). Το άρθρο επικεντρώνεται στη διερεύνηση των ομοιοτήτων και των διαφορών στην κατανόηση της χρήσης των παρεμβάσεων ΜΧ, ΕΔ και ΤΧ μεταξύ των επαγγελματιών στο Ηνωμένο Βασίλειο και στην Κορέα. Ακολουθώντας ποιοτική μεθοδολογία μελέτης περίπτωσης, η συλλογή δεδομένων έγινε μέσα από ημι-δομημένες συνεντεύξεις με έξι Κορεάτες και έξι Βρετανούς επαγγελματίες υγείας σε τρείς περιοχές επαγγελματικής δραστηριότητας: ιατρική, διαλογισμό και μουσικοθεραπεία. Από την ανάλυση προέκυψαν ομοιότητες (σε προοπτικές και σκοπούς, μεθόδους, ενδιαφέροντα και προβληματισμούς, τρόπους ανταπόκρισης και προσεγγίσεις) και διαφορές (σε ιστορικές και παραδοσιακές επιρροές, μοτίβα συμπεριφοράς και ιδιαίτερες επισημάνσεις). Η αξία της διαπολιτισμικής και διεπιστημονικής έρευνας αναγνωρίζεται ολοένα και περισσότερο και οι ΜΧ, ΕΔ και ΤΧ ως θεραπευτικές παρεμβάσεις για το τρίπολο νους-σώμα-πνεύμα εκτιμώνται ως χρήσιμες ολοκληρωμένες παρεμβάσεις. Το παρόν άρθρο συνεισφέρει στη διαπολιτισμική ποιοτική έρευνα ανάμεσα στη Νότια Κορέα και το Ηνωμένο Βασίλειο και την ενοποίηση θεωρίας και πρακτικής των παρεμβάσεων ΜΧ, ΕΔ και ΤΧ.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσική χαλάρωσης, ενσυνείδητος διαλογισμός, τεχνικές χαλάρωσης, φροντίδα υγείας, Ηνωμένο Βασίλειο, Νότιος Κορέα, διαπολιτισμική έρευνα