



APPROACHES

An Interdisciplinary Journal of Music Therapy

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EDITORIAL

Reflecting on the impulse to connect and the role of distinction

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Making meaning of our practice as music therapists is a curious and multi-faceted process. Who we are trying to communicate our ideas to and our motivation for sharing and describing our work can profoundly impact the way we describe therapeutic practices and encounters, shaping the discourse of our field in important ways. With a breadth of influences and intended audiences informing the ideas emerging from our discipline, there is great scope for variety and diversity of thought and action in music therapy. This breadth of perspectives challenges us as a profession to witness and hold space for complexity, which can feel exciting and hopeful, uncertain and unclear, and downright uncomfortable on occasion – as complexity so often does.

As I sat down to write this editorial, I noticed my own intention to find commonalities in the many perspectives on music therapy research and practice presented in this issue of *Approaches*. I felt my desire to seek a shared theme that would neatly 'bring together' the concepts presented the articles; to create a common thread between the authors' ideas that I could present and discuss cohesively in the shared context of music therapy. It felt natural to seek these connections, and I found some. I identified, for example, the different perspectives on relationships explored theoretically by Hadar in their meta-analysis of dyadic improvisation, practically by Christensen and Gattino in their case study with a boy with Down Syndrome, and professionally by Krüger et al. in their reflection on relationship building with other disciplines during student place-based learning. I also noted a theme around novel practice approaches that encompassed the diverse use of sound and vibration in music therapy by both Gal and Elefant and Leandertz and Ala-Ruona, as well as Avery et al.'s and Knight and Blank's evaluation of online practices with adolescent and early childhood groups respectively, and Margett's study of a music therapy consultation model.

It was satisfying to find these connections or 'themes', but deeper reflection prompted me to consider the loss of nuance and important novelty – so critical to a healthy discourse – that can occur when grouping papers in this way. Each of these papers has a unique positioning of ideas that is a novel contribution to our field, and each respond to a different question or perceived knowledge 'gap'.

Finding links that represent common foundations can be a satisfying way to demonstrate cohesion or clarity within our profession, but it is the new ideas that push at the edges, reframe, and sit outside the shared foundations of music therapy that continue to drive our discipline forward. I invite you all to read this issue of *Approaches* with an eye out for not only the ideas that resonate, but for the ideas that push at the edges of your thinking as well. Our move at *Approaches* towards a rolling model of publication in 2026 aligns with the notion of approaching each new article as a discrete and novel offering. I hope you enjoy this upcoming transition and the opportunities it presents for discrete and timely access to new knowledge and ideas.

ΣΗΜΕΙΩΜΑ ΣΥΝΤΑΞΗΣ

Αναστοχασμοί για την επιδίωξη της σύνδεσης και τον ρόλο της διακριτικότητας

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ΒΙΟΓΡΑΦΙΚΟ ΣΗΜΕΙΩΜΑ

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Ελληνική μετάφραση: Μίτσου Ακογιούνογλου

Η κατανόηση της πρακτικής μας ως μουσικοθεραπευτών είναι μια ενδιαφέρουσα και πολύπλευρη διαδικασία. Το ποιοι είναι οι αποδέκτες των ιδεών μας και το κίνητρό μας για να μοιραστούμε και να περιγράψουμε το έργο μας μπορούν να επηρεάσουν βαθιά τον τρόπο με τον οποίο περιγράφουμε τις θεραπευτικές πρακτικές και συναντήσεις, διαμορφώνοντας σημαντικά τον διάλογο στον κλάδο μας. Με μια πληθώρα επιρροών και στοχευμένων ακροατηρίων που ενημερώνουν τις ιδέες που αναδύονται από την επιστήμη μας, υπάρχει μεγάλο περιθώριο για ποικιλία και διαφορετικότητα σκέψης και δράσης στη μουσικοθεραπεία. Αυτή η ευρύτητα προοπτικών μας προκαλεί ως επαγγελματίες να παρακολουθούμε και να κρατάμε χώρο για την πολυπλοκότητα, η οποία μπορεί να είναι συναρπαστική και ελπιδοφόρα, αβέβαιη και ασαφής, και, ενίοτε, εντελώς άβολη – όπως συμβαίνει συχνά με την πολυπλοκότητα.

Καθώς κάθισα να γράψω αυτό το σημείωμα σύνταξης, παρατήρησα την πρόθεσή μου να βρω κοινά σημεία στις πολλές ερευνητικές και πρακτικές προοπτικές της μουσικοθεραπείας που παρουσιάζονται σε αυτό το τεύχος του *Approaches*. Ένωσα την επιθυμία να αναζητήσω ένα κοινό θέμα που θα «συνέδεε» αρμονικά τις έννοιες που παρουσιάζονται στα άρθρα, να δημιουργήσω ένα κοινό νήμα μεταξύ των ιδεών των συγγραφέων που θα μπορούσα να παρουσιάσω και να συζητήσω με συνοχή στο κοινό πλαίσιο της μουσικοθεραπείας. Μου φάνηκε φυσικό να αναζητήσω αυτές τις συνδέσεις και βρήκα μερικές. Για παράδειγμα, εντόπισα διαφορετικές απόψεις σχετικά με τις σχέσεις που διερευνήθηκαν θεωρητικά από την Hadar στη μετα-ανάλυσή της για τον αυτοσχεδιασμό σε δυάδες, εφαρμοσμένα από τους Christensen και Gattino στην περιπτωσιολογική τους μελέτη με ένα αγόρι με σύνδρομο Down, και επαγγελματικά από τους Krüger et al. στον αναστοχασμό τους σχετικά με την καλλιέργεια σχέσεων με άλλες επιστημονικές ειδικότητες κατά τη διάρκεια της πρακτικής άσκησης των φοιτητών. Σημείωσα επίσης ένα θέμα γύρω από καινοτόμες πρακτικές προσεγγίσεις που περιλάμβαναν τη διαφορετική χρήση του ήχου και των δονήσεων στη μουσικοθεραπεία τόσο από τους Gal και Elephant όσο και από τους Leandertz και Ala-

Ruona, καθώς και την αξιολόγηση των Avery et al. και Knight και Blank σχετικά με τις διαδικτυακές πρακτικές με ομάδες εφήβων και νηπίων αντίστοιχα, και τη μελέτη της Margett σχετικά με ένα μοντέλο μουσικοθεραπευτικής συμβουλευτικής.

Ήταν ικανοποιητικό να εντοπίσω αυτές τις συνδέσεις ή «θέματα», αλλά μια βαθύτερη σκέψη με ώθησε να εξετάσω την απώλεια των αποχρώσεων και των σημαντικών καινοτομιών – τόσο κρίσιμων για έναν υγιή διάλογο – που μπορεί να προκύψει όταν ομαδοποιούμε τα άρθρα με αυτόν τον τρόπο. Κάθε ένα από αυτά τα κείμενα παραθέτει μια μοναδική διαμόρφωση ιδεών που αποτελεί μια καινοτόμο συμβολή στον τομέα μας, και κάθε ένα απαντά σε μια διαφορετική ερώτηση ή σε ένα αντιληπτό «κενό» γνώσης. Το να βρίσκουμε συνδέσμους που αντιπροσωπεύουν κοινά θεμέλια μπορεί να είναι ένας καλός τρόπος για να επιδείξουμε συνοχή ή σαφήνεια στο επάγγελμά μας, αλλά είναι οι καινοτόμες ιδέες που ωθούν τα όρια, αναπλαισιώνουν και ξεφεύγουν από τα κοινά θεμέλια της μουσικοθεραπείας, που συνεχίζουν να προάγουν την επιστήμη μας. Σας προσκαλώ όλους να διαβάσετε αυτό το τεύχος του *Approaches* με προσοχή, όχι μόνο στις ιδέες που σας αγγίζουν, αλλά και στις ιδέες που ωθούν τα όρια της σκέψης σας. Η μετάβασή μας στο *Approaches* σε ένα κυλιόμενο μοντέλο δημοσίευσης (rolling publication model) το 2026 ευθυγραμμίζεται με την ιδέα της προσέγγισης κάθε νέου άρθρου ως μιας διακριτής και πρωτότυπης προσφοράς. Ελπίζω να απολαύσετε αυτή την επικείμενη μετάβαση και τις ευκαιρίες που προσφέρει για διακριτή και έγκαιρη πρόσβαση σε νέες γνώσεις και ιδέες.

ARTICLE

Moments of thirdness in music therapy: A qualitative meta-analysis embedded in Jessica Benjamin's intersubjectivity

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ABSTRACT

Background: The study of intersubjective processes is evident across various therapeutic schools, among them music therapy. Several researchers deal with the intersubjective meanings of musical experiences in music therapy. Focusing on unpacking the formation of intersubjective relations through dyadic improvisation, this research centered on six music therapy studies, all entailing thick descriptions of clinical improvisations or music therapy informed (but non-clinical) improvisation, which also emphasise relational aspects. **Methods:** Following a four-step methodological sequence, a meta-analysis was performed. After identifying a research question, the researcher gathered related qualitative and mixed-methods studies. Six studies met the inclusion criteria, after which a thematic analysis was conducted to capture underlying themes which reflected intersubjective essence of dyadic improvisation. Finally, the researcher formed a conceptual organisation of different phases of thirdness as reflected in clinical improvisation, forming the results section. **Results:** Two central themes were identified through the thematic analysis which highlighted distinct developmental phases in clinical improvisation and reflected intersubjective processes as described by Jessica Benjamin: (1) Emerging musical recognition: approaching "one in the third"; (2) Recognition of musical separateness: reaching "third in the one". **Discussion:** Embedded in Jessica Benjamin's intersubjective theory, this paper dealt with the complex construct of thirdness and possible manifestations of it within clinical improvisation. This paper showed how improvisational processes may allow the opening of an intersubjective space between client and therapist and enable mutual recognition in each other's otherness.

KEYWORDS

music therapy,
improvisation,
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INTRODUCTION

Clinical improvisation has been a central theme in music therapy research. It has been examined from various perspectives, e.g., music-centred (Nordoff & Robbins, 2007), developmental (Carpente et al., 2022), humanistic (Ansdell, 2014), and psychodynamic (Odell-Miller, 2001), as well as in treatment of different populations, e.g., adults and children in psychiatric wards (Chen, 2019; Oldfield et al., 2012), Autistic children (Carpente et al., 2022; Geretsegger et al., 2015; Salomon-Gimmon & Elefant, 2019), groups (Gardstrom, 2007; McFerran & Wigram, 2005) and more (for further expansion see Sutton, 2019). Several guidebooks for improvisation in music therapy (e.g., Bruscia, 1997; Carroll & Lefebvre, 2013; Nordoff & Robbins, 2007; Wigram, 2004) provide different techniques and models for using improvisation in therapy. Foubert et al. (2020; 2021) and Trondalen (2016; 2019) provided relational frameworks for examining and understanding clinical improvisation, contextualising music therapy practice within object relation theory, thus expanding the psychodynamic understanding of music therapy in this direction. Trondalen's relational perspective argues that a foundational element in music therapy is a therapist's position rooted in recognition, characterised by acceptance, empathy, and confirmation. This stance, grounded in insight, understanding, and respect, extends beyond the therapist's internal state to manifest in the therapeutic relationship itself. Trondalen emphasises the importance of a recognisable relationship as a prerequisite for transformative development. This relationship allows for self-assertion and individuality (autonomy), as well as for connection and confirmation. The client's perception of empathic and respectful regard, affirming their intrinsic value and self-esteem, is deemed crucial, with potential implications for therapy outcomes. Furthermore, Trondalen (2016) underscores the significance of respecting the client's integrity and freedom as fundamental values in music therapy.

Embedded within a relational perspective, this paper aimed to further expand our understanding about the subtle relational processes facilitated in clinical improvisation, more specifically in client-therapist dyadic improvisation. In this paper, the author used the term improvisation to refer to moments when therapist and client engage in musical spontaneously and authentically, expressing their relational being through sound and intention. This study aimed at integrating theory of music therapy improvisation techniques with approaches which view improvisation as representing psychoanalytic processes. Through synthesising findings of six studies, the author investigated the question of how dyadic improvisations created the grounds for deep intersubjective connections to transpire.

Intersubjectivity in music therapy

The literature about relationality in music therapy improvisation encompasses various clinical orientations: from Langenberg's (1997) discussion on the resonator function and Lvinge's (2015) illustration of relationality in music therapy to, for example, Bensimon's (2020) theorisation about relational music therapy with victims of trauma. It appears that many theorists who studied *moments* in the parent-infant context (Stern, 2004, 2010; Trevarthen & Malloch, 2000) and in the music therapy context (Foubert et al., 2020, 2021; Hadar & Amir, 2021; Smetana et al., 2023) navigated from the ephemeral essence of the moments to its wider relational influence on parent and infant or client and

therapist. In many cases, the researchers found a theoretical home among intersubjective theory (Birnbaum, 2014; Mårtensson Blom, 2010; Smetana et al., 2023; Trondalen, 2016, 2019). The construct of intersubjectivity entails a wide spectrum of meanings, originating in the phenomenological thinking of Husserl (1964) and Buber (1971). Within the music therapy literature, Trondalen (2016) specified three main branches stemming from this term: (1) a framework for relational transference and countertransference; (2) an oscillation between intra-psychic phantasies and intersubjective recognition; and (3) a developmental process of parent-infant mutual co-creation. Trondalen explained that intersubjectivity emerges from the micro-context of moment-to-moment connection of two individuals. Trondalen emphasised the role of mutual recognition between client and therapist in creating an intersubjective relationship. Furthermore, she explained how the sensitive musical exchanges and verbal conversation in therapy enable such recognition, which act as fundamental building blocks of the therapeutic relationship. A manifestation of therapists' recognition can be seen, for example, when the therapist accepts a child's suggestion in group therapy, when acknowledging a musical gesture maintained by music therapy group members, or when reflecting a client's transformative moment (Trondalen, 2016).

The current research suggests a possible theoretical and experiential leap: from the "here and now" moment to the intersubjective connection, while trying to unravel the subtle layers of musical recognition as manifested in clinical improvisation. As this piece focuses on Jessica Benjamin's theory, I will next expand on intersubjectivity by exploring Benjamin's concept of *Thirdness* (Aron, 2006; Benjamin, 2002, 2004).

Jessica Benjamin's theory of thirdness

Jessica Benjamin's theory evolved as a result of a significant shift in theoretical and clinical focus within the psychoanalytic field, often referred to as the "relational turn". This shift, which gained momentum in the latter half of the 20th century, moves away from traditional Freudian and Kleinian emphasis on individual intrapsychic processes and instead places a greater emphasis on the interpersonal and relational aspects of human experience. The relational turn recognises the importance of relationships, both past and present, in shaping an individual's psychological development. It emphasises that the mind is not isolated but is deeply embedded in a social and cultural context. This perspective challenges the earlier notion of a detached, autonomous individual and underscores the significance of the therapist-client relationship in psychoanalytic treatment (Aron, 2006). One key concept, central to relational approaches is the analytic third.

The concept of the analytic third was used by various psychoanalytic schools (e.g., Green, 2004; Ogden, 1994; Storolow & Atwood, 1992; Winnicott, 1971) and meant different things to different theorists (Aron, 2006; Coelho, 2015). Winnicott (1971) originated the concepts of transitional object and transitional space, which allows the child to create a psychological area that exists between the subjective inner world and the external reality. This intermediate space is crucial for the development of creativity, imagination, and a sense of self. The transitional space is not only about the physical object but also about the experiences and processes that occur in the in-between zone where inner and outer realities meet. Winnicott's *third* represents the intermediate zone where subjective and

objective realities meet, fostering the development of creativity, cultural engagement, and a more authentic sense of self.

Green (2004), who was influenced by object relations theories, emphasised the importance of triangulation in the development of psychic space and in the emergence of thirdness. According to Green, triangulation involves the introduction of a third element into the dyadic relationship, contributing to the complexity of psychic life. Furthermore, Green engaged with Freud's Oedipus complex but extends it beyond a focus on parental figures. For Green, the Oedipus complex is a broader process of structuring psychic space through the interplay of multiple objects. The *third*, in this context, represents the symbolic dimension that allows for the representation and displacement of desires. Symbolism, according to Green, is a fundamental aspect of psychic life, and the *third* plays a key role in the development of symbolic thinking.

Thomas Ogden's reading of thirdness introduced the analytic third as a crucial concept in psychoanalysis. The analytic third represents a mental space or a dimension created in the therapeutic relationship. It is not a person or an external entity but rather a psychological space where the analyst, the patient, and the evolving analytic process come together. The analytic third is dynamic and emerges through the interactions and associations within the therapeutic relationship (Aron, 2006).

Benjamin specified her own definition of this construct, which entails two types of thirdness: (1) "one in the third"; and (2) "third in the one." Benjamin's positions of *thirdness* are contrasted to "complementary positions", referring to moments when the therapeutic relation (or any relation) is polarised into two definite and rigid positions of *twoness* (Aron, 2006; Benjamin, 1990, 1995, 2004). Benjamin's "one in the third", or "rhythmic third" pertains to moments when client and therapist are sharing a rhythm or harmony in a way that both are accommodating to it. According to Benjamin, such moments of reciprocity and shared experiences highlight the shared grounds of the relationship, the possibility of similarity and mutual accommodation. One should note that though emphasising shared experiences, Benjamin pointed at moments which required the attunement of both actors, suggesting that such moments exist developmentally from birth (Aron, 2006.; Benjamin, 2002, 2004). In this sense, Benjamin aligns with Stern's developmental perspectives regarding the baby's active search after subjectivity from birth (Stern, 2000, 2004). In "third in the one," however, Benjamin highlighted a sense of separateness between the dyad. In such moments, the therapist (or parent) is *marking* their subjective response, or version of an experience.

Benjamin (2004) described the therapeutic relationship as a dialectic dance between the two types of thirdness, as well as between moments of collapsing to the position of twoness. Benjamin (2004, 2018) articulated the distinction between the dyadic nature of twoness (i.e., complementarity) and the potential realm of thirdness. According to the author, within the framework of complementarity, interdependence takes on a coercive quality. In fact, the coercive interdependence that pulls each individual into the escalating reactivity of the other is a notable feature of the impasse. Conflict, in such a scenario, is unable to be effectively processed, observed, embraced, mediated, or navigated. Instead, it manifests at a procedural level as an unresolved opposition between the individuals, maintaining a split within the relationship.

Meaningful moments in music therapy

At the core of the therapeutic encounter exist moments of meeting between therapist and client (Stern, 2010). Researchers such as Stern (1971, 1995, 2004) and Trevarthen and Malloch (2000) pioneered the microanalysis methodology when looking into the parent-infant primary interactions, bringing researchers' as well as clinicians' attention to the importance of *moments*. Malloch and Trevarthen's ground-breaking work and extensive observations gave rise to the idea of *communicative musicality* (Malloch & Trevarthen, 2010; Trevarthen & Malloch, 2000). The researchers emphasised the early communication, or proto conversations, between parents and infants. Most relevant to the understanding of infant development as well as to the theory around relationality in music therapy practice, is Trevarthen and Malloch's discussion about the musical basis of parents' and infant's early reciprocal exchanges, i.e., their joint timing and shared melodic textures and contours. Their research highlighted the ability of very young infants to co-create an intersubjective space with their parents.

In the music therapy context, theorists who studied *moments*, highlighted various aspects of the therapeutic encounter: the musical interaction per-se (Hadar & Amir, 2021; Smetana et al., 2023), the psychological sharing of two individuals (Fachner, 2014), the interaction as a whole (Amir, 1992; 1995; Brown & Pavlicevic, 1996; Gilbertson, 2015; Tucek et al., 2022), and the verbal connection between therapist and client (Tucek et al., 2022). Gilbertson (2015) asked six music therapists to re-enact their hand position in a meaningful moment in therapy and captured it in a body cast. Representing contemporary approaches of multiplicity (Matney, 2021) and art-based research (Ledger & Edwards, 2011), Gilbertson explored participants' embodied knowledge as felt, perceived, and created with him during the research process. Wosch et al.'s (2007) seminal guide of various research methods of micro-analysis marks a milestone in the positioning of a microanalytic epistemology within the music therapy domain and the acknowledgment of micro-processes present within music therapy sessions.

Amir (1995, 1996) was among the first researchers to consolidate the idea of meaningful moments in music therapy and argued for the fundamentality of moments of insight and transformation. Such moments, she explained, occur on the intrapersonal level, though they affect both client and therapist. Meaningful moments transpire during creative processes and can take place in different realms of the human experience (the physical, intellectual, emotional and spiritual). In receptive music therapy, Grocke's (1999) study marked a landmark in the research of meaningful moments in Guided Imagery and Music (GIM) approach, which was followed by additional work connecting moments in GIM to intersubjective theory (Mårtenson Blom, 2011; Trondalen, 2019). Additional categorisations of moments include De Backer's (2008) *moments of synchronicity* and Ruud's (2008) and Stern's (2004) *now moments*. While Amir (1992, 1995, 1996) referred mostly to the intrapsychic levels of client and therapist, Fachner (2014) emphasised the contextual meaning of the *moment* (as opposed to the internal musical logic of the music, for example), emphasising the *shared* aspects of the moment, thus implying an intersubjective essence to the microanalysis methodology.

Tucek et al. (2022) examined the feasibility of advanced tools such as Electroencephalogram (EEG) hyper-scanning to study the correlations of clients' neural activity and their perceptions of meaningful moments in music therapy. The researchers defined such moments as moments of interest (MOI). According to the authors, such moments encompass "a musical meeting or a shared awareness or perception of a (non)verbal interaction." Similar to Fachner (2014), the authors

highlighted the situatedness and intersubjective essence of such moments. In a recent publication, Smetana et al. (2023) presented qualitative results of a study incorporating 17 dyads of music therapist-adult improvising on a piano for five minutes. The researchers put an emphasis on the clients' perspectives (as opposed to investigating only therapists' views on this issue) and on the differentiation between meaningful moments (shorter segments of interactions) and time periods (longer segments of interaction). The authors chose the umbrella term *situations* to cover a broader range of possible events between client and therapist. In addition, Smetana et al. examined the intersubjective character of meaningful situations, through comparing the extent of overlap between the dyads in their study.

Focusing on meaningful moments, this study aimed at capturing the possible relational structures within dyadic (and group) improvisation, and specifically to centre on the evolvment of *musical thirdness* in this context. Aligning with Benjamin's (2002, 2004) structural and developmental perspective of the intersubjective space, this paper aimed at identifying the paths created through joint musical improvisation, which allowed the client and therapist to experience one another as separate as well as connected human beings. Benjamin (2004) interprets the third as a position of surrender and thirdness as the mental space that facilitates or results from surrender. In addition, the term surrender also implies the gesture of recognition, of being able to connect to another's mind while accepting one's separateness and difference. When thirdness emerges, one has survived the possibility of their subjectivity being "destroyed," negated, or modified by the other. It also implies the freedom from any intent to control or dominate.

In her writings about the client-therapist relationship, Benjamin (2004, 2018) highlights the dyadic exploration of the "connection-separation" continuum as one involving *accommodation*. According to Benjamin, accommodation is an integral part of being recognised and involves the ways in which individuals adjust or adapt to each other's subjectivities. It is not about one person dominating or submitting themselves to the other, but rather a dynamic process of negotiation and mutual understanding. As highlighted by Benjamin, *accommodating* is fundamentally rhythmic by its nature. In this piece, I wish to further explore not only the rhythmic component of the recognitive function, but to unravel additional musical components which may carry the act of recognition and may establish a musical (sort of) thirdness.

The author's engagement with Jessica Benjamin's theory: A personal note

From the very beginning of my research of improvisation and joint improvisation, I was drawn to its dialogic nature. Focusing on the various musical approaches utilised by music therapists to create dialogues, I realised the range of relatedness facilitated by dyadic improvisation (Hadar, 2018; Hadar & Amir, 2021). In the past few years, I started deepening my engagement with intersubjective approaches, which culminated in a psychoanalytic course I took focusing on Jessica Benjamin's intersubjective approach. Gaining familiarity with Benjamin's theory influenced the way I listen to improvisation and understand it as a relational phenomenon. From the beginning of my acquaintance with Benjamin's theory, I felt a deep connection between her relational and developmental perspective, and salient developmental and relational approaches often used in music therapy (e.g., Stern, 2010; Trevarthen & Malloch, 2000, Trondalen, 2016). Eventually it urged me into seeking possible ties

between the relational psychoanalytic approach and the improvisational one, and to expand the musical-clinical vocabulary music therapists could use when interpreting their improvisational connections using Benjamin's approach. Moreover, I had a strong feeling about the possible ability of the improvisational perspective in further illuminating hidden aspects of Benjamin's theory. With the aforementioned ambitions and aiming at identifying a music therapy reading of Jessica Benjamin's theory, I planned the current research.

METHODS

This study utilised qualitative meta-analysis as its principal method. Meta-analysis is a term used to describe methods for integrating findings of several interpretivist (or objectivist) studies, in order to form a broader perspective regarding a phenomenon (Levitt, 2018; Meadows & Wimpenny, 2016, 2017; Timulak, 2009; Timulak & McElvaney 2013). In such inquiry, the analysis is focused on a research question, which guides the procedure of analysis (Timulak, 2009). Through consolidating themes of several studies, the researcher seeks to uncover underlying structures which might explain the recurrence and similarities taking place among different studies and can suggest further insight regarding the examined phenomenon (Levitt, 2018; Meadows & Wimpenny, 2017). In this study, the researcher followed a four-step procedure: (1) Identifying an area of research and research question; (2) Identifying and collating qualitative and mixed-methods studies related to the research question across a wide range of literature, using inclusion/exclusion and quality criteria; (3) Comparing and analysing findings of all studies, and preparing an underlying framework which created a conceptual organisation; and (4) Integrating findings of all studies to form the results section (Timulak, 2009; Timulak & McElvaney 2013). In the following section the author will expand on each step separately.

Procedure

Identifying an area of research and research question

The inquiry encompassed studies which discussed relational aspects of client-therapist dyadic (and group) improvisation. The first research question was:

1. What are the central intersubjective characteristics of therapist-client dyadic (and group) improvisation?

As the analysis was expanded, further research questions were added:

2. How is Benjamin's reading of thirdness manifested within dyadic (and group) musical improvisation?
3. What are the possible musical approaches that enable music therapists and clients to move from a complementary position of resistance in therapy to exploring territories of *thirdness*?

Identifying and collating qualitative and mixed-methods studies related to the research question across a wide range of literature, using inclusion/exclusion and quality criteria

The author searched a range of databases (e.g., Medline, PsycINFO) and music therapy journals (e.g., *Nordic Journal of Music Therapy*, *Journal of Music Therapy*), examining data from the past decade (1.2012-1.2023). Given that initial database searches resulted in over 70 studies (search words: “improvisation”; “music therapy”; “intersubjective”; “relational”), the author further narrowed the pool of studies to include only ones including explicit descriptions of improvisation, leaving the author with 17 potential studies (see Appendix 1). Finally, the author focused on studies which met three inclusion criteria: (1) incorporated thick descriptions of client-therapist improvisation; (2) included open-ended interviews with therapists and/or clients regarding their experience of improvisation, or written reflections of therapists; and (3) incorporated an underlying, implicit or explicit, intersubjective perspective about dyadic improvisation in music therapy context, i.e., emphasised and elaborated on aspects of relationship as manifested through dyadic (or group)¹ improvisation. This final step resulted in the inclusion of six studies (see Table 1).

Study	Number of participants	Methods
Hadar & Amir, 2021	10 participants	Qualitative
Foubert et al., 2019	N/A	Qualitative
Salomon-Gimmon & Elefant, 2019	4 participants	Mixed methods
Hadar, 2024	10 participants	Qualitative
Smetana et al., 2022	17 dyads	Mixed methods
Warner, 2014	5 participants	Qualitative

Table 1: Studies included in the meta-analysis

Comparing and analysing findings of all studies, and preparing an underlying framework which created a conceptual organisation

In this phase, the author focused on the findings of the six studies as well as on the discussion section. Themes, categories, and descriptions which deemed relevant to the meta-analysis were extracted from the original publications. Once data from all six studies were gathered, the author sought for an underlying framework that would establish a clear conceptual organisation of the data. It was identified that all explored studies included two prominent stages within their description of dyadic improvisation: one consisting of *a preliminary stage*, in which the clinical musical relation was formed, and *a more advanced stage*, in which the relationship was expanded and could include more complex interactions, musical and non-musical. Thereafter, the author further reviewed the papers and classified various descriptions of improvisational moments as either pertaining to preliminary stages of therapy or representing moments of more complex musical interactions. For example, Foubert’s

¹ Though the focus of this study was on the client-therapist dyadic music making, the author chose to include a study discussing group improvisation. Although group dynamics raises additional complexities and intricacies of multiple relationships occurring in the therapy room in a given moment (Mcferran & Wigram, 2005; Stige et al., 2010), the author focused on the interventions offered by the therapist, which provide information highly relevant to this study’s subject matter.

description of moments of therapist's acknowledgement of the silence in the room was coded as "preliminary stages in therapy", whereas Salomon-Gimmon and Elefant's illustration of moments when the therapist could divert their vocal response from the client's initial expression was coded as "advanced". Through this analysis, the author drew connections between the nature of primary and advanced moments in music therapy improvisations to Benjamin's two phases of thirdness. Guided by Benjamin's relational framework, the author continued to seek specific moments which resonated with Benjamin's two stages of thirdness. Consequently, all extracted data was rearranged into a framework including two broad levels in the process of dyadic improvisation: *Primary stages in dyadic improvisation* and *Advanced stages in dyadic improvisation*. In the process of classifying different moments as pertaining to one of two stages (i.e., Primary stages versus Advanced stages), the researcher further elaborated and refined the evolving framework, which finally crystallised into two themes: *Emerging musical recognition: approaching "one in the third"*; and *Recognition of musical separateness: reaching "third in the one."* In addition, resonating with Benjamin's complementary positions, moments of resistance and/or inability to establish musical connections were acknowledged and incorporated into the findings.

Epistemological reflexivity

Reflexivity in qualitative research relates to researchers' ongoing examination of how their personal backgrounds shape research and how they, in return, are shaped by research themselves (Dowling, 2006; Palaganas et al., 2017). While reflexivity can be practiced in several ways pertaining to the authors' involvement in their study, in the current study, the author opted to focus on epistemological reflexivity (Palaganas et al., 2017). Epistemological reflexivity deals with authors' possible biases regarding the methodological approaches undertaken, the articulated research questions, and the form of interpretation ascribed. In other words, epistemological reflexivity provides an opportunity to ponder on the implications of such biases on the study's findings. The author of this paper is involved in the study of improvisation and dyadic improvisation for several years and has published in this field. Therefore, prior to conducting the meta-analysis, the author has already acquired preliminary understandings and theories around the subject matter which have influenced her perspectives and choice of research questions. In addition, two of the studies included in this meta-analysis were authored or co-authored by the author of this paper. These conditions created a certain research context for the current study and enforced inherent limitations for this study. To balance the researcher's predisposition, a wide range of literature was included in the first stages of investigation and the manuscript was sent to two academic colleagues of various expertise to obtain a wider scientific scope.

FINDINGS

The integration of six studies focusing on relational aspects in the context of dyadic and group improvisation identified two central themes: *Emerging musical recognition: approaching "one in the third"* and *Recognition of musical separateness: reaching "third in the one."* Relying on all studies' theorisation of similar developmental sequencing, this paper further added an intersubjective lens, suggesting that the two stages captured in the themes indicate the foundation of an intersubjective space between

therapist and client. Table 2 & Figure 1 summarise the various music-centred description and definitions of all six studies included in this review, with regard to the two developmental phases described in this section.

Position of thirdness	Authors	Music therapy perspective/moment
Towards 'One in the third'	Hadar & Amir (2021)	• Moments of listening and attuning to the client's being • Transforming the moment: utilising the temporal dimension in joint improvisation to lay a basis for meaningful moments to arise
	Foubert et al. (2021)	• Inter-corporal listening • Emergence of shared pulsation
	Salomon-Gimmon & Elefant (2019)	• Exact vocal resonance
	Hadar (2024)	• Augmented time frame (moments of silence) • Emotional time (time-free moments)
	Smetana et al. (2023)	• Relating qualities within the dyadic improvisation • Self-focused qualities within the dyadic improvisation • Intra-/inter-personal phenomena within the dyadic improvisation
	Warner (2014)	• Moments of disconnection, fragmentation (e.g., moments of bursts of crescendo) • Moments of timelessness • Moments of therapist's holding
'Third in the one'	Hadar & Amir (2021)	• Synchronisation discrepancies (established by therapist, e.g., playing around the client's beat) • Moments of insight through joint improvisation
	Hadar (2024)	• Synchronisation discrepancies (established by client and therapist, e.g., following clients' ritardando and fermatas)
	Foubert et al. (2019)	• Moments of polyphonic flow
	Salomon-Gimmon & Elefant (2019)	• Resonance with changes • Creating new vocalisation with/without words
	Smetana et al. (2022)	• Moments of unpleasant feelings, conflict, and autonomy within the dyadic improvisation
	Warner, 2014	• Moments of clear differentiated musical statement (made by the client, e.g., choice of different beat)

Table 2: Moments of thirdness in music therapy improvisation as presented in all six studies

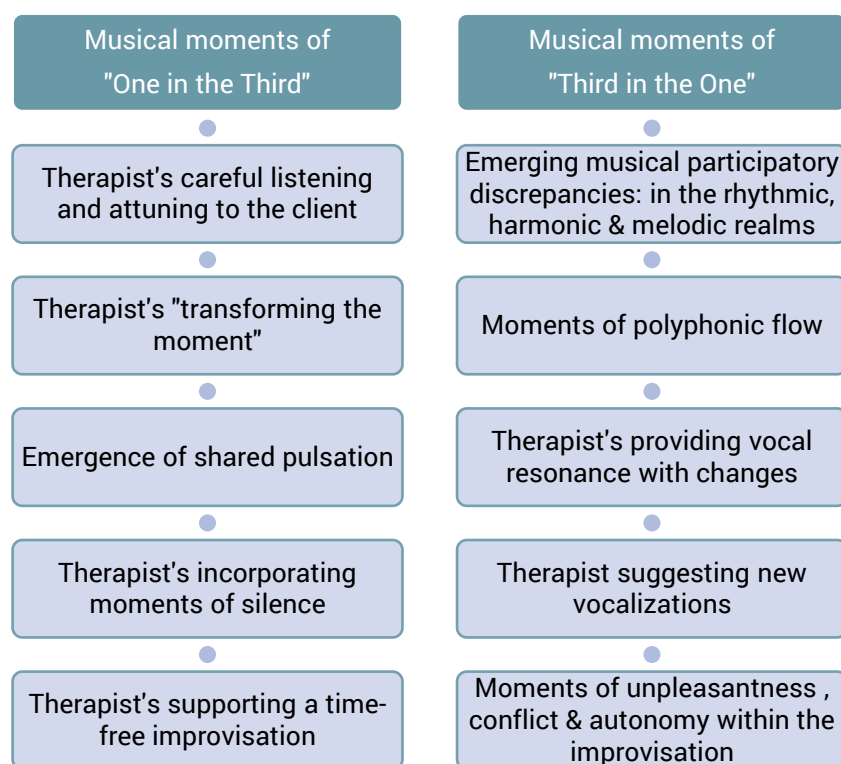


Figure 1: Musical moments of "one in the third" and "third in the one"

Emerging musical recognition: Approaching "one in the third"

Hadar and Amir (2021) identified two types of primary musical invitations of the therapist, namely, *Moments of listening and attuning to the client's being*, and *Transforming the moment: utilising the temporal dimension in joint improvisation to lay a basis for meaningful moments to arise*, which were labelled as primal moments in joint improvisation. Whereas *Moments of listening and attuning* represented moments in which therapists were carefully matching their clients' sounds and attuning to their movements and behaviours in the room using musical approaches, *Transforming the moments* subscribed to various musical techniques used by music therapists to adapt the temporal musical structures in ways that would encourage clients' musical and non-musical responses. Such techniques included the use of harmonic repetitions and the inclusion of pauses within a given musical structure.

A comparable clinical approach was illustrated by Foubert et al. (2021), who presented an improvisational frame for supporting people with personality disorder (PD) in developing a sense of trust within a relationship. Similar to Hadar and Amir (2021), Foubert et al. identified a developmental sequence, moving between four stages of the improvisational relationship. The first and second stages of their improvisational frame, i.e., *inter-corporal listening* and *emergence of shared pulsation*, comport with Hadar and Amir's (2021) *primal moments*. While moments of *inter-corporal listening* illustrated moments when the therapist became receptive to the audible silence in the room, listening to how it influences the client's state, and awaiting first opportunities to make initial contact, moments of *emergence of shared pulsation* were composed of short episodes of shared pulse between client and therapist (Foubert et al., 2021).

Salomon-Gimmon and Elefant (2019), who identified different vocalisation trends in music therapy sessions with Autistic children, also pointed to such a preliminary stage, when highlighting the vocal technique of *exact vocal resonance*. Comporting with Hadar and Amir (2021) and Foubert et al. (2021), Salomon-Gimmon and Elefant discussed the developmental relation between two vocal interventions: the more fundamental *exact vocal resonance* versus the more intricate *vocal resonance with changes*. Furthermore, Salomon-Gimmon and Elefant (2019) emphasised that primary stages of therapy are characterised by vocalisations of low communicative nature, which supported clients' reaching a state of regulation and self-stimulation.

Hadar (2024) studied the temporal aspect of Paul Nordoff and Clive Robbins' clinical improvisations. Based on an analysis of music therapy sessions with children that Nordoff and Robbins worked with, Hadar (2024) formed a developmental time model which describes four temporal phrases. Hadar's first temporal phase (*Augmented time frame*) subscribed to therapists' careful attunement and incorporation of many musical rests within the musical intervention. The author showed how the use of interspersed musical pauses allowed clients enough time to process the musical invitations and occasionally to respond to it, while being contained within a musical structure composed by the therapist. The author's third time phase (*Emotional time*) presented moments in which Nordoff was repeating a musical motif for many times, while the client was free to explore and discover their inner musical selves. It seems that both time phases emphasise pre-communicative qualities whereby initial responses were evoked and initial consciousness on behalf of the client was awakened. Resonating with the pre-communicative nature of Salomon-Gimmon's and Elefant's (2019) *Moments of exact resonance*, and with Hadar and Amir's (2021) and Foubert et al. (2021) primary stages of the improvisational interaction, such moments seem to support an emerging sense of thirdness, namely "one in the third" (Aron, 2006).

Situated within a psychodynamic orientation, Warner (2014) utilised a participatory action research approach for an in-depth, post-hoc investigation of the musical intervention within a music therapy group for adults with learning disabilities and severe challenging behaviours. In cycle 1 of Warner's reflective description, the therapist is described as attuning closely to the sound quality (i.e., register and volume) of the group members and gradually, similar to Foubert et al.'s (2019) portrayal of this stage, forming a preliminary pulsation between them. Moreover, the therapist is described as responding mainly to the gestural content of the participants, to their vitality contours (Stern, 2000; Trevarthen & Malloch, 2000). Corresponding with Hadar (2024), Warner highlighted the sense of timelessness inherent to this primary stage of therapy and pointed to the therapist's role in tying together the fragmented and somewhat disconnected sounds present in the room by creating a sense of holding and containment of the musical space. Another quality mentioned by Warner relates to a sense of detachment and opponency among clients' play, illustrated by bursts of crescendo and throwing instruments, or even leaving the room. Such moments posit even a greater challenge on behalf of the therapist to invite an opportunity for establishing thirdness.

Similarly, Smetana et al. (2023) described a spectrum of relatedness in non-clinical improvisation between adult participants and trained music therapists. The authors specified three

categories² that resonate with Hadar and Amir's (2021) *primal moments*, i.e., *relating qualities*, *self-focused qualities*, *intra-/interpersonal phenomena*, all pertaining to initial stages of relatedness within clinical (or clinical-informed) musical improvisation. Hadar and Amir specified that such moments resemble mother-infant interaction and the emergence of reciprocity.

Employing a relational standpoint, and specifically Benjamin's theorising regarding "one in the third", I argue that all of the *moments* described in this section, reflect musical interventions which structured the possibility of creating moments of *thirdness* between the client and therapist in music therapy. Benjamin's *one in the third* pertains to moments when client and therapist are already celebrating a shared, co-created experience.

However, parallel moments in the music therapy context seem to depict a more subtle phase where the client is only awakening towards the possibility of *sharing*, while the therapist is holding, musically, the possibility of actual *oneness*. In this sense, it seems that *musical thirdness* allows a distinct, preliminary opportunity for inviting a client to connect.

Recognition of musical separateness: Reaching "third in the one"

In their concept of *Mature moments*, Hadar and Amir (2021) presented a stage within the client-therapist dyadic improvisation involving free and authentic dialogues, ones that could tolerate discrepancies in musical elements: e.g., rhythm, tempo, harmony, and melody. Moreover, an essential part of such moments entailed the dyad's capability to contain musical conflicts and disagreements. In "Music time & self" (Hadar, 2024), the author highlighted not only moments capturing the therapist's initiating different tempi and musical directions, but moments in which *clients* took the lead to differentiate themselves from the therapist's tempo and musical expression. Similarly, Foubert et al.'s (2021) third and fourth stages of their improvisational framework entailed moments of polyphonic flow and interpersonal trust. The word *polyphony* not only conveys the rich musical textures of the improvisation, but also points to the independent quality illustrated in the distinct paths chosen by each part of the dyad.

Among the 16 types of vocal interventions in music therapy with Autistic children, Salomon-Gimmon and Elefant (2019) highlighted the vocal technique *vocal resonance with changes*, which represented developmental growth and signified more complex relationships between client and therapist. According to the authors, *vocal resonance with changes* resembles advanced types of parent-infant communicative patterns, in which the parent feels confident enough to allow variations and diversions from the infant's original sounds. In agreement with Hadar, Warner (2014) emphasised the significance of moments in which the client made a clear musical statement of differentiating themselves from the therapist's musical expression by choosing a different beat for example. Warner also highlighted the spectrum stretched between a destructive differentiation and a healthy and constructive differentiation.

Smetana et al. (2023) specified the significance of feelings of separation as crucial for the emergence of an intersubjective musical space. They highlighted the existence of a more complex

² All three categories included specific subthemes which further strengthen their connections to Benjamin's conceptualization of "one in the third" (see Smetana et al., 2023).

relational stage, which includes unpleasant feelings, conflict, and autonomy. This does not necessarily ascribe to one of the dyad's members needing to create distance in the musical relationship, but rather as needing to allow for self-differentiation within the relationship.

From an intersubjective point of view, such musical communication may imply the client and therapist reaching a more complexed and advanced position of *thirdness*, while being able to express their authentic musical voice in dialogue with another, i.e., the "third in the one" position. Benjamin (2004, 2018) describes the nature of the "third in the one" position as asymmetrical, emphasising how it enables the therapist and client to communicate within a symbolic realm, which involves interpretations and multiple world views, and creates the grounds for insights to take place in therapy (Aron, 2006). In that sense, the theme *moments of insights through joint improvisation* represents moments when dyadic improvisation enabled moments of contained separateness, when clients could perform an inner mental movement or when the therapist was able to share their viewpoints (Hadar, 2018).

DISCUSSION

From musical resistance to emerging pulsation: A micro-analytic view of the "one in the third"

All studies included in the meta-analysis utilised a developmental model for understanding processes of change within clinical improvisation (Foubert et al., 2021; Hadar, 2024; Hadar & Amir, 2021; Salomon-Gimon & Elefant, 2019; Smetana et al., 2023; Warner, 2014). All the aforementioned studies described a preliminary stage of dyadic (or group, see Warner, 2014) improvisation, which included only emerging dialogues or even at a more fundamental stage, such as entailing a possible transition from a stage of disconnection between client and therapist to establishing initial rapport, due to one or more reasons: (1) clients' initial resistance to engage in the therapeutic process (Hadar & Amir, 2021; Hadar, 2024; Smetana et al., 2023; Warner, 2014) or (2) clients' initial unawareness of the therapist (Foubert et al., 2021; Salomon-Gimon & Elefant, 2019). Overall, this initial stage was illustrated by all studies as incorporating careful listening and attunement between client and therapist, as well as therapists' musical adherence to clients' sounds and suggestion of emerging pulsation, i.e., establishing "one in the third". Therapists in this stage were described as taking almost full responsibility over establishing musical contact, until reaching a point whereby initial signs of clients' responses emerged.

Melodic, harmonic, and rhythmic participatory discrepancies: Utilising the musical relationship for stepping into separateness

Nevertheless, all studies included in the meta-analysis described also a more advanced musical and relational step, which was predominated by clients' and therapists' mutual recognition of each other's musical separateness and otherness, and was manifested in participatory discrepancies between therapist and client in the temporal (Foubert et al., 2019; Hadar, 2024; Hadar & Amir, 2021; Warner,

2014), harmonic (Hadar, 2024), or melodic (Salomon-Gimmon & Elefant, 2019) realms. In such moments, the client and therapist were able to freely make their own musical choices and to initiate their separate being, i.e., “third in the one.”

A dialectic movement between musical disconnection to musical negotiation

Benjamin discusses a constant dialectic movement between two positions of thirdness as well as between moments of thirdness and moments of twoness (Aron, 2006; Benjamin, 2004, 2018). Similarly, as portrayed in Figure 2, this dialectic movement was also manifested within the musical improvisational relationship, stretching between moments of resistance in clinical improvisation to temporal, harmonic, and melodic discrepancies. In other words, this meta-analysis showed that there is a constant tension between resisting a relationship, making contact, and being able to form a differentiated self within a relationship, all of which taking place within the musical interaction. It appears that dyadic improvisation enabled progressive processes emerging from moments of cautious pauses and careful listening to the client's being, to moments in which the therapist and client both surrendered to each other's realities (Benjamin, 2004) and negotiated their individual existence in time, harmony, and melody. In those precious moments of recognition of each other's otherness, I argue that therapists and presumably clients were embracing the position of ‘*third in the one*’ (Benjamin, 2004). Salomon-Gimmon and Elefant (2019) emphasised the simultaneous occurrence of different stages in therapy (i.e., moment of *exact vocal resonance* and moment of *resonance with change*), thus creating a more complex view of child development, which resonate with the idea of “the third in the one.” In this regard, it seems that the acknowledgment in one's *otherness* is a momentarily achievement, which has to be continuously approached within the musical relationship in a spiral manner.

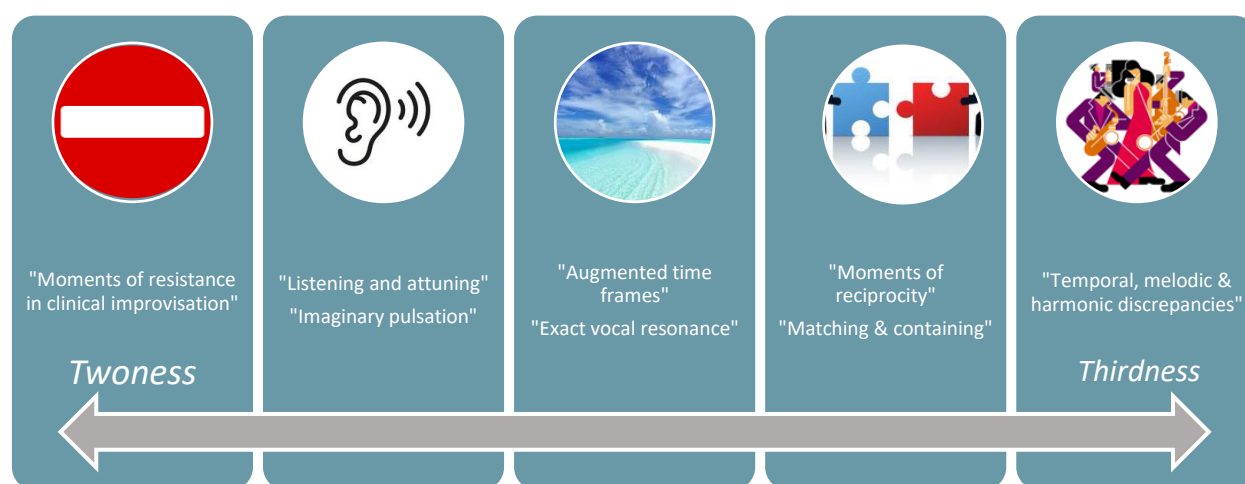


Figure 2: A dialectic movement from moments of musical disconnection (twoness) to moments of musical negotiation (thirdness) in clinical improvisation

The therapeutic relation as a multi-dimensional reality: Shifting between musical disconnection, emerging musical recognition, and recognition in musical separateness

Similar to earlier research dealing with intersubjectivity in music therapy (Birnbaum, 2014; Trondalen, 2016, 2019), this paper confirms the strong links between Trevarthen and Malloch's descriptions of parent-infant proto-conversations and of communicative musicality (Malloch & Trevarthen, 2010; Trevarthen & Malloch, 2000), and the intersubjective nature of client-therapist musical interaction in music therapy. This paper further suggests that such delicate musical exchanges are instrumental for forming more complex relational patterns in advanced stages of the relationship. In alignment with Stern (2000), this paper highlights the baby's (and in this case – also client's) dual relational capacity to be *part of* and *separated from*, and for their need to practice such diverse relationality from the very beginning. In this sense, this paper provides a framework for unfolding intricate musical interactions between therapist and client by placing them within an intimate dance, which constantly shifts between *moments of (musical) disconnection*, *moments of emerging (musical) recognition*, and *moments of recognition of (musical) separateness* (see Figure 3).

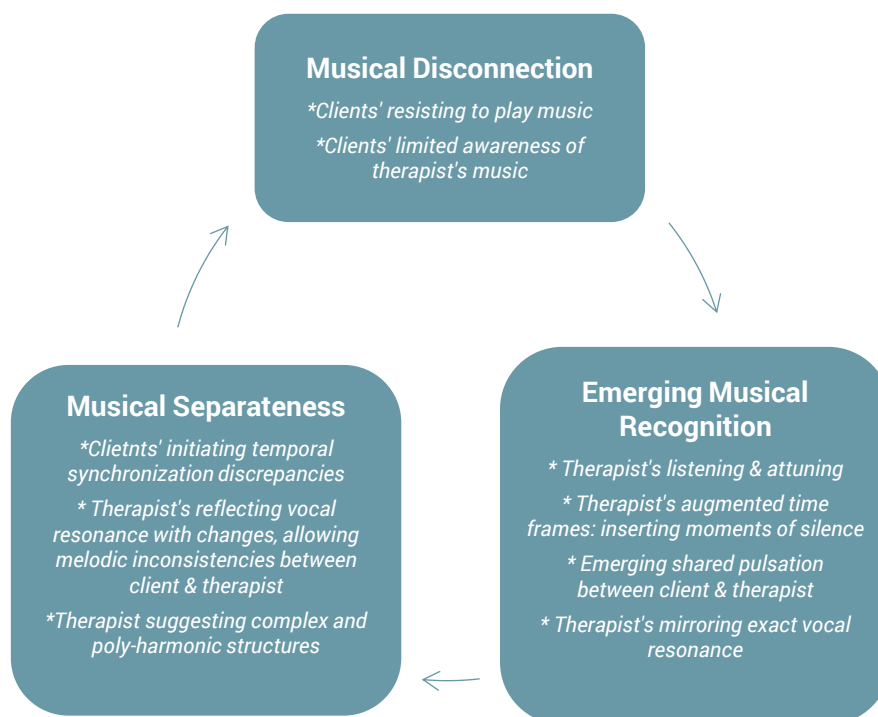


Figure 3: The client-therapist dance between moments of musical disconnection, moments of emerging musical recognition, and moments of recognition of musical separateness

CONCLUSIONS

This study proposed a conceptual link between clinical improvisation in music therapy and the idea of *thirdness* in intersubjective thought. Through portraying the gradual processes enabled via different kinds of moments in dyadic improvisation, the author showed the musical manifestations of varied positions of the client-therapist intersubjective relationship, i.e., “one in the third” and “third in the one”. Furthermore, this piece focused on tracing the musical paths stretching between several dimensions of the therapeutic relation: a complementary position of *twoness* to positions of *thirdness*, and between different types of thirdness. Results suggest that different kinds of musical moments and relations can reflect the level of intersubjectivity between client and therapist, and can imply the extent to which they can mutually recognise each other’s *otherness* yet remain authentically connected in a given moment. This type of conceptualisation can be useful in various clinical settings and assessments. For example, when a music therapist is reflecting on the type of moments they encountered within a session or when dealing with resistance and difficulties in establishing a relationship with clients. In both cases, collecting information about the type of moments emerging from a clinical improvisation might indicate the levels of intersubjectivity, and recognition of the *other* facilitated in the session, thus suggesting prospective therapeutic goals.

REFERENCES

- Amir, D. (1992). *Awakening and expanding the self: Meaningful moments in the music therapy process as experienced and described by music therapists and music therapy client*. UMI Distribution Services.
- Amir, D. (1995). Moments of insight in the music therapy process. *Music Therapy*, 12(1), 85-101.
<https://doi-org.ezproxy.haifa.ac.il/10.1093/mt/12.1.85>
- Amir, D. (1996). Experiencing music therapy: Meaningful moments in the music therapy process. In M. Langenberg, K. Aigen & J. Frommer (Eds.), *Qualitative music therapy research* (pp. 109-130). Barcelona Publishers
- Ansdell, G. (2014). *How music helps in music therapy and everyday life*. Ashgate.
- Aron, L. (2006). Analytic impasse and the third: Clinical implications of intersubjectivity theory. *International Journal of Psychoanalysis*, 87(2), 349-368. <https://doi.org/10.1516/15EL-284Y-7Y26-DHRK>
- Austin, D. (2009). *The theory and practice of vocal psychotherapy*. Jessica Kingsley Publishers.
- Bateman, A., & Fonagy, P. (2013). Mentalization-based treatment. *Psychoanalytic Inquiry*, 33(6), 595-613.
<https://doi.org/10.1080/07351690.2013.835170>
- Benjamin, J. (1990). An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology*, 7 (Suppl.), 33-43.
<https://doi.org/10.1037/h0085258>
- Benjamin, J. (1995). Recognition and destruction: an outline of intersubjectivity. In *Like Subjects, Love Objects*. Yale University Press.
- Benjamin, J. (2002). The rhythm of recognition comments on the work of Louis Sander. *Psychoanalytic Dialogues*, 12(1), 43-53.
<https://doi.org/10.1080/10481881209348653>
- Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly*, LXXIII, 5-46.
- Bensimon, M. (2020). Relational needs in music therapy with trauma victims: The perspective of music therapists. *Nordic Journal of Music Therapy*, 29(3), 240-254. <https://doi.org/10.1080/08098131.2019.1703209>
- Birnbaum, J. C. (2014). Intersubjectivity and Nordoff-Robbins Music Therapy. *Music Therapy Perspectives*, 32(1), 30-37.
<https://doi.org/10.1093/mtp/miu004>
- Blanco B., M., & Sorzano, O. L. (2021). Performance practices and the conflict of memory in Colombia: working towards a 'decolonial' digital archive and epistemological justice. *Contemporary Theatre Review*, 31(1-2), 172-190.
<https://doi.org/10.1080/10486801.2021.1878511>
- Brown, S., & Pavlicevic, M. (1996). Clinical improvisation in creative music therapy: Musical aesthetic and the interpersonal dimension. *Arts in Psychotherapy*, 23(5), 397-405. [https://doi-org.ezproxy.haifa.ac.il/10.1016/S0197-4556\(96\)00033-0](https://doi-org.ezproxy.haifa.ac.il/10.1016/S0197-4556(96)00033-0)
- Bruscia, K. E. (1987). *Improvisational models of music therapy*. Charles C. Thomas Publishers.
- Buber, M. (1970). *I and thou* (Trans. with prologue and notes by W. Kaufmann). Charles Scribner's.
- Carpente, J., Casenhiser, D. M., Kelliher, M., Mulholland, J., Sluder, H. L., Crean, A., & Cerruto, A. (2022). The impact of imitation on engagement in minimally verbal children with autism during improvisational music therapy. *Nordic Journal of Music Therapy*, 31(1), 44-62. <https://doi.org/10.1080/08098131.2021.1924843>
- Carroll, D., & Lefebvre, C. (2013). *Clinical improvisation techniques in music therapy: A guide for students, clinicians and educators*. Charles C Thomas.

- Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, 41(5), 545-547. <https://doi.org/10.1188/14.ONF.545-547>
- Coelho Junior N. E. (2016). The origins and destinies of the idea of thirdness in contemporary psychoanalysis. *The International Journal of Psycho-analysis*, 97(4), 1105-1127. <https://doi.org/10.1111/1745-8315.12433>
- Chen, Y. Y. (2019). Single-session improvisational group music therapy in adult inpatient psychiatry: a pilot study of the therapist's experience. *Nordic Journal of Music Therapy*, 28(2), 151-168. <https://doi.org/10.1080/08098131.2018.1528560>
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications.
- De Backer, J. (2008). Music and psychosis: A research report detailing the transition from sensorial play to musical form by psychotic patients. *Nordic Journal of Music Therapy*, 17(2), 89-104. <https://doi-org.ezproxy.haifa.ac.il/10.1080/08098130809478202>
- Dewinter J., Van Parys H., Vermeiren R., van Nieuwenhuizen C. (2017). Adolescent boys with an autism spectrum disorder and their experience of sexuality: An interpretative phenomenological analysis. *Autism*, 21, 75-82. doi: 10.1177/1362361315627134.
- Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, 13(3), 7-21.
- Fachner, J. (2014). Communicating change—meaningful moments, situated cognition and music therapy: A response to North. *Psychology of Music*, 42(6), 791-799. <https://doi.org/10.1177/0305735614547665>
- Forinash, M. (1992). A phenomenological analysis of Nordoff-Robbins approach to music therapy: The lived experience of clinical improvisation. *Music Therapy*, 11(1), 120-141. <https://doi.org/10.1093/mt/11.1.120>
- Forinash, M., & Grocke, D. (2005). Phenomenological inquiry. In B. L. Wheeler (Ed.), *Music therapy research* (2nd Ed., pp. 321-334). Barcelona Publishers.
- Forinash, M., & Gonzales, D. (1989). A phenomenological perspective of music therapy. *Music Therapy*, 8(1), 35-46. <https://doi-org.ezproxy.haifa.ac.il/10.1093/mt/8.1.35>
- Foubert, K., Gill, S. P., & De Backer, J. (2021). A musical improvisation framework for shaping interpersonal trust. *Nordic Journal of Music Therapy*, 30(1), 79-96. <https://doi.org/10.1080/08098131.2020.1788627>
- Foubert, K., Sebrechts, B., Sutton, J., & De Backer, J. (2020). Musical encounters on the borderline. Patterns of mutuality in musical improvisations with Borderline Personality Disorder. *The Arts in Psychotherapy*, 67, 101599. <https://doi.org/10.1016/j.aip.2019.101599>
- Gardstrom. (2007). *Music therapy improvisation for groups*. Barcelona Publishers.
- Geretsegger, M., Holk, U., Carpentier, J., Elephant, C., Kim, J., & Gold, C. (2015). Common characteristics of improvisational approaches in music therapy for children with autism spectrum disorder: Developing treatment guidelines. *Journal of Music Therapy*, 52(2), 258-281.
- Green, A. (2004). Thirdness and psychoanalytic concepts. *The Psychoanalytic Quarterly*, LXXIII(1), 99-135
- Grocke, D. E. (1999). *A phenomenological study of pivotal moments in Guided Imagery and Music (GIM) therapy*. [Doctoral Dissertation, University of Melbourne]. <http://hdl.handle.net/11343/39018>
- Hadar, T. (2018). The meaning of joint improvisation: Between client and therapist and between two jazz musicians. [Doctoral dissertation]. Bar Ilan University. DOI: 10.13140/RG.2.2.32060.80007
- Hadar, T. (2024). *Music, time and self: A time model for Nordoff-Robbins clinical improvisation*. Barcelona Publishers.
- Hadar, T., & Amir, D. (2021). Intimacy, mutuality & negotiations: Dialogic moments in joint improvisation. *Nordic Journal of Music Therapy*, 30(5), 460-484. DOI: 10.1080/08098131.2021.1915855
- Howard, K., Katsos, N., & Gibson, J. (2019). Using interpretative phenomenological analysis in autism research. *Autism*, 23(7), 1871-1876. <https://doi-org.ezproxy.haifa.ac.il/10.1177/1362361318823902>
- Husserl, E. (1964). *The phenomenology of internal time consciousness* (J.S. Churchill, Trans.) Indiana University Press.
- Kenny, C. (2006). *Music and life in the field of play: An anthology*. Barcelona Publishers.
- Lacan, J. (1975). *The seminar of Jacques Lacan, Book I, 1953-1954*, trans. J. Forrester. Norton, 1991.
- Langenberg. (1997). On understanding music therapy: Free musical improvisation as a method of treatment. *World of Music*, 39(1), 97-109.
- Lee, C. (2016). Aesthetic music therapy. In J. Edwards (ed.), *The Oxford handbook of music therapy* (pp. 515-537). Oxford University Press.
- Ledger A., & Edwards J. (2011). Arts-based practices in music therapy research: Existing and potential developments. *Arts in Psychotherapy*, 38, 312-317. <https://doi.org/10.1016/j.aip.2011.09.001>
- Lévin, A. (2015). *The music of being. Music therapy, Winnicott and the school of object relations*. Jessica Kingsley Publishers.
- Levitt, H. M. (2018). How to conduct a qualitative meta-analysis: Tailoring methods to enhance methodological integrity. *Psychotherapy Research*, 28(3), 367-378. <https://doi.org/10.1080/10503307.2018.1447708>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.
- Major, C., & Savin-Baden, M. (2010). *An introduction to qualitative research synthesis: Managing the information explosion in social science research*. Routledge.
- Malloch, S., Shoemark, H., Črnčec, R., Newnham, C., Paul, C., Prior, M., & Burnham, D. (2012). Music therapy with hospitalized infants: The art and science of communicative musicality. *Infant Mental Health Journal*, 33(4), 386-399.
- Malloch, S., & Trevarthen, C. (Eds.). (2010). *Communicative musicality: Exploring the basis of human companionship*. Oxford University Press.
- Matney, W. (2021). Music therapy as multiplicity: Implications for music therapy philosophy and theory. *Nordic Journal of Music Therapy*, 30(1), 3-23. <https://doi.org/10.1080/08098131.2020.1811371>
- Mårtensson Blom, K. (2011). Transpersonal-spiritual BMGIM experiences and the process of surrender. *Nordic Journal of Music Therapy*, 20(2), 185-203. <https://doi.org/10.1080/08098131.2010.487645>
- McFerran, & Wigram, T. (2005). Articulating the dynamics of music therapy group improvisations. *Nordic Journal of Music Therapy*, 14(1), 33-46. <https://doi.org/10.1080/08098130509478123>
- Meadows, A., & Wimpenny, K. (2016). Synthesis of reflexive research. In B. Wheeler and K. Murphy (Eds.), *Music Therapy Research* (3rd ed.). Barcelona Publishers.
- Meadows, & Wimpenny, K. (2017). Core themes in music therapy clinical improvisation: An arts-informed qualitative research synthesis. *The Journal of Music Therapy*, 54(2), 161-195. <https://doi.org/10.1093/jmt/thx006>
- Moustakas, C. (1994). *Phenomenological research methods*. Sage.

- Odell-Miller, H. (2001). Music therapy and its relationship to psychoanalysis. In Y. Searle & I. Streng (Eds.), *Where analysis meets the arts* (pp. 127-152). Karnac Books.
- Oldfield, A., Bell, K., & Pool, J. (2012). Three families and three music therapists: Reflections on short term music therapy in child and family psychiatry. *Nordic Journal of Music Therapy*, 21(3), 250-267. <https://doi.org/10.1080/08098131.2011.640436>
- Ogden, T. (1994). *Subjects of analysis*. Jason Aronson
- Palaganas, E. C., Caricativo, R. D., Sanchez, M. C., & Molintas, M. V. P. (2017). Reflexivity in qualitative research: A journey of learning. *The Qualitative Report*, 22(2), 426-438. <http://nsuworks.nova.edu/tqr/vol22/iss2/5>
- Ruud, E. (2008). Music in therapy: Increasing possibilities for action. *Music & Arts in Action*, 1(1), 46-60. <http://www.musicandartsinaction.net/index.php/maia/article/view/musicintherapy>
- Smetana, M., Stepniczka, I., & Bishop, L. (2023). COME_IN: A qualitative framework for content, meanings and intersubjectivity in free dyadic improvisations. *Nordic Journal of Music Therapy*, 32(2), 157-178. DOI: 10.1080/08098131.2022.2084638
- Smith, J. A., & Osborn, M. (2003). Interpretive phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51-80). Sage.
- Smith, J. A. (2004). Reflecting on the development of interpretive phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54. <https://doi-org.ezproxy.haifa.ac.il/10.1191/1478088704qp004oa>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, method and research*. Sage.
- Stern, D. N. (1971). A micro-analysis of mother-infant interaction: Behavior regulating social contact between a mother and her 3 1/2-month-old twins. *Journal of the American Academy of Child Psychiatry*, 10 (3), 501-517.
- Stern, D. N. (1995). *The motherhood constellation*. Basic Books.
- Stern, D. N. (2000). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. Basic Books
- Stern, D. (2004). *The present moment in psychotherapy and everyday life*. W. W. Norton & Company.
- Stern, D. N. (2010). *Forms of vitality: Exploring dynamic experience in psychology, the arts, psychotherapy, and development*. Oxford University Press.
- Stige. (2016). Culture-centered music therapy. In J. Edwards (ed.), *The Oxford handbook of music therapy* (pp. 538-556). Oxford University Press.
- Stige, B., Ansdell, G., Elefant, C., & Pavlicevic, M. (2010). *Where music helps: Community music therapy in action and reflection*. Routledge.
- Stolorow, R., & Atwood, G. (1992). *Contexts of Being. The Intersubjective Foundations of Psychological Life*. Analytic Press.
- Timulak, L. (2009). Qualitative meta-analysis: a tool for reviewing qualitative research findings in psychotherapy, *Psychotherapy research*, 19, 591 – 600. <http://dx.doi.org/10.1080/10503300802477989>
- Timulak, L., & McElvaney, R. (2013). Qualitative meta-analysis of insight events in psychotherapy. *Counselling Psychology Quarterly*, 26, 131-150. <http://dx.doi.org/10.1080/09515070.2013.792997>
- Trevarthen, C., & Malloch, S. (2000). The dance of wellbeing: Defining the musical therapeutic effect. *Nordic Journal of Music Therapy*, 9(2), 3-17. <https://doi.org/10.1080/08098130009477996>
- Trondalen, G. (2016). *Relational music therapy*. Barcelona Publishers.
- Trondalen, G. (2019). Musical intersubjectivity. *The Arts in Psychotherapy*, 65, 101589. <https://doi.org/10.1016/j.aip.2019.101589>.
- Tucek, G., Maidhof, C., Vogl, J., Heine, A., Zeppelzauer, M., Steinhoff, N., & Fachner, J. (2022). EEG Hyperscanning and qualitative analysis of moments of interest in music therapy for stroke rehabilitation—A feasibility study. *Brain Sciences* (2076-3425), 12(5), 565. <https://doi-org.ezproxy.haifa.ac.il/10.3390/brainsci12050565>
- Warner, C. (2014). The evolution of group participation through sounds and musical play: Participatory action research. In J. De Backer & J. Sutton (Eds.), *The music in music therapy: psychodynamic music therapy in Europe: Clinical, theoretical and research approaches* (pp. 284-300). Jessica Kingsley Publishers.
- Wigram, T. (2004). *Improvisation – Methods and techniques for music therapy clinicians, educators and students*. Jessica Kingsley Publishers.
- Wosch, T., & Wigram, T. (Eds.). (2007). *Microanalysis in music therapy: Methods, techniques and applications for clinicians, researchers, educators and students*. Jessica Kingsley Publishers.

Ελληνική περίληψη | Greek abstract

Στιγμές τριτότητας στη μουσικοθεραπεία: Μια ποιοτική μετα-ανάλυση βασισμένη στη διυποκειμενικότητα της Jessica Benjamin

Tamar Hadar

ΠΕΡΙΛΗΨΗ

Υπόβαθρο: Η μελέτη των διυποκειμενικών διαδικασιών είναι εμφανής σε διάφορες θεραπευτικές σχολές, μεταξύ των οποίων και η μουσικοθεραπεία. Πολλοί ερευνητές ασχολούνται με τα διυποκειμενικά νοήματα των μουσικών εμπειριών στη μουσικοθεραπεία. Εστιάζοντας στη διερεύνηση της διαμόρφωσης των διυποκειμενικών σχέσεων μέσω του δυαδικού αυτοσχεδιασμού, η παρούσα έρευνα επικεντρώθηκε σε έξι μελέτες μουσικοθεραπείας, οι οποίες περιλαμβάνουν εκτενείς περιγραφές κλινικών αυτοσχεδιασμών ή μουσικοθεραπευτικά ενημερωμένων (αλλά μη κλινικών) αυτοσχεδιασμών, οι οποίοι επίσης δίνουν έμφαση

σε σχεσιακές διαστάσεις. *Μέθοδος*: Ακολουθώντας μία αλληλουχία τεσσάρων βημάτων, πραγματοποιήθηκε μετα-ανάλυση των έξι μελετών. Μετά τον εντοπισμό του ερευνητικού ερωτήματος, η ερευνήτρια συνέλεξε σχετικές μελέτες ποιοτικής και μικτής μεθοδολογίας. Κρατώντας έξι μελέτες στην ανάλυση, διεξήχθη θεματική ανάλυση, για την κατανόηση των υποκείμενων νοημάτων που αντανakλούν τη διυποκειμενική ουσία του δυαδικού αυτοσχεδιασμού. Τέλος, η ερευνήτρια διαμόρφωσε μια εννοιολογική οργάνωση των διαφορετικών φάσεων της τριτότητας, όπως αυτές αντανakλώνται στον κλινικό αυτοσχεδιασμό, διαμορφώνοντας την ενότητα των αποτελεσμάτων. *Αποτελέσματα*: Μέσω της θεματικής ανάλυσης εντοπίστηκαν δύο κεντρικά θέματα, τα οποία ανέδειξαν διακριτές αναπτυξιακές φάσεις στον κλινικό αυτοσχεδιασμό και αντανakλούν τις διυποκειμενικές διαδικασίες, όπως περιγράφονται από την Jessica Benjamin: (1) Την αναδυόμενη μουσική αναγνώριση: προσεγγίζοντας «τον έναν στο τρίτο», και (2) την αναγνώριση του μουσικού διαχωρισμού: προσεγγίζοντας «τον τρίτο στον έναν». *Συζήτηση*: Βασισμένη στη διυποκειμενική θεωρία της Jessica Benjamin, η παρούσα μελέτη πραγματεύεται την σύνθετη έννοια της τριτότητας, και των πιθανών εκδηλώσεών της στον κλινικό αυτοσχεδιασμό. Αυτό το άρθρο δείχνει πώς οι αυτοσχεδιαστικές διαδικασίες επιτρέπουν το άνοιγμα ενός διυποκειμενικού χώρου μεταξύ πελάτη και θεραπευτή και καθιστούν δυνατή την αμοιβαία αναγνώριση της ετερότητας του άλλου.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, αυτοσχεδιασμός, διυποκειμενικότητα, τριτότητα, μετα-ανάλυση, Jessica Benjamin

ARTICLE

An open door to the job market? Music therapy students' reflections on practice placement in Norway

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ABSTRACT

This study explores the transition between learning at university and learning in a work context through practice placement. It was conducted at the University of Bergen (UiB), which offers a five-year programme in music therapy. Practice placement is integrated at all levels of the programme, starting with observation of music therapy, to a placement where students work more autonomously. The aim of this study was to learn from the experiences of students participating in the programme, as their insights are crucial for informing the programme's content. Our question was: How do students from the UiB five-year integrated music therapy programme reflect on their internship experiences, and how can we understand their reflections from a work-based learning perspective? To investigate this, we conducted two focus groups, each with five students. Following a thematic analysis of the data, three main themes and six sub-themes were developed: 1. Developing an identity as a music therapist (1.1. Gaining a professional identity, 1.2. Finding a voice in interdisciplinary meetings); 2. An open door to the job market (2.1. Learning from experience, 2.2. Developing new networks); and 3. Challenges with the music therapy practice placement (3.1. Feeling side-lined, 3.2. Lack of a broader teaching model). The themes, grounded in the empirical findings, are discussed from a sociocultural perspective, drawing on concepts such as apprenticeship learning, community of practice, and weak ties. This article concludes with implications for practice and suggestions for further research.

KEYWORDS

music therapy
education,
practice placement,
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work based learning,
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INTRODUCTION

Practice placement is usually a central component of music therapy education (Bolger & Murphy, 2024). This article concerns students' reflections on their practice placement experiences during and after their five-year integrated music therapy programme at the University of Bergen (UiB). The article has been written as a collaborative process between an educator, a student, and a graduate from UiB, and in discussion with an educator from Queen Margaret University, Edinburgh. The UiB music therapy programme includes five compulsory periods of practice placement, which support students' learning from active observation to working independently as practitioners. Thus, upon completing the programme, music therapy graduates are ready to practise autonomously. The aim of practice placements is to help students develop a reflective, critical, and creative relationship with their work. This study does not focus on the details of how practice placements are organised and implemented, but instead aims to contribute to a dialogue between students and staff about these practical components of the programme. While the authors of this article are listening to the students' experiences from one music therapy programme (and, in doing so, hope to respond and increase the programme's quality), they consider the relevance more broadly and to other training programmes too. The purpose of this article is to explore and reflect on the integral role of practice placements in music therapy education, specifically within the context of the five-year integrated programme at UiB.

Background literature

To investigate the objective of this study, we carried out a literature search to explore relevant previous studies in this area. Search terms including "work-based" and "practice-based learning" were used, and there was found to be little research concerning music therapy students' reflections on practice placement, although we recognise that some programmes gather such feedback on a regular basis through placement audits and other staff/student consultation.

We position our study in the context of what has been labelled work-based learning (WBL). WBL, which in this context can also be referred to as practice-based learning (PBL), involves independent practice with the guidance of a supervisor, often a music therapist. According to the Bologna process, all university degrees must qualify students for real working life (Schomburg & Teichler, 2011). The Organisation for Economic Co-operation and Development (Samuelsen et al., n.d.) labels educational initiatives that integrate academic learning with 'real-world' work experiences as WBL (Shoenfelt et al., 2013). WBL is important in educational settings to meet the rapidly changing trends of globalisation and technological change. WBL can be described as a structured approach combining classroom teaching with practical work experience, allowing students to acquire and apply knowledge and skills in a professional setting (Tellmann, 2017). By bridging theory and practice, WBL provides students with opportunities to gain 'hands-on' experience for a particular profession and, indeed, across different professions, and may be in the form of a placement, internship, apprenticeship, cooperative education programme, or mentorship. The Bologna Process

(Schomburg & Teichler, 2011) highlighted the voices of students in higher education as one of the key principles in promoting student-centred learning.

Turning to music therapy research literature, we searched for relevant studies to focus initially on research that highlights students' experiences. The chosen studies demonstrate the value of listening to the voices of the students and learning from local contexts. We believe that the positioning of students' voices is essential to ensure that practice placements are grounded in mutuality and collaboration and learning from student's experiences. Following this line of reasoning, we see students as being on the frontline of the profession. Their first-hand experiences provide valuable insights into the evolving needs and emerging trends in music therapy, and they help us identify gaps in the existing curricula. By incorporating student feedback, the programme can ensure that their programmes remain relevant and responsive to the demands of real-world practice (Matthews & Dollinger, 2023).

From an Australian perspective, Seah and McFerran (2015) followed five music therapists in the first six months of their practice, focusing on their transition from student to therapist. They found that the students experienced a mix of being able to develop mental strengths and personal resources while also experiencing challenges related to taking ownership of the situation. The interviews revealed a paradoxical feeling of excitement and nervousness when entering practice. In a more recent USA study, Byers and Meadows (2022) found six major barriers to professional identity formation: (1) a lack of access to and support from fellow music therapists; (2) workplace bureaucracy and tedium; (3) feeling misunderstood by non-music therapist team members; (4) constantly needing to advocate and prove their worth; (5) low job satisfaction, including excessive work hours, unrealistic productivity goals, low salaries, and lack of job security; and (6) the emotionally draining nature of clinical work. They suggest that creating support systems through professional organisations is essential for supporting early career identity formation. Support incentives can, for example, be early career support programmes that include mentorship, supervision, and advocacy training.

In the USA, Wheeler (2002) interviewed music therapy students with the aim of investigating their experiences and concerns during internships. Different areas of interest were identified, such as challenges with fear and anxiety encountered by students when meeting clients for the first time, the means of dealing with such challenges in terms of developing self-devised strategies for dealing with discomfort, involvement with clients, and areas of learning, supervision issues, and structure of the practicum (Wheeler, 2002). Wheeler's study calls for flexibility in approaching clinical training and for working to meet individual student's needs. In a quantitative study, Oklahoma et al. (2019) explored differences between the students' and supervisors' understanding and expectations of learning in practice. Results showed perceptual differences between students and supervisors in evaluating practicum experience, training expectations, and evaluation of students' clinical, musical, and professional competencies.

This is the first research study into music therapy WBL in a Norwegian setting. As such, the study fills an identified knowledge gap. Learning from previous studies, and leaning into our hope to share practice and inform others, we asked the following question: How do students from the UiB five-year integrated music therapy programme in Norway reflect on their internship experiences, and how can we understand their reflections from a WBL perspective?

METHOD

This study draws its epistemological foundations from phenomenology and hermeneutics, situated within the broader framework of constructionism (Kvale et al., 2014; Matney, 2018). The process of writing this article started with a shared interest between students and staff in exploring the role of PBL within the UiB's five-year music therapy programme. This research is consequently motivated by a desire to find out how music therapy students reflect on their experiences from practice placements, discuss implications for practice, and contribute to the ongoing development of the programme. By interviewing students from the programme, we gained insight into their experiences and specific challenges related to practice placement. The project grew out of a general interest in how practice placement works at the integrated music therapy programme in Bergen. The first author of this article applied for funding from Polyfon, a music therapy knowledge cluster located at UiB (Polyfon, 2023). The first author invited a selection of recent graduates and final-year students to reflect in focus groups on their internship experiences, such as job opportunities, alumni networks, self-care, and relationships with colleagues. A call was made, and current and past students were recruited based on the response. Criteria for participation were based on their status as students in the programme, either fifth year or one-year post-graduating. Two focus groups were organised, one with students and one with music therapists. Participation was voluntary and current students were reassured that their choice about participation would not affect their programme or learning in any way.

Recruitment and a brief description of the participants in the study

Ten students participated in the study, seven identified as male, and three as female, aged between 23 and 25 years. They were chosen as part of a purposive sampling approach, which seeks to recruit information-rich cases that can be studied (Kvale & Brinkman, 2015). We wanted to talk with specific individuals who were either enrolled in the five-year integrated music therapy programme and in their fifth (final) year, or with those who had graduated from the programme within a year. All participants had taken part in practice placements throughout their programme in different work areas. As such, they had gained experiences with music therapy in different contexts, such as hospitals, schools, child protection and drug rehabilitation centres.

Conducting the focus groups

We conducted two focus groups with five persons in each group. Across the two focus groups, each lasting approximately 60 minutes, we allowed participants to elaborate on what they felt was important to discuss. Our choice of research method was inspired by a narrative, episodic interview approach (Flick, 2000; Mueller, 2019), which aligns with our goal of capturing rich, experiential insights from the perspectives of students and graduates. The focus groups were facilitated using an interview guide that also allowed room for spontaneous follow-up comments or questions (Clarke & Braun, 2014). The prompts included asking participants about their experiences of job opportunities, alumni networks, self-care, and relations with colleagues. Before the focus groups began, participants were reminded of the study's purpose and consent, and that they were being

audio-recorded. They were conducted in Norwegian and translated into English later in the analysis process. The participants were invited to read and check through the interview transcriptions afterwards, but only a small number of informants responded to this offer. Where they did, we used the feedback to enhance our understanding. This procedure is like member checking, which aims to enhance trustworthiness, accuracy, credibility, and transferability (Seale, 1999).

Reflections on biases and positionalities

The positionalities of the authors need to be clarified as each brings a different perspective. The first author, Viggo Krüger, has a role as both a teacher of some of the participants and researcher. The second author is a graduate of the programme, and the third author was a student whilst this article was being written. The fourth author is from another music therapy programme at a different university. Krüger's role as teacher and researcher likely influenced how and what participants shared about their experiences and which topics they chose to discuss. Acknowledged as problematic and paradoxical in the research literature, the double role presents challenges, and it is imperative to examine the specific benefits and pitfalls for the particular research context (Kvale, 1999). Negative aspects include potential bias in responses and findings due to an established teacher-student relationship. However, efforts were made during the focus groups to maintain open dialogue, allowing participants to express themselves freely.

Thematic analysis

Thematic analysis was chosen as the analytic technique for its suitability in uncovering patterns and underlying meanings within the diverse dataset obtained from the focus group discussions. Given the study's exploratory nature and the aim of understanding students' reflections on their internship experiences, thematic analysis offered a flexible and adaptable framework (Hoskyns, 2016) yet rigorous approach to identify and interpret key themes emerging from the data. Following guidelines outlined by Clarke and Clarke (2014), the process of analysing the data followed these steps:

1. *Data transcription*: The interview audio files were transcribed using Microsoft Word. While the first author conducted the focus groups, the second author transcribed them and then translated them from Norwegian to English.
2. *Data familiarisation*: While reading and re-reading the transcription, notes were written of initial impressions, emerging ideas, and noteworthy observations.
3. *Generating initial codes*: Each initial code generated in this stage was crafted to encapsulate specific aspects and nuances in the data. This systematic coding process organised the data into manageable units, facilitating further analysis. In this part of the process, the codes and relevant quotes were also translated from Norwegian to English, and English was used from this point on in the analysis.
4. *Identifying and collating themes*: In this phase, the analysis shifted focus towards identifying overarching themes. This entailed a methodical and in-depth review of the generated codes

to identify commonalities, recurring concepts, and patterns that transcended individual codes. Codes were grouped into potential themes and sub-themes, thus providing a framework for further exploration.

5. *Reviewing and refining themes*: In this stage, the themes were viewed in relation to the entire data set and the initial codes, which led to the refinement of the identified themes.

For the theoretical discussion, we relate to a sociocultural perspective inspired by Lave and Wenger (1998), Lave (1988) and Granovetter (1973). We discuss how a WBL-oriented approach to music therapy education can be understood in terms of concepts such as community of practice, apprenticeship learning and weak ties. These are concepts previously discussed in the literature on practice placement and music therapy. For example, Vaillancourt (2012) writes about apprenticeship in supervision. She relates the term apprenticeship to Lave and Wenger (1991), who advocate that apprenticeship should continue as it resonates with the idea of passing on good practice. However, like a folk tune being passed on aurally, it is important that knowledge is not fixed, and practice can evolve through such embodied exchange. Arnesen (2005) also emphasises the need to train the supervisors and discusses how to facilitate and ensure the quality of a good internship. The third author was responsible for carrying out the first three steps of the method. In the fourth step, the first three authors were involved in a collective analysis process, as influenced by Eggebø (2020). During this process, we reviewed the data and discussed the data material. Towards the end of the analysing process, the fourth author was invited to join the discussion through online meetings.

Ethical considerations

The study was approved by RETTE (System for Risk and Compliance), which is UiB's system for the processing of personal data in research. The participants were informed of all aspects of the study and signed consent before taking part. Careful planning and consideration of all parties ensured that the focus group was conducted ethically and appropriately.

FINDINGS

The results are presented as constructed themes based on the analytical steps described, and translated extracts of the participants' focus groups (taken from the transcription) are included. Some of the codes from the original analysing process are included for clarity.

1.0 Developing an identity as a music therapist	2.0 An open door to the job market	3.0 Challenges with the music therapy practice placement
1.1 Gaining a professional identity	2.1 Learning from experience	3.1 Feeling side-lined
1.2 Finding a voice in interdisciplinary meetings	2.2 Gaining access to new networks	3.2 Lack of a broader teaching model

Table 1: Overarching themes and subthemes identified during data analysis

1.0 Developing an identity as a music therapist

1.1 *Gaining a professional identity*

The first subtheme concerns insights on gaining an identity as a professional. All the participants regarded practice placement as important and a good start in exploring their professional role as a music therapist. The participants conveyed various accounts of how practice placement formed their professional identity. Practice placement was expressed as a good experience and as important for their developing identity as a music therapist. For some, practice placement was the most important part of the programme, where they could get the most out of the programme by utilising skills and techniques learned at university.

Deeper understanding

Practice placement was described as an important way for students to gain a deeper understanding of theoretical concepts they were learning about at the University. As one participant explained:

The scientific part [of the programme] is one thing, and the articles to which you are introduced about music therapy are another thing, but when you put it together with practice, it at least gives me a much greater meaning and greater insight.

Moreover, practice placements were described as time for exploring oneself as a therapist, as this participant highlighted, “For my part, it was just about finding myself as a therapist.”

1.2 *Finding a voice in interdisciplinary meetings*

In the focus groups, participants talked about how they experienced meeting other healthcare professionals from professions such as medicine, psychology, and social work. The second sub-theme concerns these experiences and their need to find their voice.

Exploring the cornerstone model of music therapy

Some of the students explained that some models of music therapy supported them in talking about music therapy, as illustrated by this participant: “I’m a big fan of the fact that we have some such cornerstones and explanatory models for music therapy to preserve space that we as music therapists can put into it.”

Being misunderstood and learning to adapt

However, some felt that the challenge of protecting the uniqueness of music therapy also put them in difficult situations. They expressed a feeling of not being able to communicate in a way that their practice could be understood, and the language of music therapy was somehow problematic, as explained here: “I get a bit frustrated as to why we use such vague words from the programme that other professionals can only vaguely interpret [...] this creates room for misunderstanding.” In finding their voice as music therapists, it was important for them to reconsider or adapt certain

familiar concepts, especially when working in an area where music therapy is less well known, as conveyed by this statement:

I think we must think about how we can adapt to and enter the fields we want. If this comes at the expense of not using words such as "musicking" and all these terms, then I think it is a price worth paying.

Reciprocity of finding your voice

To maintain a voice, participants felt it was necessary to relate to the language of other disciplines and understand how other professionals communicated, expressed by one of the participants in the following way: "Being well-versed in terminology that is common between disciplines and between professional fields means that you [...] interact with other professions." Finding your voice as a professional music therapist was described as a reciprocal process, as this participant explains:

[finding your voice] occurs when it goes both ways [...] if we can express ourselves, and if we know languages from other fields, but can still preserve our own so that others can also spin off our proposals [...] otherwise, it is not interdisciplinary.

2.0 An open door to the job market

2.1 Learning from experience

Most participants considered the placement a soft transition to work life, a transition where safety (particularly through frequent supervision) played a key role. Practice placement was described as an arena for experiential learning, where meeting people experiencing very difficult life circumstances was very important for their own growth and development as a therapist, as this quote illustrates, "You meet slightly different people in practice, so you at least have a little insight into how you react in challenging situations, for example if you meet someone with a history of abuse." Moreover, one challenge experienced by the students was that they sometimes felt overprotected, hindering them from learning from experiences, described in this quote: "You are not allowed to work with the most urgent cases [...], so you never quite know how to react in real life when something even more extreme comes up."

2.2 Developing new networks

Creating job opportunities

The students described practice placement as a strategy for making connections and looking for potential job opportunities in the future. Learning through practice placement incorporated learning to create networks: "It could be that your plan is to go back to the lung department in a doctoral position, then practice [placement] was very important for making contacts."

The role of improvisation

Creating networks for future job possibilities was described in musical terms to nurture relationships with others, explained by this participant:

It is about how we engage with that network, and how you treat those contacts afterwards. There might be a little musical improvisation in a way... that you can't just come and ask if you can get a job very braggingly. You must be dynamic in a way it as relational interaction, you must be humble in a way.

3.0 Challenges with practice placement

3.1 *Feeling side-lined*

Lack of integration

The lack of integration of practice placement components into the study programme was raised as a concern. Some participants suggested that the university programme should focus more on preparing the students before their first practice placement and that being put in a situation where they were out of their comfort zone felt like “being a fish on dry land,” as one of the participants said.

Lack of supervision in how to engage in interdisciplinary teams

One of the challenges with placements was described by the participants as the lack of possibilities for being included in an interdisciplinary team and a lack of supervision from the programme, illustrated by this quote from one of the participants: “The challenge is that if you do not receive training in how to work in an interdisciplinary team, you can quickly be sidelined.” Furthermore, to avoid the feeling of being sidelined, one of the participants proposed that the students should not only stick with the practice teacher during placement but, rather, try to get involved as much as possible with other professionals at the workplace.

3.2 *Lack of a broader teaching model*

This subtheme concerns participants' reflections on how the programme lacked a broader teaching model, which risked students becoming too narrowly focused. For example, one of the participants felt that too much focus on the musical aspects of music therapy could be limiting and reduce the possibility of wider understanding and reflected in the following way: “Because you may have a lot of focus on the musical, that is something that is a disadvantage.”

The need for a wider range of knowledge

One of the students felt that the programme's teaching did not cover the full picture regarding interdisciplinary knowledge and skills: “It's fair enough that you have a specialist skill, but at the same time, there should be a wider range (of knowledge) because otherwise, you might even feel that you are being left side-lined.” Another participant felt that they lacked the counselling skills they needed for practice: “Conversation technique, that was something I felt was lacking in practice and

you are thrown into things that you don't feel confident in doing." This lack of confidence seemed to create a sense of uncertainty and a lack of understanding of what was needed in certain situations: "I thought about it afterwards, that I need more training in how to ask and answer questions."

Learning from other disciplines

Some participants said the programme should review their learning models to encompass learning from other disciplines: "If we only adopt the psychology models, then we won't be able to bounce back and forth in the same way."

Supervising the supervisors

One of the students explained that the programme should facilitate more supervision for practice placement supervisors, and furthered: "Those who are internship supervisors should simply get a kind of introduction to supervision [...] everyone should have some sort of insight when you are a supervisor."

DISCUSSION

We continue with a theoretical discussion based on the empirical findings from a sociocultural perspective. In summary, our study has revealed that practice placement plays a crucial role in the music therapy master education programme at UiB. Current and past students in the programme have emphasised the importance of this readiness for future work, including the ability to establish networks, collaborate with professionals from other fields, and address challenges that arise during practice placement. Participants expressed that confidence in practice is vital for developing a professional identity, which often stems from effectively navigating unexpected situations. Additionally, participants reported meaningful experiences for both themselves and their clients during practice placement, fostering a sense of achievement and belief in their ability to make a positive difference. Practice placements offer students the opportunity to apply learning and skills from the programme and facilitate the development of professional competencies such as communication and teamwork. The benefits of practice placement include gaining hands-on experience, developing skills and knowledge, learning from experienced professionals, and building professional networks, which can significantly impact future employment prospects. However, our study highlights that practice placement is a nuanced and complex subject, requiring multifaceted solutions as there is no one-size-fits-all approach to WBL.

Our findings are consistent with those of previous qualitative studies on students' experiences of practice placement, which have highlighted both the positive and negative (Beyers et al., 2022; Lim & Quant, 2017; Seah & McFerran, 2015; Wheeler, 2002). These studies showed that students can develop their music therapist self during practice placement and learn how to navigate different clinical situations. We view the student's placement experience as their transition from being less to more experienced. Throughout this transition, students require support from both their fellow students and the programme team for mentorship and guidance. We understand that students' networking efforts involve maintaining close contact with familiar individuals and actively seeking out new connections, leading them to encounter new people and emerging contexts. Developing new

networks is an important avenue for creating work opportunities upon graduation. Indeed, a survey of graduates' employment from the University of Limerick, Ireland (Kelly & Moss, 2022) revealed that 34% of students continued to work in their final placement setting after qualifying. According to Byers and Meadows (2022), who frequently observed that students felt misunderstood by non-music therapist team members, our study underscores the importance of supporting students navigating work settings where music therapy may be less well understood.

Practice placement as learning through work

Our study underscores the significance of placement learning tailored to networks beyond the academic programme and highlights specifically the transition from university learning to practice situations. WBL, as discussed in the introduction, focuses on generating new integrative knowledge to tackle complex real-world issues. This knowledge emerges from dealing with the 'messy' complexities of real-life problems and is inherently emergent and complex. As some participants in our study noted, it is also not always a comfortable process. In Norway, music therapists are employed in diverse areas where increasingly challenging situations occur. Recent job market shifts require newly qualified music therapists to be prepared for a broader spectrum of work. This shift creates new demands for music therapy education providers (Halås & Fuhr, 2020). The expanding employment opportunities for music therapists, particularly within the mental health sector, including child protection and substance abuse treatment, underscore the evolving contexts for practice placements. Consequently, music therapy programmes must adapt to remain aligned with these developments in the field.

Creating new identities and navigating perspectives

Participants reflected that their music therapist self is being formed through their practice placement learns. According to Wenger (1998), apprenticeship learning involves establishing connections within professional networks and contributes to constructing a new identity. The study revealed that practical experience is crucial for students to learn new terminologies and participate in new ways. Wenger defines identity as a negotiated experience within a community where individuals define themselves through their participation. Expanding on this, it is essential to nurture individual trajectories so that students can develop their own approach as music therapists. Students need a supportive environment with thoughtful colleagues and supervision to practise, innovate and lead. Becoming a music therapist involves engaging with multiple communities of practice. As students navigate various contexts, each community will contribute to their development. Wenger emphasises that learning occurs not only within separate communities but also between overlapping and interrelated ones, described as the nexus of multi-membership, as described in the following way:

The job of brokering is complex. It involves processes of translation, coordination, and alignment between perspectives. It requires enough legitimacy to influence the development of a practice... It also requires the

ability to link practices by facilitating transactions between them, and to cause learning by introducing into practice elements of another. Toward this end, brokering provides a participative connection. (p. 109)

Brokering, as described by Wenger (1998), is a complex process involving translation, coordination, and alignment between perspectives. The interviews conducted for our study showed that students gained practical experiences which were valuable for future connections. As one participant noted, maintaining humility in interactions was important for preserving relationships post-placement, as these connections could be beneficial for future employment. Although dated, Granovetter's (1973) concept of "the strength of weak ties" (p. 1360) remains relevant for this view. According to Granovetter, weak ties, characterised by lower levels of intimacy, trust, and emotional intensity, can be more useful than strong ties in career development. Weak ties, such as a brief encounter with a lead practitioner or researcher, can provide access to new information, resources, and opportunities. In the trajectory from the programme to the job market, weak ties can facilitate access to new professional networks and offer different perspectives. However, strong ties such as friends, colleagues or peers still play a significant role. As we have learned, the interplay between strong and weak ties matters when graduates look to the professional job market.

Implications for practice

Based on the findings from this study, we present the following implications for the programme at UiB and others that have a similar structure. Firstly, professionals from other disciplines should collaborate with the programme through teaching or research. One example that could be drawn on is the Practice-Academic Home Framework fostered at Queen Margaret University Edinburgh. This framework enables exchange between practitioners, educators, and service users so that there is easier movement between practice and university. Such a collaboration in a community of co-learning, education and knowledge exchange allows, for example, practitioners to undertake research and academic staff to continue practice. Secondly, as we have seen narrated by the participants in this study, students regarded the role of placement supervisor as key to their support and learning but also appreciated being allowed to work autonomously and discover for themselves. Following this line of thinking, the programme team needs to support each student and pay close attention to their individual learning processes. Regular supervision is essential to this. A third suggestion is to ensure supervisors from other professions are invited to supervise music therapy students. Such interdisciplinary learning is essential and can also support the growth of employment possibilities.

Limitations of study

This study has limitations that are important to consider. As outlined earlier, participants in both focus groups knew the facilitator. As this was not an external facilitator but someone from the programme, it may have influenced how they spoke about their experiences with practice placement. There were also limitations in how we interpreted and discussed the findings. We chose to follow

certain ideas and subjects more than others and engaged in the discussion with a sociocultural perspective, choosing language connected to that discourse.

Suggestions for future research

This study has only revealed a small part of an issue we believe is worth continuing to explore. Following the needs outlined in the Bologna Process (Schomburg & Teichler, 2011), we need to learn more from both students and staff on how to facilitate WBL optimally to prepare students for the future. Firstly, further research could include longitudinal studies to track music therapy students' evolving perspectives and experiences over the duration of their academic programmes and into their professional careers. What happens with the students after five, ten, or fifteen years? Do they stay in the profession or find other paths? Secondly, we suggest undertaking comparative analyses between music therapy students and other practicing professionals such as nurses or social workers. It would be interesting to learn from the differences, similarities or challenges faced with PBL. Thirdly, we suggest adopting student-centred approaches to explore other relevant issues such as research collaborations, policy development, stakeholder ownership, and transdisciplinary. According to the Bologna Process, University programmes should listen to and prioritise student feedback. Our study aligns with this, as the aim was to assess a central component of the programme at the UiB. Future research should regard the students as key stakeholders whose perspectives are essential in assessing the programme's quality (Matthews & Dollinger, 2023).

Concluding reflections

This qualitative focus group study was grounded in the belief that the Norwegian education system requires research to glean insights from students both during and after their university education programme. Despite being conducted within a Norwegian context, we believe this study holds relevance for other music therapy training programmes and their PBL. Drawing on the findings of this study, it appears pertinent to further explore how students can access the job market, aligning with the overarching goal of higher education, as outlined by international policy recommendations.

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REFERENCES

- Arnesen, M. T. (2005). Å lære i praksis [To learn in practice]. In I. Berger (Ed.), *Musikkterapi [Music Therapy]* (pp. 9-18). Norsk Forening for Musikkterapi.
- Bolger, L., & Murphy, M. (2024). Understanding the impact of international music therapy student placements on music therapy practice and professional identity. *Nordic Journal of Music Therapy*, 33(3), 189–207. <https://doi.org/10.1080/08098131.2023.2268692>
- Byers, C., & Meadows, A. (2022). Professional identity formation of early career music therapists. *Music Therapy Perspectives*, 40(1), 33-41. <https://doi.org/10.1093/mtp/miab024>
- Clarke, V., & Braun, V. (2014). Thematic analysis. In T. Teo (Ed.), *Encyclopedia of critical psychology* (pp. 1947–1952). Springer.

- Eggebo, H. (2020). Kollektiv kvalitativ analyse [Collective qualitative analysis]. *Norsk Sosiologisk Tidsskrift* [Norwegian Journal of Sociology], 4(02), 106-122. <https://doi.org/10.18261/issn.2535-2512-2020-02-03>
- Flick, U. (2000). Episodic interviewing. In M. W. Bauer and G. Gaskell (Eds.), *Qualitative researching with text, image and sound* (pp. 75–92). SAGE.
- Granovetter, M. (1973). The strength of weak ties. *American Journal of Sociology*, 78, 1360–80.
- Halås, M. S., & Fuhr, G. (2019). *Kartlegging av musikkterapeuter som profesjonsgruppe* [Mapping the profession of music therapy in Norway]. Norsk Forening For Musikkterapi [Norwegian Association for Music Therapy].: <https://www.musikkterapi.no/nyheter/kartlegging/oppgave?fbclid=IwAR2I0D7qRsKSLCZ3WdwsSSluJT6Qzi47LvTAVdnnei9SAmlR7xNSE1S7mc>
- Hoskyns, S. (2016). Thematic analysis. In K. Murphy & B. L. Wheeler (Eds.), *Music therapy research* (3rd ed., pp. 563-569). Barcelona Publishers.
- Kelly, L., & Moss, H. (2022). Employment after graduation from the MA music therapy, University of Limerick. *Polyphony: Journal of the Irish Association of Creative Arts Therapists*. <http://polyphony.iacat.me/words/employment-after-graduation-from-the-ma-music-therapy-a-survey-of-graduates-from-the-university-of-limerick>
- Kvale, S., & Brinkmann, S. (2015). *Det kvalitative forskningsintervju* [The qualitative research interview]. Gyldendal akademisk.
- Kvale, S. (1999). The psychoanalytic interview as qualitative research. *Qualitative Inquiry*, 5, 87–113. doi:10.1177/107780049900500105
- Lave, J. (1988). *Cognition in practice*. Cambridge University Press.
- Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge University Press.
- Lim, H. A., & Quant, S. (2017). Perceptual differences in music therapy clinical supervision: Perspectives of students and supervisors. *Nordic Journal of Music Therapy*, 28(2), 131-150. <https://doi.org/10.1080/08098131.2018.1528559>
- Matthews, K. E., & Dollinger, M. (2023). Student voice in higher education: The importance of distinguishing student representation and student partnership. *Higher Education*, 85, 555–570. <https://doi.org/10.1007/s10734-022-00851-7>
- Mueller, R. A. (2019). Episodic narrative interview: Capturing stories of experience with a methods fusion. *The International Journal of Qualitative Methods*, 18, 1-11. <https://doi.org/10.1177/1609406919866044>
- Polyfon (2023). *Polyphonic knowledge cluster for music therapy*. Universitas Bergensis. <https://www.uib.no/polyfon>
- Samuelsen, S., Kalamova, M., & Lynch, L. (n.d.). Higher education in Norway - labour market relevance ... <https://www.khrono.no/files/2018/06/08/9789264301757-en.pdf>
- Schomburg, H., & U. Teichler (2011). *Employability and mobility of Bachelor graduates in Europe: Key results of the Bologna process*. Sense Publishers.
- Seah, C. H., & McFerran, K. S. (2015). The transition to practice experiences of five music therapy graduates. *Nordic Journal of Music Therapy*, 25(4), 352-371. <https://doi.org/10.1080/08098131.2015.1080288>
- Seale, C. (1999). *The quality of qualitative research*. Sage.
- Shoenfelt, E. L., Stone N. J., & Kottke, J. L. (2013). Internships: An established mechanism for increasing employability. *Industrial and Organizational Psychology*, 6(1), pp. 24-27.
- Tellmann, S. (2017). *Råd for samarbeid med arbeidslivet: En underveisevaluering* [Advices for collaboration in working life: An evaluation report] (Report 2017/9). Nordic Institute for Studies in Innovation, Research and Education.
- Vaillancourt, G. (2011). Creating an apprenticeship music therapy model through arts based research. *Voices: A World Forum for Music Therapy*, 11(1). <https://doi.org/10.15845/voices.v11i1.341>
- Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. Cambridge University Press
- Wheeler, B. L. (2002). Experiences and concerns of students during music therapy practica. *Journal of Music Therapy*, 39(4), 274-305. <https://doi.org/10.1093/jmt/39.4.274>

Ελληνική περίληψη | Greek abstract

Μια ανοιχτή πόρτα στην αγορά εργασίας; Αναστοχασμοί φοιτητών μουσικοθεραπείας για την πρακτική άσκηση στη Νορβηγία

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ΠΕΡΙΛΗΨΗ

Αυτή η μελέτη διερευνά τη μετάβαση από τη μάθηση στο πανεπιστήμιο στη μάθηση σε ένα εργασιακό περιβάλλον μέσω της πρακτικής άσκησης. Η μελέτη διεξήχθη στο Πανεπιστήμιο του Bergen (UiB), το οποίο προσφέρει ένα πενταετές πρόγραμμα στη μουσικοθεραπεία. Η πρακτική άσκηση είναι ενσωματωμένη σε όλα τα επίπεδα του προγράμματος, ξεκινώντας με την παρατήρηση της μουσικοθεραπείας και προχωρώντας σε πρακτική άσκηση όπου οι φοιτητές εργάζονται πιο αυτόνομα. Ο στόχος αυτής της μελέτης ήταν να μάθουμε από τις εμπειρίες των φοιτητών που συμμετείχαν στο πρόγραμμα, καθώς οι απόψεις τους είναι ζωτικής σημασίας για την ενημέρωση του περιεχομένου του προγράμματος. Η ερώτηση

μας ήταν: Πώς οι φοιτητές του πενταετούς ενσωματωμένου προγράμματος μουσικοθεραπείας στο UiB αναστοχάζονται σχετικά με τις εμπειρίες τους από την πρακτική άσκηση και πώς μπορούμε να κατανοήσουμε τους προβληματισμούς τους από την οπτική της μάθησης μέσω εργασιακής εμπειρίας; Για να διερευνήσουμε αυτό το ερώτημα, πραγματοποιήσαμε δύο ομάδες εστίασης, με πέντε φοιτητές η καθεμία. Ακολουθώντας μια θεματική ανάλυση των δεδομένων, αναπτύχθηκαν τρεις κύριες θεματικές ενότητες και έξι υποθέματα: 1. Ανάπτυξη ταυτότητας ως μουσικοθεραπευτή (1.1 Απόκτηση επαγγελματικής ταυτότητας, 1.2 Εύρεση φωνής σε διεπιστημονικές συναντήσεις), 2. Μια ανοιχτή πόρτα στην αγορά εργασίας (2.1 Μάθηση από την εμπειρία, 2.2 Ανάπτυξη νέων δικτύων), και 3. Προκλήσεις σχετικά με την πρακτική άσκηση στη μουσικοθεραπεία (3.1 Αίσθημα περιθωριοποίησης, 3.2 Έλλειψη ευρύτερου μοντέλου διδασκαλίας). Οι θεματικές ενότητες, οι οποίες βασίζονται στα εμπειρικά στοιχεία, συζητούνται από κοινωνικοπολιτισμική σκοπιά, αντλώντας από έννοιες όπως η μαθητεία, η κοινότητα πρακτικής και οι αδύναμοι δεσμοί. Αυτό το άρθρο κλείνει αναλογίζοντας επιπτώσεις για την πράξη και προτάσεις για μελλοντική έρευνα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

εκπαίδευση μουσικοθεραπείας, πρακτική άσκηση, ανώτατη εκπαίδευση, μάθηση μέσω εργασιακής εμπειρίας, κοινωνικοπολιτισμική θεωρία

ARTICLE

Multimodal vibroacoustic music therapy for functional neurological disorder: The MTFUND clinical protocol and initial impressions from multiple perspectives

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ABSTRACT

Functional Neurological Disorder (FND) is a neuropsychiatric condition caused by problems with the functioning of the nervous system, in which patients experience neurological symptoms, resulting in significant functional impairment and distress. The various subtypes of FND categorise the wide range of diverse symptoms common with the disorder, from motoric to sensory and cognitive. The diverse symptom experience, coupled with common comorbidities and risk factors such as anxiety and mood disorders, make it especially difficult to determine suitable individualised treatment plans for FND patients. Literature suggests that multimodal treatment options would have implications for success with this population, due to the ability to integrate the physiological care and psychological needs of patients. The MTFUND clinical protocol utilises multimodal vibroacoustic music therapy, in which the elements (vibroacoustic therapy and active music therapy) meet the need for individualised care due to their inherent flexibility as interventions, while providing a consistent structured treatment protocol. The MTFUND protocol is presented and details regarding the ongoing research study are outlined. To evaluate the protocol, we conducted semi-structured discussions with patients and therapists. Two separate inductive reflexive thematic analyses were conducted to examine their experiences. The themes contribute to a comprehensive understanding of the patients' experiences with FND, and the therapists' perspectives on implementing the protocol, ultimately contributing towards evaluating the efficacy of the protocol

KEYWORDS

vibroacoustic therapy,
music therapy,
multimodal,
functional
neurological disorder,
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INTRODUCTION

Functional Neurological Disorder (FND) is a neuropsychiatric condition in which patients experience motor and sensory symptoms. However, the pathophysiological experience of symptoms are not due to abnormalities of structures in the brain, but rather changes in the functioning of brain networks, resulting in significant functional impairment and distress (Bennett et al., 2021; Espay et al., 2018; Hallett et al., 2022; Voon et al., 2016). FND is also known as conversion disorder and while both terms are used in the DSM-5, the term “conversion” is thought to be outdated due to the revised diagnostic criterion in the DSM-5, eliminating the requirement of association with psychological stressors to “convert” to symptoms and including positive physical diagnostic features rather than relying on a diagnosis of exclusion (Voon et al., 2016). People with FND can experience a range of diverse symptoms with a wide scope of comorbid diagnoses including depression, anxiety disorders, and dissociation (Butler et al., 2021; Hallett et al., 2022; Pick et al., 2019). FND patients experience comparable levels of disability and physical-health related quality of life as patients with Parkinson’s Disease, but further experience poorer mental-health related quality of life (Voon et al., 2016), and are the second most common reason for a neurological consultation behind a headache (Bennett et al., 2021). FND affects more women than men (around 3:1) and can occur across all ages, but is rare in children under 10 years of age (Bennett et al., 2021; Espay et al., 2018). On a global level, the disorder is as prevalent as multiple sclerosis, with a prevalence of 50-100 cases in 100,000 (Espay et al., 2018).

The most common presentations of FND, or subtypes, are that of functional seizures (also dissociative or psychogenic non-epileptic seizures) and functional movement disorders including tremors, dystonia, limb weakness, or gait disorders. Patients may also experience functional cognitive disorders including symptoms such as chronic dizziness or other cognitive dysfunction (Espay et al., 2018; Hallett et al., 2022). Common treatments for patients with FND include psychotherapy, physical therapy, occupational therapy, speech and language therapy, and hypnosis (Bennett et al., 2021; Espay et al., 2018).

Patients often endure multiple referrals and appointments with a number of different specialists and therapists, hoping for answers to, and relief for, their symptoms. Approaching FND from a biopsychosocial framework allows for the acknowledgement of predisposing, precipitating, and perpetuating factors from biological, psychological, and social viewpoints. Multiple factors within this framework constantly interact with one another at all times, which can trigger FND and/or perpetuate the experience of symptoms (Hallett et al., 2022; Pick et al., 2019; Voon et al., 2016). From this framework, FND presents a clear overlap between the disciplines of psychiatry and neurology. This multifactorial approach to predisposing, precipitating, and perpetuating factors unique to each patient, combined with the diverse range of symptom experience, makes it difficult for professionals to determine treatment plans individualised to their patients’ needs.

Literature specifically regarding conversion disorder/FND and music therapy is limited. However, principles of music therapy literature from psychiatric and neurological contexts allow us to see its implications for use for many symptomatic and/or mechanistic features of FND (Hallett et al., 2022), such as emotional processing (Moore, 2013), anxiety/stress reduction (De Witte et al., 2022; Lu et al., 2021), sensorimotor stimulation (Kogut et al., 2016; Ruotsalainen et al., 2022; Sihvonen et al., 2017), and cognitive functioning (Thaut, 2010).

There are current recommendations for multidisciplinary approaches to consultation, diagnosis, and treatment within FND literature, with some studies suggesting that a multimodal approach to therapy has strong implications for success in integrating both the care of physiological symptoms and psychological needs of patients with FND (Demartini et al., 2014; M. J. Edwards, 2019; Ezra et al., 2019; Jimenez et al., 2019; Lidstone et al., 2020). Thus, this present research has proposed the use of a treatment protocol consisting of a multimodal approach to music therapy utilising vibroacoustic therapy (VAT) and active music therapy methods. In order to further develop and refine this interdisciplinary and multimodal clinical protocol, the present research consists of multiple individual case studies. This paper, specifically, looks to patient and therapist experience of the clinical protocol. The resulting outcomes may contribute to the conceptualisation of clinical results in future publications.

The term multimodality, in reference to treatment, typically refers to the simultaneous application or implementation of multiple therapeutic/treatment modalities to treat a diagnosis. With roots in psychotherapy, the term multimodal therapy (Lazarus, 1976) ensures that multiple areas of concern, are addressed in a treatment plan encompassing methods or techniques from a range of theoretical approaches or disciplines, in order to address the needs of the individual on all system levels (Kozłowska et al., 2012; Lazarus, 1976, 2006). Extending to medicine, the term multimodality tends to emphasise a multidisciplinary aspect, often referred to as combination therapy, indicating the use of more than one method to treat a disease (Combination Therapy, n.d.). Ultimately, both views aim for multiple modalities to assist one another in their outcomes, whether in regard to prognosis, treatment productivity, and/or efficiency (duration) of the treatment plan, contributing to an efficient and effective model of care. For a complex and multifaceted disorder such as FND, the multimodal approach to treatment is naturally complimentary to the biopsychosocial framework, as it acknowledges multiple aspects of a person, looking to the interactions between these factors and how it relates to the disorder. To add an additional layer, we can also consider multimodal interventions as addressing multiple facets of FND simultaneously. Therefore, multimodality, in the context of this protocol, exists in the multiple modes of intervention (how FND is treated) as well as in multiple needs/symptoms being treated simultaneously within that intervention (what elements of FND are being treated).

The treatment modalities within this protocol were selected based on compatibility with current FND treatment recommendations, an inherent element of flexibility or adaptability to allow for individualised care, and being conducive to a multimodal approach to intervention and treatment, as recommended in current literature. In our proposed protocol, we use the terminology “multimodal vibroacoustic music therapy” in order to capture the multiple intervention modalities present within the clinical protocol, those being vibroacoustic therapy (VAT) and active music therapy. When considered as music experiences (Bruscia, 2014), it has been previously suggested that VAT can

contribute to, or inform, active music making, and encourages the therapeutic relationship (Hooper, 2001).

Vibroacoustic therapy (VAT) is a multimodal approach to music therapy, and combines the use of pulsed sinusoidal low-frequency sound, music listening, and therapeutic interaction to treat a patient's physiological and psychological needs simultaneously (Grocke & Wigram, 2007; Hooper, 2001; Punkanen & Ala-Ruona, 2012). Literature outlining the use of vibroacoustic therapy for people with FND is scarce. However, anecdotal clinical evidence suggests that VAT has proven effective for many concerns, symptoms, and comorbidities that are prevalent in patients with FND including muscle tone and range of movement (Katušić & Mejaški-Bošnjak, 2011; Wigram, 1997a, 1997b), stress, anxiety and mood disorders (Campbell et al., 2017; Kantor, Vilímek, et al., 2022; Rüütel, 2002), and chronic pain (Campbell et al., 2017; Kantor, Campbell, et al., 2022; Naghdi et al., 2015).

Active music therapy methods involve the patient by participating in music interactively with the music therapist, for example, through clinical improvisation (Bruscia, 1987; Erkkilä et al., 2012). Clinical improvisation is a well-established music therapy method, used in many contexts for various needs. Not only does active music-making require a physical component to play different instruments, it allows a symbolic distance at which emotional or latent material can be expressed and explored further. The use of clinical improvisation has been documented in many clinical contexts as improving both psychological and physiological outcomes. Many of these outcomes overlap with symptoms, concerns, and comorbidities related to FND including anxiety and mood disorders (Erkkilä et al., 2011; Lu et al., 2021), and personality disorders (Foubert et al., 2021; Haslam et al., 2022). Additionally, the use of music interventions for physical and rehabilitative purposes, specifically for neurological conditions and related physical symptoms, has been well reported (Katlen da Silva et al., 2021; Kogutec et al., 2016; Sihvonen et al., 2017).

THE CURRENT PAPER: IN TWO PARTS

The following paper is divided into two parts: (1) the Music Therapy for FUnctional Neurological Disorder (MTFUND) clinical protocol, and (2) results from the thematic analyses exploring the phenomenological experiences of, and implications from, the implementation of the protocol from the perspectives of patients and therapists involved. First, the MTFUND clinical protocol is outlined in detail, including descriptions of subprotocols, roles of therapeutic intervention, process timeline, and session outline. The second part explores experiences within the MTFUND protocol from the perspectives of patients and therapists, based on data collected from semi-structured interviews following the conclusion of therapy.

The aim of this paper is to better understand experiences within the MTFUND protocol from multiple perspectives, in effort to provide valuable context for subsequent publications of clinical outcomes. Thus, this paper focuses on the establishment, implementation, and general experiences of participants within the MTFUND protocol during the initially completed pilot studies, and not on the clinical outcomes of individual cases. The themes presented will contribute to a comprehensive understanding of patients' experiences with FND, as well as towards evaluating the efficacy of the presented protocol.

Part 1: MTFUND protocol

The MTFUND protocol was developed and refined from the preliminary clinical protocol, as a result of a pilot case study conducted in 2017-2018, and published in 2021 (Leandertz et al., 2021). In addition to existing anecdotal observations from clinical practice, the results of this pilot study yielded positive implications for use and further development in subsequent studies. The preliminary treatment protocol was further refined and organised into four sub-protocols: Recruitment/Referral, Assessment/Evaluation, Treatment, and Follow-up. The resulting MTFUND protocol encourages multidisciplinary collaborative involvement throughout, includes a comprehensive and multimodal assessment and evaluation sub-protocol, defines interventions which can be consistent (structurally) across multiple cases yet be flexible to meet individual needs, and includes a post-treatment follow-up module. The current protocol has been established for use in a series of individual pilot case studies, in order to build the necessary foundation to warrant future large-scale studies.

The protocol, as implemented in the present research, takes place over a six-month time period. The assessment (4 sessions) and active treatment (12 sessions) span eight weeks, comprising sixteen one-hour long sessions biweekly. The interventions offered within the protocol are consistent across all cases and across all sessions. However, the intention of the intervention may vary, a point which will be elaborated on in Subprotocol 3. A follow-up appointment is scheduled six months from the starting point, in order to monitor any long-term impact on symptoms and/or functioning, as well as to allow the patient space to share any reflections about the therapy process with the therapist.

An overview of the protocol, including schedule and outcome measures can be seen in Table 1, followed by a description of the subprotocols (1-4). Outcome measures are further defined and described in the outline of Subprotocol 2a.

RECRUITMENT/REFERRAL	ASSESSMENT Week 1-2 Sessions 1-4	MD CONSULTATION I	TREATMENT Week 3-8 Sessions 5-16	EVALUATION	MD CONSULTATION II	FOLLOW-UP Week 26 (6 months)
	<i>Test Point 1:</i> HADS-A MADRS DES RAND-36 CORE-OM WHODAS 2.0 MT Assessment, Treatment Plan VAS 1, 2			<i>Test Point 2:</i> HADS-A MADRS DES RAND-36 CORE-OM WHODAS 2.0 MT Clinical Report		<i>Test Point 3:</i> HADS-A MADRS DES RAND-36 CORE-OM WHODAS 2.0 Reflective Discussion

Table 1: MTFUND protocol overview

Subprotocol 1. Recruitment and referral

Procedurally, the recruitment and referral subprotocol aims to utilise as many naturalistic elements as possible, in order to compliment the study's interest in multimodal approaches, as well as allow for easier "translation" from a research context to clinical practice applications. Thus, the "recruitment" for the current research project is intended to resemble a treatment referral to music therapy. For the purpose of this research, a collaborative relationship has been established between the researcher's affiliate university and a local hospital. Two medical doctors (MDs) from the neurology department and psychiatry department of the healthcare district, are named as Research MDs in the current protocol. The hospital has a standard procedure already set in place for assessing and diagnosing patients with FND, which is followed as usual. The Research MD is responsible for determining patients' suitability for the study. Suitability is determined based on age (18-67), a positive diagnosis or likely case of FND, and absence of contraindicators for treatment. It is currently suggested that vibroacoustic therapy is contraindicated for patients with acute inflammatory conditions, pacemakers, psychosis, pregnancy, or low blood pressure (Grocke & Wigram, 2007). Once suitability has been confirmed, the Research MD will approach the patient with information about the study and invite them to participate.

After the patient has consented to participate in the study, the referral is made to music therapy. The referral contains a brief epicrisis, containing information about the patient's FND diagnosis, relevant medical history, symptoms, comorbid diagnoses/symptoms, and concurrent treatments (including medications). Standard care proceeds as normal during the study. Any additional therapies or treatments continue parallel with music therapy. This is reflective of a naturalistic procedure, with the patient possibly receiving multiple referrals and/or prescriptions following diagnosis, as well as the principles of a multimodal approach to treatment – that each mode may compliment or contribute to another.

Subprotocol 2. Multimodal assessment and evaluation

The assessment protocol for the study is also multimodal in nature, in that it consists of both qualitative and quantitative perspectives. These are meant to work together during the assessment phase, to aid in the formulation of a comprehensive patient profile from a biopsychosocial framework, thus ensuring a highly individualised treatment plan. By using already established clinical music therapy assessment tools in combination with commonly used standardised psychological inventories, the aim is to produce a treatment plan using a 'common language' which all collaborating physicians and therapists may comprehend and utilise throughout the work together.

a. Standardised inventories

Standardised inventories were completed by participants with the primary supervisor of the project. The inventories were completed at three time points: prior to the first assessment session, during the week following the final treatment session, and during the six-month follow-up appointment. The inventories used include the Hospital Anxiety and Depression Rating Scale – Anxiety Subscale (HADS-A; Zigmond & Snaith, 1983), Montgomery Åsberg Depression Rating Scale (MADRS; Montgomery & Åsberg, 1979), RAND-36 Quality of Life Inventory (Hays et al., 1993), Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), Clinical Outcomes Routine Evaluation – Outcome

Measure (CORE-OM; Evans et al., 2002), and the World Health Organisation Disability Assessment Schedule (WHODAS 2.0; Ustun et al., 2010). The selected standardised inventories are commonly used in FND clinical research (Pick et al., 2020) and would monitor patients' levels of anxiety, depression, health-related quality of life, dissociative tendencies, general psychological distress, and general functioning levels.

b. Music therapy assessment

The music therapist completes the clinical music therapy assessment during the first four sessions. It is a masked procedure, meaning that the music therapist is not made aware of the initial standardised inventory outcomes. This is so that the standardised outcomes will not influence the outcomes of the clinical assessment.

The music therapy clinical assessment used in the current research comprise a synthesis of existing music therapy assessment tools: The Music Psychotherapy Assessment (Loewy, 2000) and the Analytical Music Therapy Assessment (Scheiby, 2002). These assessment tools have common or complimentary areas of inquiry. In order to synthesise the tools, the researchers combined the common areas of inquiry based on their descriptions/defined parameters. It was found that most areas of inquiry were common, with some complimentary qualitative means of assessing them. Researchers included the kinaesthetic area of inquiry from the Analytical Music Therapy Assessment (Scheiby, 2002) in order to fulfill a physical (body-focused) area of inquiry for the assessment.

For the purpose of this research, these assessment tools were selected based on their congruency with a psychotherapeutic orientation, as well as their areas of inquiry that are compatible with a biopsychosocial framework of assessment. In addition, the two assessment tools are descriptive assessments, allowing the therapist to concretely describe their assessed observations of the patient, making connections between different areas of inquiry and the qualitative means of assessing. This type of descriptive assessment is conducive to the study's overarching aim of gathering information about FND and the various associated interacting factors on an individualised level. The intention is that by completing a descriptive assessment and allowing the therapist the time needed to write rich descriptions of their assessed observations, it will aid the therapist in formulating a comprehensive patient profile and an individualised treatment plan. The therapist is encouraged to use language in the descriptions (and in the treatment plan) that are conducive to multidisciplinary work as much as possible, approaching this assessment from a biopsychosocial perspective. This approach to writing will complement the interdisciplinary nature of the study, and positively impact the consultation module of the protocol.

c. Visual analog scales (VAS)

A set of visual analog scales from the VIBRAC Skille-Lehikoinen Centre for Vibroacoustic Therapy and Research are administered pre- and post-vibroacoustic treatment during sessions 1 and 4 of the assessment period, and completed by the patient. These outcomes aid the therapist in assessing the patient's experience of VAT, in order to suggest a suitable treatment program duration and volume (intensity) in the treatment plan. The visual analog scales measure general arousal (restless-calm), vitality (tired-alert), mood (depressed-happy), relaxation (tense-relaxed), pain (unbearable-no pain),

quality of sleep (poor-good), range of movement (spastic-flexible), quality of life (poor-good), and limb temperature (cold-warm).

d. Patient profile and treatment plan

The completed assessment and outcomes from the standardised inventories will be used to formulate a patient profile in order to form individualised clinical aims and objectives within the treatment plan. Using the information gathered from both the assessment methods and a comprehensive patient profile, the therapist may use this information to formulate individualised clinical aims and objectives, as well as outline other important components of the therapeutic process including interventions to be used, recommended VAT treatment program and duration, and follow-up plan/procedure. This document, consisting of the patient profile (brief statement summarising information included in the epicrisis and outcomes of the mixed assessment methods), and relevant treatment plan information, will be reviewed with the referring physician during MD Consultation I.

e. Clinical report

After treatment has concluded, the therapeutic process will be evaluated, and the therapist will compose a clinical report as a means of following up and evaluating the original patient profile and therapeutic aims and objectives. Similar to the patient profile and treatment plan, outcomes of standardised inventories conducted during Test Point 2 are available to the therapist to further contribute to their evaluation documented in the clinical report. The clinical report additionally allows the therapist to recommend further treatment or referrals based on their clinical judgment. Once completed, the clinical report is forwarded to the referring physician for review during the second consultation.

Subprotocol 3. Treatment

The basic session structure will remain consistent for all patients participating in the study (Table 2), as will the number of sessions (16 total). Elements within Table 2 are further explained in subsections 3 a-e. However, taking into account the fact that a) the current study is a series of pilot case studies, b) that only anecdotal clinical evidence exists for this clinical population with this approach to treatment, and c) that the study's overarching aim is to further refine and develop the treatment protocol, it is imperative that the therapist use their own knowledge of the patient and clinical expertise to determine if/how the basic session structure provided can be made ideally suitable for each patient they see.

<i>Verbal check-in</i>	Assess patient's current state and needs
<i>Vibroacoustic treatment</i>	40 Hz; Monitor and adjust duration, volume
<i>Verbal processing</i>	Cognitive, symbolic, emotional, sensorimotor levels of processing
<i>Active music therapy</i>	Active music intervention in collaboration with the therapist
<i>Verbal processing/close</i>	Recap the session, reorient (if needed)

Table 2: Basic session structure

The session structure itself has intentionally been established with relatively loose terminology and broad purpose descriptions to describe why interventions have been placed in the structure, while

leaving flexibility within that structure to enable the implementation of an individualised treatment plan. The flexibility is an imperative component of the MTFUND protocol, as that is what lends to the true ability to ensure individualised care for each patient. Though the common factor of patients participating in this study is their FND diagnosis, it is likely that no two experiences will be the same. Similarly, though interventions (structurally) remain consistent for all patients, internal elements of those interventions and the intent supporting their use will likely vary for each patient. Description of interventions and therapeutic reasoning for each can be found below:

a. Verbal check-in

The verbal check-in takes place at the beginning of the session and lasts approximately five minutes, depending on the needs of the patient. The purpose of the check-in is for the therapist to briefly assess the patient's current state as they enter the session, ensuring that the patient is settled, oriented, and comfortable in the clinic space before beginning with any active treatment interventions.

b. Vibroacoustic treatment

For the purpose of these pilot studies, and in aiming to accommodate the possibility of differing needs of patients and intentions of the VAT intervention, the Red Multivib program has been selected for use in the MTFUND protocol. The program provides the basic frequency of 40 Hz, which follows the principle for common practice in VAT, where it has been suggested that sound vibrations of 40 Hz would be a starting point for basic research (Ala-Ruona et al., 2015). The treatment program is played through a vibroacoustic bed, with 4 built-in low frequency transducers.

An underlying factor of inquiry for this research is to better understand individual experiences of an FND diagnosis. This includes understanding how the dynamic variables of such a diagnosis change and interact over time, from a biopsychosocial perspective and from the patient's own perspective. Because these individual experiences of the diagnosis can be quite diverse due to the broad range of symptoms, in addition to the comorbidities and risk factors that all have an influence on experience (Drane et al., 2021; Pick et al., 2019), it is necessary to assume that each patient will also have diverse experiences and outcomes from the VAT intervention. The VAT intervention may directly impact the patient's current experience of FND symptoms, a secondary symptom, and/or induce a relaxed state of mind and body. The many possible experiences will determine the intervention's role and emphasis within the session. Essentially, the therapist has the flexibility within the treatment plan to adjust the session structure as needed to best address the clinical aims for each patient. Ongoing assessment procedures and monitoring through visual analog scales allow the therapist to monitor patient responses to the VAT intervention and adjust program duration as per the patient's needs.

Patient-preferred music for relaxation should be played during the vibroacoustic treatment through mounted speakers in the therapy space. The therapist should familiarise themselves with the types of music that the patient typically listens to in order to relax, so that the therapist can choose music based on their preferences and suitability to the therapy itself. Music should be fairly predictable in nature, with no sudden changes in dynamics or tempi.

c. Verbal processing

As mentioned, each individual's experience of the VAT intervention will be unique, which is why it is crucial to process the experience on multiple levels. The discussion immediately following VAT is

meant to bring awareness through multiple levels (cognitive, symbolic, emotional, sensorimotor), by encouraging the patient to reflect on any thoughts, images, memories, emotions, and bodily sensations that occurred during the VAT intervention (Punkanen & Ala-Ruona, 2012). By breaking the experience down into different levels of processing, this not only helps the patient isolate certain significant moments of the intervention, but may also aid in the processing itself, by integrating several separate pieces of cognitive, symbolic, emotional, and sensorimotor awareness to a larger complete picture of the experience, and perhaps even of other aspects of the patient's life outside of the therapeutic setting.

Keeping in mind this holistic, biopsychosocial approach to discussion (and as emphasised throughout this protocol), the opportunity exists for the patient to learn how to integrate multiple levels of an experience, with encouragement and support from the therapist. By encouraging this integrative approach to therapy, not only does this reinforce the biopsychosocial approach to the clinical protocol through a more holistic understanding of the patient and their experiences, but it may also help the patient in forming a better understanding of their diagnosis.

d. Active music therapy

The active music therapy intervention, specifically clinical improvisation, has been included in the clinical protocol as a means to further process previously verbalised material on a non-verbal level, or as a medium to uncover new material related or unrelated to the verbal processing (Erkkilä et al., 2012). It is important to remember that the music created during the clinical improvisation can have varying purposes, depending on the therapeutic aims, the patient's current needs, and the progression of therapy. The music itself can be therapeutic, the physical aspect of playing instruments can be emphasised, the music can work as an intermediary object or symbolic means, or the music can work as a catalyst that prompts deeper work. Just as patients will have different experiences of the VAT intervention, the intent for incorporating clinical improvisation into the treatment plan will also vary. Further verbal reflection following the active music therapy intervention allows the opportunity to process once more on cognitive, symbolic, emotional, and sensorimotor levels (Punkanen & Ala-Ruona, 2012), bringing continuity to the experience between interventions, and integrating the entire session as a whole.

Similar to the flexibility of the VAT intervention, the intent behind engaging in clinical improvisation with the patient, and the prominence of this intervention in relation to the session as a whole, will depend on the outcomes of the assessment, the established treatment plan, and ongoing assessment/clinical observation.

There are three instrument configurations included in this protocol for the purposes of this research. The first includes two melodic percussion instruments (with mallets); the second consists of two djembes; and the third is two keyboard instruments. Each pair of instruments are set up so that the therapist and patient are facing one another, each playing their own instrument. Between the three possible options there are opportunities for a range of experiences within clinical improvisations. The instruments provide opportunity for melodic or percussive playing, different timbres, as well as differing practical levels of accessibility in terms of grip strength, finger dexterity, and sensory sensitivity.

e. Verbal check-in (close)

Like the opening verbal check-in, the closing check-in allows the therapist to briefly assess the patient's current state and ensure that the patient is leaving in a safe state. This final check-in should summarise the content of the session, provide an overview of any over-arching themes from session to session, and leave the patient looking towards the next session.

Subprotocol 4. Follow-up

A follow-up appointment with each patient will occur approximately six months after the initial appointment. During this appointment, the final set of standardised inventories will be administered to monitor any long-term effects of the treatment. In addition, a reflective discussion between the patient, therapist, and supervisor will be recorded. Discussion will cover themes from the individual therapeutic process itself, the patient's current experience of their diagnosis and symptoms, the diagnosis' impact on their lives, as well as the therapeutic process' impact on their individual experiences of their diagnosis and their everyday lives.

MTFUND training and supervision

Therapists working for the current phase of the MTFUND project were trained in the protocol through interactive lectures, demonstrations, and experiential-based training across ten meetings, totalling approximately twenty hours.

Regular group supervision sessions were scheduled every second week with the music therapists, led by the research supervisor/clinical supervisor. Therapists were able to seek additional supervision with the clinical supervisor or seek peer supervision with other therapists of the project, as needed. The format of group supervision was chosen as the preferred method of supervision for this research because of the opportunities it offers for the therapists to actively contribute to and learn from other therapists' experiences in similar therapeutic contexts. Regular supervision also contributed to the maintenance of treatment fidelity throughout the study, ensuring that all therapists execute the clinical protocol consistently and effectively, and completing the documentation as required.

Part 2: Experiences within the MTFUND protocol

Methodology

Design

In order to contribute to a more comprehensive understanding of patients' experiences with FND and to evaluate aspects of the efficacy of the presented MTFUND Protocol, this study explores the experiences of both the patients and therapists who participated in the initial case studies of the MTFUND Protocol case series. The study focuses on the qualitative material collected during the follow-up subprotocol (see subprotocol 4, above), in which patients provided subjective accounts of their experience in music therapy and relevant reflective material regarding their symptom experience, daily functioning, and access to care. The follow-up discussion took the form of a semi-structured

thematic interview with predetermined guiding questions, ensuring topical consistency across all interviews in the study (Kelly, 2012). Furthermore, a semi-structured discussion took place between the music therapists and supervisor of the study in order to contribute an additional perspective in evaluating the execution of the MTFUND Protocol. Pre-determined topics included in the discussion were protocol training, assessment, multidisciplinary collaboration, interventions, supervision, and patient follow-up.

Participants

Patients were all adults ($n = 6$; age range 18-65) diagnosed with FND and were referred from either the neurology department or psychiatry department of the local hospital. The two therapists are both qualified music therapists with additional training in vibroacoustic therapy. The clinical supervisor is a music therapist, psychotherapist, and trainer/supervisor of vibroacoustic practitioners.

Ethical considerations

The current study was approved by the Regional Medical Research Ethics Committee of the Central Finland Healthcare District. Patient information has been anonymized by codes and sensitive data kept confidential throughout the research.

Data sources

Audio recordings of the follow-up discussions were transcribed to text for analysis. Two follow-up discussions were in the Finnish language, two discussions were bilingual (Finnish/English), and two discussions were in English. Finnish audio was transcribed to Finnish text, prior to being translated using DeepL Translator. The translated text was then verified for accuracy prior to the analysis of the text. The audio recording of the discussion between therapists and supervisor, in English, was transcribed to text for analysis.

Analysis

This study seeks to explore the experience of individuals within the MTFUND protocol, therefore it is appropriate to approach the thematic analysis from a constructivist paradigm, in which ideas or perceptions are considered as individually constructed in various ways (Hoskyns, 2016). This allows us to view the data as comprehensive and with multiple, complex perspectives and values (including the researcher's), from within a common context.

Two separate thematic analysis processes took place to allow for themes from the patient perspective and themes from the clinician perspective to be presented separately. Multiple perspectives will aid in the analysis of clinical data and refinement of the protocol for future study. The researcher conducted an inductive reflexive thematic analysis (Braun & Clarke, 2021), which can be conceptualised as the nonpositivist, constructionist end of the 'spectrum' of thematic analysis and emphasizes the "inevitable subjectivity of data coding and analysis, and the researcher's active role in coding and theme generation" (Braun & Clarke, 2021, p. 8). The researcher's active role, in this case, extending also as music therapist, thus bringing additional viewpoints, values, and knowledge to the analysis process (Ghetti & Keith, 2016; Hoskyns, 2016). As Braun and Clarke (2021) point out, this position on the spectrum of thematic analysis makes a 'pure' inductive process impossible because

of the assumptions a researcher naturally brings with themselves to the analysis. Therefore, the inductive orientation in this research is to be considered as grounded in data. The intention is to use researcher subjectivity as a tool to strengthen, or deepen, the analysis and interpretation of the data, following an intentional, reflexive engagement with the data (Braun & Clarke, 2021). Specific to the current research, the authors were both active participants in patient follow-up interviews as well as in the therapist discussion, as indicated by their roles as either music therapist or clinical supervisor.

The process of transcribing, translating, and verifying naturally allowed the researcher to engage and become familiar with the interview data prior to the analysis. The following analytic process as described occurred two times for two separate sets of themes; first, to analyse the follow-up discussions with patients, and second, to analyse the discussion between therapists and supervisor working for the project. Analysis proceeded by working line by line through each transcript and applying codes to anything identified as meaningful. Consistent with a reflexive approach, the researcher noted her own experience of the data, reflecting on its impact on the analysis. This was especially relevant when analysing discussions in which the researcher was an active participant as therapist. Codes were then organised in a way that reflected similarities in what was expressed among the participants. Each patient's and therapist's experience within the therapeutic setting was undoubtedly unique and there were multiple important perspectives that the researcher was further able to engage with in the process of generating themes from the coded data. Thematic maps were used to further develop conceptualisation and these maps were changed as the researcher returned to and from the raw data, ensuring the analysis was grounded in the data. The development of thematic maps provided clarity regarding differences and overlap between ideas, allowing the researcher to refine the ideas and generate representative themes to be reported.

RESULTS

Patient follow-up

The analysis of the patient follow-up interviews generated five themes, one of which had two subthemes. These are defined and described further below:

1. Difference in symptom experience

Patients noticed a difference in their symptoms during music therapy sessions, whether in regard to symptom frequency, intensity, or their experience around the symptoms (for example, precipitating events or behaviours). For most, responses indicated an improvement or even elimination of symptoms outside of music therapy sessions, which had a lasting effect post music therapy. It should be noted that this was evident across FND subtypes/symptom presentations.

At the 6-month follow-up appointment, Patient 0121, whose primary FND symptom was functional tremor, stated that she, "can't remember the last time [she] had shaking." Patient 2102 stated that her dissociative seizures had stopped since the conclusion of music therapy. Patient 2104, whose primary symptoms were limb weakness and accompanying pain, also reported an elimination of her symptoms since music therapy. She says, "Legs and hands are working normally, but I think

that's the best thing here. No pain or just a little pain [in the leg]. Most days I don't have any pain at all."

For others, learning about their own experience of their symptoms gave them a sense of awareness and understanding around the experience, reducing their fears and/or anxieties. Patient 2205 described her dissociative symptoms as less extreme since concluding music therapy and that her attitude towards her dissociative experiences has changed:

I'm more aware of the dissociation and I'm able to think differently ... When you realise that your mind and body are in completely different places again, it somehow doesn't bother you so much anymore. Before, it used to bother me, like that fact that it happened again, thinking 'what was wrong with me?' So, it doesn't feel so scary anymore, maybe, now that we have talked about it and I have never really talked about my dissociation issues before. (Patient 2205)

Recognising parts of the symptom experience seems to desensitise the patient to the symptom, in a way, halting any anxiety/fear-provoked perpetuation or worsening of the symptom. Similarly, Patient 2207 also described a sense of awareness of her symptom experiences, stating that she still experienced her cognitive symptoms regularly, but they were less severe, and for shorter periods of time.

2. Attitude toward patients' own care

General dissatisfaction, confusion and/or frustration with previous care led to some patients expressing a sense of skepticism when beginning music therapy. However, patients' attitudes changed, demonstrating an improved attitude toward their own care by the end of music therapy. This was expressed in various ways, either by expressing a sense of independence in their own care, and/or describing a newfound sense of agency, enabling the patient to describe the type of care that would suit their needs best. In regard to care, the follow-up interview had an overarching forward-looking sense and tone of optimism. Patient 2102 describes her change in attitude:

I went to therapy for many years and it didn't do me any good and then I went to music therapy a couple of times, and it seems like it changed everything, because I was really skeptical, so to speak, 'how can something like this work?' (Patient 2102)

With multiple treatments and referrals to various specialists over time, many patients also described a sense of confusion and even neglect. Some pointed to the need for more education at the time of diagnosis and throughout treatments which would have aided this confusion, and others have tried so many different treatments that it's unclear what actually helps.

By the end of music therapy, and through the follow-up point, there appears to be a shift in patients' attitudes towards their own care. Many expressed feeling independent in their current care, at the time of follow-up, citing specific coping tools, and their ability to employ the coping tools in everyday life situations. Patient 2205 spoke about learning about her inner resources and learning how to use them to cope:

Maybe you noticed that you have more resources in yourself than you imagined ... I don't think so negatively about myself anymore. I used to think that I was no good, but then... I realised that I still [have] some resources left. So I don't think so badly of myself. (Patient 2205)

Patient 0121 had a similar realisation, in terms of learning emotional coping and processing skills, stating, "I have been so many years in therapy, I feel like I will now try on my own. I think I cope well enough. I got a lot of tools to survive." Patient 2207 described what felt like "freeing her mind", by learning how to compartmentalise, which was a prevalent coping tool in her process:

In the past it was that you were constantly thinking about what you should do, and what you have done, but now I can push things aside more, and then when it's time to think about them again, [bring it back] from the side. (Patient 2207)

Patients who saw an elimination of their functional symptoms entirely, such as patient 2104, were confident in their recovery, stating, "I don't think I need anything. [...] I think I'm going to be fine, so that's it."

For some patients, further treatment was recommended by their therapist in the final clinical report. During the follow-up interview, some patients shared that they have had ongoing care from therapies including rehabilitation psychotherapy, psychophysical physiotherapy, and psychology with a focus on psychoeducation, and/or regular follow-ups with neurology or psychiatry. Though recommendations for further treatment in these cases were made by the music therapist in the final clinical report, it's important to note the patients' attitudes towards this ongoing care, which were evident during the follow-up interviews. Patients seemed motivated to continue the work they had uncovered in music therapy. There was a sense of agency over their own care, with patients able to describe the kind of focus they would need in further care. Patient 2102 said that at the conclusion of music therapy, she acknowledged that she would need further support processing material that she hadn't been able to access, as well as more coping skills for everyday life. At the time of follow-up, 2102 had been seeing an adolescent rehabilitation psychotherapist as continued support. Patient 2205 stated that at the conclusion of therapy, she had wanted to learn more about her FND diagnosis, her symptoms, and possibilities for further treatment. At the time of follow-up, 2205 had been receiving continued support with psychophysical physiotherapy.

3. Therapeutic interventions were multimodal, multisensorial, and multipurpose

a. VAT as a multimodal intervention provides tactile sensory input, allows the body to relax, and/or enables the patient to uncover suppressed/previously inaccessible content.

VAT provides a multisensorial experience, with unique, individual experiences of those sensory stimuli, prompting an individualised, integrative processing across multiple cognitive levels with the therapist in order to progress the therapeutic work. Patients spoke of VAT removing some kind of "block" and allowing them to uncover material or themes to process further with the therapist. Patient 0121 and Patient 2205 spoke of this block being released with the vibrations.

It's like opening a bottle, [but] I wasn't opening the bottle, the machine [vibroacoustic bed] was doing it and somehow... something was under the shakes [symptom], like what emotion was hiding there? ... I think it's just because I am holding some emotion and it kinda wanted to come out. (Patient 0121)

Physically it feels like that vibration somehow disconnected those things. From there, from somewhere, and then they helped so that they came from there. And I can't explain what I mean, but it's like I'm stuck there. And then when it vibrates, and then things come out of there that just came to mind. (Patient 2205)

The patients of MTFUND also indicated that VAT allowed the mind and body to relax, and that this was important to accomplish at the beginning of a session. Patient 0121 describes this process, "First I got to relax... then the body is not that tense. Kinda gave more opportunity to be more open. When the body is tense, it kind of starts affecting a little bit the emotions." Patient 2207 reflects a similar experience of getting out of her own mind and learning how to relax:

When you're kind of forced to relax, in a way it's a good break from your own stress. And of course, we also dealt with the thoughts that are in your mind, that you are thinking about at the time and can't relax. (Patient 2207)

Patient 2206 found that VAT allowed him to relax because it served as a distraction from his chronic pain. He says, "it takes my stress away for a while, so I can concentrate different things. I can put those pains behind and just relax and enjoy the moment."

Some patients refer specifically to the multisensory sensations experienced during VAT, specifically tactile sensation (feeling the vibrations) and auditory stimuli (listening to the background music). Patient 2205 describes difficulty in being able to experience both stimuli simultaneously and this reception to stimuli changing over time:

I either heard the music or felt the vibration, it was little one or the other, like the lights were flicking on and off. And then sometimes I felt both at the same time... Not the first few times I could not combine the sound and vibration, but then at the end there were some moments that there was both and it was really interesting. (Patient 2205)

Patient 2206 described in great detail how the VAT was able to resonate in his body and reach the "right points" where he experiences chronic pain. He elaborates on the experience, saying, "when I have that vibration, it's like at the start it feels like waves, like, coming through body parts when it's going... so it feels just like my whole body is vibrating."

b. Active music making as an intervention can have multiple purposes

Active music making as an intervention served different purposes within therapeutic processes: rehabilitative music making, music making as release (mental/physical), and the use of music making as a tool for processing. Patient 2104 recalled the active music making intervention as a rehabilitative exercise. She referred specifically to music making exercises designed to encourage crossing of the

midline to work on proprioceptive abilities, saying, “I think it was very good that you made those exercises happen across the line.”

Active music making also allowed for further processing or exploring of emotional content using a nonverbal medium. Patient 0121 reflected on her experience of learning new perspectives about what was in her mind. She was able to use music to try and describe a feeling, to move the processing deeper, or to approach the processing from a different perspective:

If there is a situation, when a person is not able to talk about feelings or talk about something, going there and playing piano or some kind of instrument, because music also tells things. So that's kind of some sort of way to communicate. (Patient 0121)

This kind of emotional release through music making allowed patients to learn about their emotional processing abilities, and structure those experiences non-verbally and verbally. In the follow-up interview, Patient 2205 described how music making allowed her to structure and organise her thoughts in different ways in order to easily process them further. Patient 2207 found that improvisation complimented the VAT intervention well, reflecting that improvising music contributed to her practice of relaxing the mind and “letting go.”

4. Integration as a therapeutic agent

According to patients' reflections, the process(es) of integration – of body and mind, and/or of fragmented parts of the self – served as a major working element within sessions, which had direct and prolonged effects outside of the therapy context. Mind-body awareness and the related integration process was a focus across many of the therapeutic processes. Patient 0121 described this learning experience and how she gained more autonomy over her body and emotions. The patient learned that when her body felt tense, it meant that there was a buildup of emotions within that physical tension. Typically, her body would “release” that emotion and tension by shaking (FND symptom), but she learned that she could also independently process that emotional content, reducing the need to shake. Patient 2205 described her experience of integration, and how it felt surprising to have the mind and body connected, even if just for a moment of time:

When you're used to being completely detached from yourself... it feels very strange when you're not used to it. Somehow it feels liberating, free. Now there have been more of them [connected moments], and it's like you notice that your body and mind are together and then you get a little bit of a startle. (Patient 2205)

Patients also described learning more about themselves, discovering new sides of themselves making connections, and integrating the experience. Patient 2205 spoke about understanding herself better and on a more serious level:

...how much it has affected like, my experience of myself, which I think is probably the best thing. The fact that I am not what has happened to me. Like all the ways I see myself more now and how I experience things. So that's probably the most important thing. (Patient 2205)

Patient 2207 described learning more about herself by allowing her mind to relax, which prompted therapeutic work with the therapist. She says, "and then the relaxation thing happened, and all kinds of really strange images came up, and we dealt with them. It was quite good to get out of the mind that where they really come from."

5. Everyday life impact

Music therapy seems to have been a positive experience with noticeable effects that translated to overall functioning capabilities and sense of wellbeing in everyday life, which have been maintained since its conclusion. As mentioned before, the overall tone of the follow-up discussions thus far have been optimistic and forward-looking. This tone translated into discussions of the patients' everyday lives. In terms of overall functioning in society, many patients had a positive outlook when planning for the future. This includes making career plans post-graduation, applying to university studies, and pursuing weekly volunteer work. Patient 2102 reflected that music therapy "helped – to get on with life; planning for the future."

Patients also commented on an overall better mental state, improved mood, increased stamina and energy, and improved confidence. It was important to many of the patients that they were able to participate in hobbies or activities that they enjoy, because this also contributes to their mental health positively. When their symptoms prevent them from being able to participate in activities that they enjoy, it's disappointing. Prior to music therapy, Patient 2104 was only able to walk a few kilometers on a "good day," and some days half a kilometre was too long. At her follow-up appointment, she reported a significant change:

I have had few days that I have walked over 20 km and no problem... so legs are working well. I walk faster than before, so that saves time to do something else. I can do things which I enjoy and love, and get more relaxed because I don't have to use so much time going from one place to another. (Patient 2104)

Patient 2206 explains that his mental health has been very positive because he is able to participate in activities outside that he enjoys such as hiking, fishing, and hunting, and being with friends. He continually tries to improve his fine motor stamina by playing his guitar daily for short periods of time.

Therapist discussion

The discussion between therapists and supervisor was held with the aim of providing an additional perspective of the protocol. At the time of discussion, both therapists had utilised the protocol in multiple cases, thus enabling an in-depth critical discussion. The analysis of the therapists' discussion generated five themes, which are defined and described further below:

1. MTFUND training was comprehensive, and balanced the theoretical background information with practical elements of the protocol

MTFUND training ensured that therapists were prepared and equipped with the necessary information without having any expectations or bias regarding working with this clinical population. Therapist TL stated that he was “very happy for the theoretical background” provided, and that it allowed a certain level of preparation, “to kind of look more carefully what is going to be in this group [...] because it’s not common, and quite complex.” Therapists felt that there was a certain balance that needed to be achieved within the training, to provide the necessary theoretical background for understanding a complex phenomenon and to provide effective therapy. This allowed the therapists to enter into the clinical application of the protocol with an open mind to avoid expectations of outcomes or preconceived notions about working with the diagnosis. Therapist ML described this balance as having “enough knowledge and background, but also going into it with an open mind.” Therapists agreed that regular group supervision contributed to the training process, offering a means of on-going training by learning from each other.

2. The MTFUND protocol places an emphasis on a holistic approach to viewing the patient, thus encouraging an individualised, flexible approach to interventions within a reliable structured therapy framework

Therapists indicated that interventions within the MTFUND protocol are implemented in a way that is tailored to the individual, with the purpose objectively defined in the treatment plan. A holistic, biopsychosocial approach to the protocol, including both assessment procedures and treatment, highlights the need for more than just a symptom-focused response.

FND itself, yes, it’s an experience of some kind of symptom or a series of symptoms. Yes, you’re experiencing those symptoms, but it’s a lot bigger than that for the person because they might not understand why, because there’s nothing broken. Next, their dealings with the system and other healthcare professionals could be very weak or damaged, so that’s another layer. And then also how their symptom experience impacts their everyday life and functioning. Are they able to work? Are they able to go for walks with their kids? It’s so much of a bigger picture than just dealing with the symptom. These are things that fulfill [their] life, that now they can’t do, because [they] don’t understand what’s going on with their body. So, it’s multilayered. (Therapist ML)

This reflection also brings focus to the necessity of an individualised treatment, and the balance required in design of the MTFUND protocol, between individualised care to meet the complexity of the diagnosis through a certain degree of clinical freedom available to the therapist, and the frame of a consistent protocol

The therapists agreed that the structure of the protocol provided stability for the therapist to lean on, but also provided a sense of familiarity for the patients, aiding the establishment of safety and trust. The structure allowed therapists to switch modalities in order to build momentum within a session – to build on a current theme using a different modality, and this offered a way to optimise

the care with a compounding effect. It was also discussed that it is the therapist's responsibility to recognise the moments of transition, in order to integrate all of these possible experiences within a session, on multiple levels and modalities of processing and uncovering material.

Sometimes it's easy to recognise some theme being evoked from the vibroacoustic part and you can clearly take that with you and then move on towards the more active part and when you're investigating that, you are exploring that what was already evoked there and then that continuum is rather seamless. (Supervisor EAR)

Therapists disclosed some struggles when it came to balancing decisions made within sessions that would be consistent with their everyday practice and decisions made to fulfill requirements of the protocol. Along with the supervisor, the discussion questioned the degree of flexibility available to the therapist within a research context and the difficulty in finding the ideal balance. Though the interventions included in the protocol are intended to be flexible enough to address different needs and have varying purposes depending on the needs, the therapist needs to ensure that the execution of interventions is ultimately grounded in the clinical aims. The roles of interventions should be objectively defined within the treatment plan, so that the therapist may concretely rely on this throughout the implementation of the treatment plan. Though this poses a potential challenge when evaluating the interventions to include in future studies, ML points out that, "the treatment itself, the protocol, the tools, the interventions offered within that, we've been able to modify and be flexible enough within that and have successful outcomes, which is generally good."

3. The assessment subprotocol is an organised process of condensing, connecting, and evaluating relevance of assessment information from multiple sources in order to effectively compose a treatment plan

The assessment sub-protocol is an organised, but time-consuming process, offering a wealth of information about the patient from different perspectives. The process of determining relevant and pertinent information, and condensing the assessment outcomes to a profile statement is valuable, integrative, translative process, and highlights the important differences between treatment-planning assessment and diagnostic assessment. Regarding organisation in the procedure, TL pointed out that the templates provided for use during the assessment offered an organised way to manage a lot of information and to gradually condense the information to the necessary information required for building the treatment plan. ML commented that though a lot of information result from the multimodal assessment, it allows for therapists to make conclusions based on information from multiple sources that complement each other, helping to determine the relevant information to include in the patient profile statement.

What items are connected between what I have assessed versus what we see in the questionnaires? Taking the time to look at the sets of information and determine what it actually means about the person... what it tells us about the person and what we should be concerned with in the therapy. (Therapist ML)

Though it was time consuming, therapists agreed that it was a valuable process to look at all of the information from different sources and determine what is pertinent to include in the profile statement to the referring physician, what information is relevant to the case and to the formulation of a treatment plan, and finally how to translate the therapist's output to a common language in order to effectively collaborate and communicate with the referring physician.

I think it all contributed to the other...I don't think we could get a full comprehensive look of the patient with just the music therapy assessment, and I don't think we could have a comprehensive look of the patient just from the questionnaires. I think we gained perspectives of the patient from each, and they kind of answered to each other. (Therapist ML)

Once more, attention is brought to the crucial difference between diagnostic (symptom-focused) assessment and treatment planning assessment. The therapists point out the importance in moving past a symptom-focused assessment, and that when using this multimodal assessment, it provides a comprehensive view of the patient and their needs. Through this, therapists have the opportunity to integrate this information into an individualised treatment plan.

4. The therapeutic effect of MTFUND

In regards to the generalisable elements of the therapeutic effect, therapists described MTFUND as an intensive process which fosters a supportive, equal, and collaborative approach to care, contributing to the establishment of the therapeutic alliance early in the therapy process. Though each patient's experiences are unique, therapists recognise the process of integration as being a multifaceted process and crucial to the patient's sense of self and autonomy.

In a protocol which emphasises the importance of individualised care, the therapeutic alliance becomes a crucial aspect to the effect of therapy as a whole. The therapists point to an equal partnership between patient and therapist. ML referred to this as a "supportive and collaborative approach." EAR elaborated on the concept of "not knowing as an approach":

So that you are there at the same level with the person and you are not offering anything like answers to someone's problems, but instead of that, you are expressing your willingness to share things together and start to think about, okay, what we are having here and how could we understand that and where does it relate to? (Supervisor EAR)

This type of approach was fundamental, especially given that the protocol was being piloted, and there is limited evidence available for music therapists working with this clinical group. Although therapists cannot answer all the questions that these patients may have, they are willing to support and collaborate with patients throughout the therapy process. With patients actively involved in the process, therapist TL pointed out the sense of curiosity and enthusiasm many patients felt as they learned the possibilities within the protocol, "What's happening here? What else is possible?" Indeed, it was this sense of enthusiasm and motivation that therapists noted as impacting patients' everyday lives, and at the end of therapy, noticing an improved sense of agency in their own care needs. Actively

involving the patient in the therapy process provided a feeling of safety in care. Given that many patients had had a difficult and lengthy treatment history, this feeling of safety and involvement is a contrast to what patients are accustomed to, giving them a voice in their own care.

The therapists also discussed the role that VAT may have in establishing the therapeutic alliance quickly. With the use of VAT as an intervention, the therapist is trained to ensure the patient's sense of safety and comfort by providing a safe, caring, and nurturing. Physically, the therapist ensures that the patient is in a comfortable position, using pillows to support the neck, lower back, etc. as needed, and places a blanket over the patient, offering an additional nurturing element to the interaction. Additionally, care is expressed through the personalised elements of the intervention, such as the use of the patient's preferred relaxation music during VAT. Initially, VAT is an unknown situation and perhaps could be considered a vulnerable space, where the patient is quickly putting their trust into the therapeutic context and the therapist. It's important in this space that the therapist acknowledges and validates the patient's unique experience of VAT and providing care by listening to the patient's experience from multiple levels of reflection, which further contributes to a personalised, caring atmosphere to the session. The VAT itself, is a unique and individual experience for each patient, and provides them the opportunity to reflect on their experience on multiple levels in the moment with the therapist. TL points out that because of the fresh sense of the experience, it allows for the process to go deeper, faster:

The unique experience is there just in the moment there and... then you kind of rely on that more than if there wasn't that experience of vibroacoustic there, if you start to ask your patient like, 'how do you feel in your body now? Where do you feel?' (Therapist TL)

Another generalisable quality of the therapy across the therapists' cases was a focus on integrating different parts of the experience. Therapists spoke about many patients working to integrate a fragmented reality into a more integrated sense of self throughout the therapeutic process. This was not necessarily always a specifically defined goal, but a natural product of therapy progression. In line with the collaborative approach to therapy, the patients had an active role in the integration process, and this often resulted in moments of clarity and insight for the patient throughout the therapy. Naturally, as integration progressed, patients start to mend their relationship with their own body and mind, increasing a sense of agency and autonomy, ultimately having an impact outside of the therapy setting as well. Therapist ML states, "it's another layer of the integration, constantly relating from therapy to outside therapy, and encouraging that everyday functioning and participation." In fact, the therapists found that the levels of reflection (cognitive, symbolic, emotional, sensorimotor) that were prompted through therapist discussion related well to integration and guided the process for the patient. Therapist TL further mentions that at the end of most sessions, he would often ask patients what they will take with them. He reflected that this helped to contribute to the integration process outside of therapy, the patient's level of motivation, and their sense of agency in their own care.

5. Key qualities and values of MTFUND that should be maintained and/or expanded in further research studies, in order to ensure applicability in practical contexts

The multidisciplinary woven through the protocol was a strength and the therapists agreed that this was especially important looking to future practical implementation outside of a research setting. Establishing a line of communication between the music therapist and the referring MD added value to the project, and allowed for MD input and/or consultation at different points during the therapy process. At times, the therapists felt some restriction that communication only took place digitally between the two different institutions, and this brought up questions regarding the implications for use within a common context. For example, what would the multidisciplinary aspect of MTFUND look like if it took place within one hospital or clinic? The therapists agreed that there was certainly added value and questioned how to expand this aspect of the protocol and develop it further for future phases of the research.

It opens up the opportunity for this protocol to be used as adjunct to physiotherapy or psychotherapy, or anything like that. If we have such a comprehensive assessment, and our treatment plan is able to say also, 'this patient would benefit from music therapy and physiotherapy'... You know, have that ability in a multidisciplinary team, I think that would just enhance it that much more. (Therapist ML)

Presently, there are other healthcare specialties working with patients with FND, and so when looking to potentials for practical use, music therapy should be included to expand the multidisciplinary of MTFUND to include other healthcare professionals.

When looking to the future of MTFUND research, the therapists discussed the importance of continuing to balance between practical clinical application development and systematic, methodologically grounded research in order to better understand the phenomena and gather detailed evidence.

We are working towards something... so that we can get more detailed evidence and information which is based on analysis of data that we have collected, but on the other hand, we would also need to start to create that clinical practice with those people in the medical community, and trying to build up something where all this knowledge could be easily applied. (Supervisor EAR)

It would be important to maintain as much of a naturalistic element as possible within future research of MTFUND, in order to ensure applicability and practicality of use outside of research settings. Simultaneously, the systematic delivery of therapy within a research context, is a valuable and unique aspect of the protocol that should be maintained, and even developed further in future phases of study. Naturally, as these pilot case studies are further analysed, the research in future stages will be increasingly grounded with better understanding of the phenomena, contributing further as the research progresses.

The therapists reflected on the study's exploratory nature in this pilot phase, agreeing that the outcomes are likely to provide a broad range of information, contributing to a better understanding of the phenomena. This will allow for future studies utilising MTFUND to have a narrower focus, ultimately making the protocol easier to deliver practically as a service. It's likely that the outcomes of the pilot phase of MTFUND will raise further questions, which is ultimately a positive outcome of an exploratory pilot phase. In looking at where to direct focus in future work, ML says, "Are we focusing on creating treatment plans, or are we focusing on the efficacy of the treatment that we're offering?" For future planning of research, it would be necessary to consider which aspect of MTFUND, or which sub-protocol, is being investigated further. Ultimately, narrowing the focus of subprotocols (MTFUND-Assessment, or MTFUND-Treatment, for example) would be beneficial in producing high quality research with a deep focus on a specific area of investigation. By narrowing down the focus, we also develop the clinical practice, making MTFUND more practical for delivery outside of a research context.

CONCLUSION

Considering themes from the follow-up interviews with patients and the discussion between therapists provides us with a more complete picture of the experience within the MTFUND protocol from multiple perspectives. Though the themes came from different perspectives, it is possible to see certain common core elements of the protocol.

Interventions are an important element within a treatment protocol and this is evident across both sets of themes. The interventions within the MTFUND protocol, including vibroacoustic therapy (Grocke & Wigram, 2007; Hooper, 2001; Punkanen & Ala-Ruona, 2012) and clinical improvisation (Bruscia, 1987; Erkkilä et al., 2012), were selected because of their inherent flexibility and ability to be multimodal in effect by addressing the needs of an individual on all levels (Kozłowska et al., 2012; Lazarus, 1976, 2006). The results from this study seem to indicate that the selected interventions were successful in their original intention of integrating the care of physiological and psychological needs of patients with FND within a multimodal approach to therapy (Demartini et al., 2014; M. J. Edwards, 2019; Ezra et al., 2019; Jimenez et al., 2019; Lidstone et al., 2020). We can also define the interventions as multipurpose, as therapists have the opportunity to objectively define the purpose of interventions within the treatment plan.

An important aspect to consider for future research will be how to maintain this multipurpose and flexible component of the interventions, while taking into consideration the differing sensorial experiences of patients. Further, consideration in this regard should be made in the training aspect of the MTFUND protocol, allowing for education and experiential training for potentials in multipurpose and flexible intervention use.

Responses from patients and reflections from therapists reveal that patients' symptoms and/or their experience surrounding those symptoms changed over the course of music therapy, and some experienced this as a long-term effect. These changes in symptom experience should be specified further in future publications of clinical results. Considering these changes, coupled with the intentional use of flexible interventions, it's possible to also view this change as a gradual change with how the patient and their symptoms interacted with the intervention over time. Therapists were

working within a structured protocol with consistent interventions, but the reception and interaction with the intervention changed as the interventions' interactions with the patient and their symptom(s) changed. It's also necessary to consider the range of symptoms we see represented in these initial cases. Functional symptoms related to dissociation, seizures, limb weakness, tremor, chronic pain, and cognitive symptoms are represented across these initial cases. The symptoms vary greatly, but each patient noticed a difference in their symptom experience during/after music therapy, perhaps highlighting the importance of the flexible intervention use and individualised treatment planning within MTFUND.

The concept of integration was a prominent source of discussion across the patient interviews and the therapist discussion. It is valuable to consider the concept from both of these perspectives, and how each patient and therapist experienced integration within their individual processes. Integration, whether it be between mind and body, parts of the self, aspects of the experience and interventions, or integrating therapy and outside of therapy, could perhaps be seen as an outcome of utilising a holistic (biopsychosocial) approach to assessment and treatment within MTFUND. Looking at FND from the biopsychosocial framework acknowledges the interactive relationship between predisposing, precipitating, and perpetuating factors from biological, psychological, and social viewpoints, and how these interactions influence the experience of functional symptoms, unique to the individual (Hallett et al., 2022; Pick et al., 2019; Voon et al., 2016). Integrating the biological, psychological, and social aspects of a whole person throughout sessions, as well as acknowledging these elements through assessment and treatment planning, naturally promotes internal and external integration, ultimately translating positively to everyday life through subjective feelings of wellbeing and functioning abilities in society. This was evident from the reflections of patients and therapists.

There seemed to be a positive shift in attitude toward healthcare indicated across the patients' follow-up interviews. It is an unfortunate reality that many patients with FND have negative experiences and negative associations with healthcare, whether in regard to systemic difficulties and/or with healthcare professionals (Begley et al., 2023; McLoughlin et al., 2023). Patient responses during the follow-up appointments took on an optimistic, independent, and confident tone, with many patients indicating an improved sense of agency over their own care. This was certainly a positive secondary effect of the therapy, but consideration needs to be paid as to why this effect took place in order to explore further implications. We could say that a major contributing factor to this change in attitude was the collaborative approach to care between therapist and patient. The therapists spoke about this "equal, collaborative, supportive" approach that was naturally adopted in MTFUND because of its exploratory nature. As a result, the patients within MTFUND had a voice within their own treatment. As the therapeutic alliance was strengthened, patients became more comfortable expressing their needs, their current state, changes, and questions. Patients weren't asking for answers necessarily. Rather, they were asking for support and collaboration in learning more together with the therapist. Perhaps this improved confidence in their own voices, coupled with affordances of agency through collaboration and transparency in music therapy, contributed to the resultant change in attitude toward patients' own care.

Looking to the future, there is no doubt that this core approach of equality, support, and collaboration in care between therapist and patient is key within the MTFUND protocol. It also brings forward the importance of further collaboration within this kind of multidisciplinary work, and

information sharing within that multidisciplinary team. The value in multidisciplinary lies in a diverse set of knowledge and specialties within a team, but also in what we can each gain from one another's experience within a common context. Moving forward, it will be important to strive for this balance among a diverse set of knowledge and specialties whilst maintaining a consistent and common approach to care.

The MTFUND protocol was designed as a multimodal, multidisciplinary protocol for assessment and treatment for patients with FND. The interventions within the protocol were intentionally selected for their multimodal qualities and ability to be implemented in a flexible manner, dependent on the individual needs of a patient. The use of flexible interventions within a consistently structured protocol allowed for individualised treatment for patients while maintaining the systematic delivery of therapy necessary within the current research context. The patient follow-up interviews, together with the information from the therapists' reflective discussion, provide valuable perspectives and insights regarding the experience within the MTFUND protocol, which will provide important context to future publication of clinical results from this phase of the research, as well as inform future phases of MTFUND research.

REFERENCES

- Ala-Ruona, E., Punkanen, M., & Campbell, E. (2015). Vibroacoustic therapy: Conception, development, and future directions. *Musiikkiterapia [Finnish Journal of Music Therapy]*, 30(1–2), 48–71.
- Begley, R., Farrell, L., Lyttle, N., Alty, J., Curran, D., Williams, S., & Graham, C. D. (2023). Clinicians' implicit and explicit attitudes about the legitimacy of functional neurological disorders correlate with referral decisions. *British Journal of Health Psychology*, 00, 1–15. <https://doi.org/10.1111/bjhp.126>
- Bennett, K., Diamond, C., Hoeritzauer, I., Gardiner, P., McWhirter, L., Carson, A., & Stone, J. (2021). A practical review of functional neurological disorder (FND) for the general physician. *Clinical Medicine, Journal of the Royal College of Physicians of London*, 21(1), 28–36. <https://doi.org/10.7861/CLINMED.2020-0987>
- Bernstein, E., & Putnam, F. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174(12), 727–735.
- Braun, V., & Clarke, V. (2021). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*, 9(1), 3–26. <https://doi.org/10.1037/qup0000196>
- Bruscia, K. E. (1987). *Improvisational models of music therapy*. C.C. Thomas.
- Bruscia, K. E. (2014). *Defining music therapy* (3rd ed). Barcelona Publishers.
- Butler, M., Shipston-Sharman, O., Seynaeve, M., Bao, J., Pick, S., Bradley-Westguard, A., Ilola, E., Mildon, B., Golder, D., Rucker, J., Stone, J., & Nicholson, T. (2021). International online survey of 1048 individuals with functional neurological disorder. *European Journal of Neurology*, 00, 1–12. <https://doi.org/10.1111/ene.15018>
- Campbell, E. A., Hynynen, J., & Ala-Ruona, E. (2017). Vibroacoustic treatment for chronic pain and mood disorders in a specialized healthcare setting. *Music & Medicine*, 9(3), 187–197.
- Combination Therapy. (n.d.). In *Merriam-Webster*. Retrieved 22 February 2023, from <https://www.merriam-webster.com/dictionary/combination%20therapy>
- De Witte, M., Pinho, A. D. S., Stams, G.-J., Moonen, X., Bos, A. E. R., & Van Hooren, S. (2022). Music therapy for stress reduction: A systematic review and meta-analysis. *Health Psychology Review*, 16(1), 134–159. <https://doi.org/10.1080/17437199.2020.1846580>
- Demartini, B., Batla, A., Petrochilos, P., Fisher, L., Edwards, M. J., & Joyce, E. (2014). Multidisciplinary treatment for functional neurological symptoms: A prospective study. *Journal of Neurology*, 261(12), 2370–2377. <https://doi.org/10.1007/s00415-014-7495-4>
- Drane, D. L., Fani, N., Hallett, M., Khalsa, S. S., Perez, D. L., & Roberts, N. A. (2021). A framework for understanding the pathophysiology of functional neurological disorder. *CNS Spectrums*, 26(6), 555–561. <https://doi.org/10.1017/S1092852920001789>
- Edwards, M. J. (2019). Functional neurological disorder: An ethical turning point for neuroscience. *Brain*, 142(7), 1855–1857. <https://doi.org/10.1093/brain/awz194>
- Erkkilä, J., Ala-Ruona, E., Punkanen, M., & Fachner, J. (2012). Creativity in improvisational, psychodynamic music therapy. In D. Hargreaves, D. Miell, & R. MacDonald (Eds.), *Musical Imaginations—Multidisciplinary Perspectives on Creativity, Performance, and Perception* (pp. 414–428). Oxford University Press.
- Erkkilä, J., Punkanen, M., Fachner, J., Ala-Ruona, E., Pönttiö, I., Tervaniemi, M., Vanhala, M., & Gold, C. (2011). Individual music therapy for depression: Randomised controlled trial. *British Journal of Psychiatry*, 199(2), 132–139. <https://doi.org/10.1192/bjp.bp.110.085431>
- Espay, A. J., Aybek, S., Carson, A., Edwards, M. J., Goldstein, L. H., Hallett, M., LaFaver, K., LaFrance, W. C., Lang, A. E., Nicholson, T., Nielsen, G., Reuber, M., Voon, V., Stone, J., & Morgante, F. (2018). Current concepts in diagnosis and treatment of functional neurological disorders. *JAMA Neurology*, 75(9), 1132–1141. <https://doi.org/10.1001/jamaneurol.2018.1264>

- Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180(1), 51–60. <https://doi.org/10.1192/bjp.180.1.51>
- Ezra, Y., Hammerman, O., & Shahar, G. (2019). The four-cluster spectrum of mind-body interrelationships: An integrative model. *Frontiers in Psychiatry*, 10(MAR). <https://doi.org/10.3389/fpsyt.2019.00039>
- Foubert, K., Gill, S. P., & De Backer, J. (2021). A musical improvisation framework for Shaping Interpersonal Trust. *Nordic Journal of Music Therapy*, 30(1), 79–96. <https://doi.org/10.1080/08098131.2020.1788627>
- Ghetti, C. M., & Keith, D. R. (2016). Qualitative content analysis. In B. L. Wheeler & K. Murphy (Eds.), *Music Therapy Research*. Barcelona Publishers.
- Grocke, D., & Wigram, T. (2007). *Receptive methods in music therapy*. Jessica Kingsley Publishers
- Hallett, M., Aybek, S., Dworetzky, B. A., McWhirter, L., Staab, J. P., & Stone, J. (2022). Functional neurological disorder: New subtypes and shared mechanisms. *The Lancet Neurology*, 21(6), 537–550. [https://doi.org/10.1016/S1474-4422\(21\)00422-1](https://doi.org/10.1016/S1474-4422(21)00422-1)
- Haslam, R., Heiderscheit, A., & Himmerich, H. (2022). A systematic review of scientific studies on the effects of music in people with personality disorders. *International Journal of Environmental Research and Public Health*, 19(23), 15434. <https://doi.org/10.3390/ijerph192315434>
- Hays, R. D., Sherbourne, C. D., & Mazel, R. M. (1993). The RAND 36-Item Health Survey 1.0. *Health Economics*, 2, 217–227.
- Hooper, J. (2001). An Introduction to Vibroacoustic Therapy and an Examination of its Place in Music Therapy Practice. *British Journal of Music Therapy*, 15(2), 69–77. <https://doi.org/10.1177/135945750101500205>
- Hoskyns, S. (2016). Thematic analysis. In B. L. Wheeler & K. Murphy (Eds.), *Music therapy research*. Barcelona Publishers.
- Jimenez, X. F., Aboussouan, A., & Johnson, J. (2019). Functional neurological disorder responds favorably to interdisciplinary rehabilitation models. *Psychosomatics*, 60(6), 556–562. <https://doi.org/10.1016/j.psym.2019.07.002>
- Kantor, J., Campbell, E. A., Kantorová, L., Marečková, J., Regec, V., Karasová, K., Sedláčková, D., & Klugar, M. (2022). Exploring vibroacoustic therapy in adults experiencing pain: A scoping review. *BMJ Open*, 12(4), e046591. <https://doi.org/10.1136/bmjopen-2020-046591>
- Kantor, J., Vilímek, Z., Vítězník, M., Smrčka, P., Campbell, E. A., Bucharová, M., Grohmannová, J., Špinarová, G., Janíčková, K., Du, J., Li, J., Janátová, M., Regec, V., Krahulcová, K., & Kantorová, L. (2022). Effect of low frequency sound vibration on acute stress response in university students—Pilot randomized controlled trial. *Frontiers in Psychology*, 13, 980756. <https://doi.org/10.3389/fpsyg.2022.980756>
- Katlen da Silva, L., Silva Brito, T. S., Pascucci Sande de Souza, L. A., & Luvizutto, G. J. (2021). Music-based physical therapy in Parkinson's disease: An approach based on international Classification of Functioning, Disability and Health. *Journal of Bodywork and Movement Therapies*, 26, 524–529. <https://doi.org/10.1016/j.jbmt.2020.08.015>
- Katušić, A., & Mejaki-Bošnjak, V. (2011). Effects of vibrotactile stimulation on the control of muscle tone and movement facilitation in children with cerebral injury. *Collegium Antropologicum*, 35, 57–63.
- Kelly, S. E. (2012). Qualitative Interviewing Techniques and Styles. In I. L. Bourgeault, R. Dingwall, & R. G. De Vries (Eds.), *The SAGE handbook of qualitative methods in health research*. SAGE.
- Kogutec, D. L., Holmes, J. D., Grah, J. A., Lutz, S. G., & Ready, E. (2016). Active music therapy and physical improvements from rehabilitation for neurological conditions. *Advances in Mind-Body Medicine*, 30(4), 14.
- Kozłowska, K., English, M., Savage, B., & Chudleigh, C. (2012). Multimodal Rehabilitation: A Mind-Body, Family-Based Intervention for Children and Adolescents Impaired by Medically Unexplained Symptoms. Part 1: The Program. *The American Journal of Family Therapy*, 40(5), 399–419. <https://doi.org/10.1080/01926187.2012.677715>
- Lazarus, A. A. (1976). *Multimodal behavior therapy*. Springer.
- Lazarus, A. A. (2006). *Brief But Comprehensive Psychotherapy: The Multimodal Way*. Springer Publishing Company.
- Leandertz, M., Joukainen, J., Pesonen, T., & Ala-Ruona, E. (2021). Psychotherapeutically oriented vibroacoustic therapy for functional neurological disorder: A pilot study. *Music and Medicine*, 13(1), 20–30. <https://doi.org/10.47513/mm.v13i1.754>
- Lidstone, S. C., MacGillivray, L., & Lang, A. E. (2020). Integrated therapy for functional movement disorders: Time for a change. *Movement Disorders Clinical Practice*, 7(2), 169–174. <https://doi.org/10.1002/mdc3.12888>
- Loewy, J. (2000). Music Psychotherapy Assessment. *Music Therapy Perspectives*, 18(1), 47–58. <https://doi.org/10.1093/mtp/18.1.47>
- Lu, G., Jia, R., Liang, D., Yu, J., Wu, Z., & Chen, C. (2021). Effects of music therapy on anxiety: A meta-analysis of randomized controlled trials. *Psychiatry Research*, 304, 114137. <https://doi.org/10.1016/j.psychres.2021.114137>
- McLoughlin, C., Hoeritzauer, I., Cabreira, V., Aybek, S., Adams, C., Alty, J., Ball, H. A., Baker, J., Kim, D., Burness, C., Dworetzky, B. A., Finkelstein, S., Garcin, B., Gelauff, J., Goldstein, L. H., Jordbru, A., Huys, A.-C. M., Laffan, A., Lidstone, S., ... McWhirter, L. (2023). Functional neurological disorder is a feminist issue. *Journal of Neurology, Neurosurgery & Psychiatry*, 0, 1–7. <https://doi.org/10.1136/jnnp-2022-330192>
- Montgomery, S. A., & Åsberg, M. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry*, 134(4), 382–389. <https://doi.org/10.1192/bjp.134.4.382>
- Moore, K. S. (2013). A Systematic Review on the Neural Effects of Music on Emotion Regulation: Implications for Music Therapy Practice. *Journal of Music Therapy*, 50(3), 198–242. <https://doi.org/10.1093/jmt/50.3.198>
- Naghdi, L., Ahonen, H., Macario, P., & Bartel, L. (2015). The effect of low-frequency sound stimulation on patients with fibromyalgia: A clinical study. *Pain Research and Management*, 20(1), e21–e27. <https://doi.org/10.1155/2015/375174>
- Pick, S., Anderson, D. G., Asadi-Pooya, A. A., Aybek, S., Baslet, G., Bloem, B. R., Nicholson, T. R., Brown, R. J., Carson, A. J., Chalder, T., Damianova, M., David, A. S., Edwards, M. J., Epstein, S. A., Espay, A. J., Garcin, B., Goldstein, L. H., Hallett, M., Jankovic, J., ... Tinazzi, M. (2020). Outcome measurement in functional neurological disorder: A systematic review and recommendations. *Journal of Neurology, Neurosurgery and Psychiatry*, 91(6), 638–649. <https://doi.org/10.1136/jnnp-2019-322180>
- Pick, S., Goldstein, L. H., Perez, D. L., & Nicholson, T. R. (2019). Emotional processing in functional neurological disorder: A review, biopsychosocial model and research agenda. *Journal of Neurology, Neurosurgery and Psychiatry*, 90(6), 704–711. <https://doi.org/10.1136/jnnp-2018-319201>

- Punkanen, M., & Ala-Ruona, E. (2012). Contemporary Vibroacoustic Therapy: Perspectives on Clinical Practice, Research, and Training. *Music and Medicine*, 4(3), 128–135. <https://doi.org/10.1177/1943862112445324>
- Ruotsalainen, J., Carlson, E., & Erkkilä, J. (2022). Rhythmic exercises as tools for rehabilitation following cerebellar stroke: A case study integrating music therapy and physiotherapy techniques. *Nordic Journal of Music Therapy*, 31(5), 431–453. <https://doi.org/10.1080/08098131.2022.2026452>
- Rüütel, E. (2002). The psychophysiological effects of music and vibroacoustic stimulation. *Nordic Journal of Music Therapy*, 11(1), 16–26. <https://doi.org/10.1080/08098130209478039>
- Scheiby, B. B. (2002). Improvisation as a musical healing tool and life approach: Theoretical and clinical applications of Analytical Music Therapy (AMT) improvisation in a short-and long-term rehabilitation facility. In K. Aigen (Ed.), *Analytical Music Therapy* (pp. 115–155). Jessica Kingsley Publishers.
- Sihvonen, A. J., Särkämö, T., Leo, V., Tervaniemi, M., Altenmüller, E., & Soinila, S. (2017). Music-based interventions in neurological rehabilitation. *The Lancet Neurology*, 16(8), 648–660. [https://doi.org/10.1016/S1474-4422\(17\)30168-0](https://doi.org/10.1016/S1474-4422(17)30168-0)
- Thaut, M. H. (2010). Neurologic music therapy in cognitive rehabilitation. *Music Perception*, 27(4), 281–285. <https://doi.org/10.1525/mp.2010.27.4.281>
- Ustun, T. B., Kostanjsek, N., Chatterji, S., Rehm, J., & World Health Organization. (2010). *Measuring health and disability: Manual for WHO Disability Assessment Schedule (WHODAS 2.0)* / edited by T.B. Üstün, N. Kostanjsek, S. Chatterji, J. Rehm. 88.
- Voon, V., Cavanna, A. E., Coburn, K., Sampson, S., Reeve, A., & Curt LaFrance, W. (2016). Functional neuroanatomy and neurophysiology of functional neurological disorders (Conversion disorder). *Journal of Neuropsychiatry and Clinical Neurosciences*, 28(3), 168–190. <https://doi.org/10.1176/appi.neuropsych.14090217>
- Wigram, T. (1997a). The effect of vibroacoustic therapy compared with music and movement based physiotherapy on multiply handicapped patients with high muscle tone and spasticity. In *Music Vibration and Health* (pp. 69–86). Jeffrey Books.
- Wigram, T. (1997b). The effect of vibroacoustic therapy on multiply handicapped adults with high muscle tone and spasticity. In *Music Vibration and Health* (pp. 57–68). Jeffrey Books.
- Zigmond, A., & Snaith, R. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica*, 67(6), 361–370.

Ελληνική περίληψη | Greek abstract

Πολυτροπική δονητική-ακουστική μουσικοθεραπεία για τη λειτουργική νευρολογική διαταραχή: Το κλινικό πρωτόκολλο MTFUND και αρχικές εκτιμήσεις από ποικίλες οπτικές

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ΠΕΡΙΛΗΨΗ

Η Λειτουργική Νευρολογική Διαταραχή (ΛΝΔ) είναι μία νευροψυχιατρική νόσος που προκαλείται από προβλήματα στη λειτουργία του νευρικού συστήματος, κατά την οποία οι ασθενείς εμφανίζουν νευρολογικά συμπτώματα, με αποτέλεσμα σοβαρή λειτουργική δυσλειτουργία και δυσφορία. Οι διάφοροι υπότυποι της ΛΝΔ κατηγοριοποιούν το ευρύ φάσμα ποικίλων συμπτωμάτων που είναι κοινά της ασθένειας, από κινητικά σε αισθητηριακά και γνωστικά. Το εύρος των συμπτωμάτων που βιώνουν σε συνάρτηση με συννοσηρότητες και παράγοντες κινδύνου όπως το άγχος και οι διαταραχές διάθεσης, καθιστούν ιδιαίτερα δύσκολη την σχεδίαση κατάλληλων εξατομικευμένων θεραπευτικών προγραμμάτων για ασθενείς με ΛΝΔ. Η βιβλιογραφία υποδεικνύει ότι η επιλογή πολυτροπικών θεραπευτικών προσεγγίσεων φαίνεται να μπορούν να χρησιμοποιηθούν με επιτυχία σε αυτό τον πληθυσμό, λόγω της δυνατότητας να ενσωματώνουν την σωματική φροντίδα με τις ψυχολογικές ανάγκες των ασθενών. Το κλινικό πρωτόκολλο MTFUND χρησιμοποιεί πολυτροπική δονητική-ακουστική μουσικοθεραπεία, κατά την οποία τα στοιχεία (δονητική-ακουστική θεραπεία και ενεργητική μουσικοθεραπεία) ανταποκρίνονται στην ανάγκη για εξατομικευμένη φροντίδα εξαιτίας της ευέλικτης φύσης τους ως παρεμβάσεις παρέχοντας παράλληλα ένα συνεπές δομημένο πρωτόκολλο θεραπείας. Παρουσιάζεται το πρωτόκολλο MTFUND και σκιαγραφούνται λεπτομέρειες σχετικές με την τρέχουσα ερευνητική μελέτη. Για την αξιολόγηση του πρωτοκόλλου, πραγματοποιήσαμε ημιδομημένες συζητήσεις με ασθενείς και θεραπευτές. Διεξήχθησαν δύο ξεχωριστές επαγωγικές αναστοχαστικές θεματικές αναλύσεις για να εξεταστούν οι εμπειρίες τους. Οι θεματικές ενότητες που αναπτύσσονται συνεισφέρουν σε μία ολοκληρωμένη κατανόηση των εμπειριών των ασθενών

με ΑΝΔ και των απόψεων των θεραπειών σχετικά με την εφαρμογή του πρωτοκόλλου, συμβάλλοντας ουσιαστικά στην αξιολόγηση της αποτελεσματικότητας του πρωτοκόλλου

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

δονητική-ακουστική θεραπεία, μουσικοθεραπεία, πολυτροπικότητα, λειτουργική νευρολογική διαταραχή, διεπιστημονικότητα, κλινικό πρωτόκολλο

ARTICLE

Building relationships in music therapy: A case study with a boy with Down syndrome based on transcendental phenomenological analysis

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ABSTRACT

This practice-based article came from experience that occurred during a sixth-semester internship at a primary school in Denmark with special classes for children with learning disabilities. The client of this case is a nine-year-old boy with Down syndrome. This qualitative case study investigates the impact of relationships in music therapy and how they can influence the development of the therapy. The study explores how the relationship between a music therapist and a client with Down syndrome affects the therapeutic outcome and the client's development and participation in music therapy. This study came from a qualitative case study with material derived from the four music therapy sessions using sequences of video recordings. Based on a phenomenological approach, the material had been analysed through microanalysis using thematic coding, horizontal analysis, and qualitative analysis. The results indicate that relationships are the key to development in music therapy. The client shows more initiative and becomes more independent throughout the sessions. Finally, this study indicates that the client's communicative skills and the development of the music therapy sessions show improvement as the relationship between the music therapist and the client improves.

KEYWORDS

music therapy,
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relationship,
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approach

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INTRODUCTION

Music therapy is a form of treatment that uses music to promote communicative skills and social interactions and enhance relational experiences through the client's expressions (Mössler et al., 2017). The music therapist Carpente (2009) has suggested that relationships and attachment are essential for a child's development. It is thus assumed that good relationships create good outcomes. Mössler et al. (2017) reported that psychotherapeutic studies show that the development of the therapeutic relationship can predict or act as an indicator of therapeutic change. They conducted a study with children with autism spectrum disorders (ASD). They investigated whether the therapeutic relationship in a music therapy process could indicate whether there would be general changes in the participants' social skills. The study found that the music therapy relationship was a significant predictor of the child's development of social skills as well as of their communication skills (Mössler et al., 2017).

Down syndrome (DS) is a condition in which a person has a third chromosome (Centers for Disease Control and Prevention [CDC], 2021). Babies with DS have an extra copy of one of these chromosomes, chromosome 21. People with DS present some specific characteristics that vary among different people with this condition. Some of the characteristics are: a flat face with a small nose with a low nasal bridge, almond-shaped eyes, small ears, a tongue that tends to stick out of the mouth, small feet and hands, shorter than average height, muscle laxity, and hypermobile joints (CDC, 2021). As a result of having DS, it is also common to have one or more health problems such as hearing loss, sleep apnea, ear infections, or eye diseases.

In addition to the physical characteristics, Boston Children's Hospital (n.d.) explains that this client group typically also has a low intelligence level (IQ), which means that learning may be slightly more difficult, and the children will reach developmental milestones such as walking or talking later than other neurotypical children. They may be challenged in attention, language, and communication. Behaviourally, individuals with DS appear stubborn and impulsive and can easily throw tantrums. Despite these challenges, many children in this client group have good social skills and use non-verbal communication to connect with others from the time they are newborns. In addition, they are also good visual learners and understand best when they can see something, for example, through concrete pictures or demonstrations (Boston Children's Hospital, n.d.).

There is a lack of publications regarding music therapy for DS, but at least two populations can be highlighted in this area. O'Donoghue (2017) studied music therapy on parent-child interaction, specifically focusing on children with a diagnosis of DS. This case study involves two in-depth cases of children diagnosed with DS and their primary caregivers. Scarpeta (2012) investigated the effect of music therapy on the control of dental anxiety in children with DS. When comparing the anxiety level and the behaviour of the groups during dental consultation, the following was observed: 80% of the children without anxiety were in the group exposed to music therapy versus 27% in the control group.

During the internship experiences and based on the client's development, it was interesting to observe how the relationship between the client and the music therapist affected the child's engagement in music therapy. This background leads to the following question: based on a transcendental phenomenological design (with a narrative and qualitative analysis) of an explorative, intrinsic case study with a nine-year-old boy with DS, what is the significance of relationship formation in music therapy and how does it influence the client's development and participation?

DEFINITION OF TERM AND LITERATURE REVIEW

Phenomenology

Phenomenological inquiry seeks to discover and describe the structure and meaning of a phenomenon that makes it intrinsically what it is (Jackson, 2016). This project consists of a phenomenological study based on the German philosopher Husserl's (2014) philosophical direction called transcendental phenomenology, as it attempts to create a representation of a phenomenon through analysis and further descriptions thereof (Jackson, 2016).

Phenomena (variables)

Joint attention

Joint attention is a term used especially in the context of infants but also in many studies of children with various developmental disorders, such as ASD. Kim (2006), a music therapy researcher, writes in her study that joint attention in infant developmental psychology is also called joint visual attention, which is to look at the same point as someone else. From birth until six months, an infant interacts with its mother through direct eye contact, also referred to as joint visual awareness. When a typically developing child is between six months and two years of age, they will begin to look around more and use joint attention more by shifting their focus from toys to the mother and then back to toys. Typically, joint attention occurs when the child is playing with something and wants to show it to their mother, when the child points to something, or when the child has accomplished or achieved something (Kim, 2006).

Bakeman and Adamson (1984) distinguish between two forms of joint attention between a partner and an object:

1. Passive joint involvement: when the partner carries out an activity with an object, the child's attention is often drawn to that activity but not to the partner. For example, when the mother rattles a toy, the infant's attention is only on the toy, and it will try to reach for it even though the mother's action captures the infant's attention.
2. Coordinated joint attention: the infant actively coordinates engagement between the partner and the object. For example, in addition to reaching for the rattling toy, the infant will also pay attention to the mother by smiling or pointing at the toy when she moves the toy.

In summary, joint attention is thus defined as two people having a shared focus on an object to interact with each other (Kim, 2006).

Initiative

According to The Danish Dictionary (Den Danske Ordbog, n.d.), joint attention is an action that sets a series of events or activities stemming from a specific (innovative) idea or objective in motion. In short, it means to initiate something.

Joint attention can be divided into two categories: responding to joint attention (RJA) and initiating joint attention (IJA) (Mundy & Newell, 2007). RJA refers to the child's ability to respond to the gaze direction or gestures of others used to draw attention to a shared point or object. IJA refers to the child's use of eye contact and gestures, e.g., pointing, to draw the attention of others to a particular point, object, or themselves and often occurs spontaneously.

Continuing the conversation

To participate in social communication, it is essential to develop the ability to take turns. Beginning during the child's infancy, this skill is trained by parents' responding to the child's expressions by, for example, smiling back or talking to the child when they make sounds (CDC, 2022). In addition, it is trained through conversations, play, and games throughout the years when the child is growing up.

Holck (2004) explains that in a well-functioning conversation, non-verbal, visual, and auditory cues (giving signs) are used, which make the conversation flow back and forth without interruptions or speaking all at once. This is crucial in an interaction between two or more people. Through analysing these turn-taking cues, information can be obtained about a person's social skills, regardless of whether the dialogue is verbal or nonverbal (Holck, 2004).

Shared moments

One of the concepts that guides the understanding of the variables studied in the case that will be presented is the understanding of "shared moments." According to Mössler et al. (2019; 2020), the crucial and distinct aspects of music therapy involve musical and emotional attunement and synchronisation, which are fundamental for fostering the structuring and management of relational encounters rooted in the physical realm, akin to the establishment of a connection between a baby and its caregiver during its early formative years. Engaging in music offers a means to explore diverse corporeal aspects of relational existence, potentially aiding in fostering emotional synchronization between the child and the therapist.

Music therapy DIRFloortime

One of the central approaches used to guide the case described below is the Developmental, Individual-differences, Relationship-based model also known as the DIRFloortime music therapy model. Carpentre (2009) developed this proposal from his clinical experience as a music therapist trained in the DIRFloortime ASD intervention model and the Creative Music Therapy model (also known as the Nordoff-Robbins model).

Among the main characteristics of this model is the focus on the stages of development, the understanding of the individual as someone unique and the relationships established with the patient (where the patient takes the lead in the interactions) (Carpente, 2009). In addition, the model is based on including the family in the care context (not precisely in every session). In this way, family members can continue the work carried out in the music therapy setting at home (especially concerning playful ways of creating musical experiences). Another primary feature of the model is music based on affection. The music therapist needs to demonstrate forms of affect, from how they use their voice to how they play with the patient. A third major characteristic of the model is the use of musical

improvisation. Although Carpente considers the influence of different models of improvisation on his approach, Nordoff-Robbins music therapy is the "flagship" for explaining the theoretical and practical forms of intervention. However, it is essential to note that there are fundamental differences between the Nordoff-Robbins model and DIRFloortime. The first difference is that the Nordoff-Robbins model focuses much more on music. Although the DIRFloortime model is music-centred, the relationship is equally important. In the Nordoff-Robbins model, music determines a large part of the interventions, much more than the relationships built. The other significant difference is the greater focus on the patient's leadership of the interactions. Even though the Nordoff-Robbins model focuses on the patient's leadership, the therapist has a stance of proposing musical ideas more strongly compared to DIRFloortime.

METHOD

Case study

A case study is based on a specific case that is found interesting. This can be a particular situation, a group, an organisation, an individual, an object, and more (Robson & McCartan, 2016). One examines a phenomenon and its context to understand it (Robson & McCartan, 2016) based on transcendental phenomenological design. The case design of the current project is called 'intrinsic,' as it is based on creating understanding in a specific case (Stake, 1995). The case study aims to explain what is happening and why, which makes this an exploratory case study with an intrinsic design (Murphy, 2016).

Transcendental phenomenological design

The transcendental phenomenological inquiry focuses on understanding a phenomenon by means of analysing its essential structure and thoroughly describing it (Jackson, 2016). This design phenomenological inquiry is also sometimes referred to as constructive phenomenology because the final descriptive synthesis is a conscious construction of a new understanding of the phenomenon that has been reached through a transcendence of the natural attitude. For this case, specific phenomena and processes are described considering how the client develops different forms of relationships in the music therapy process and how these relationships might impact the client during the music therapy process. In this sense, the focus is on the client's experiences and the relationship with the music therapist. Regarding the quantitative presentation of data, the quantitative information wasn't analysed, but they were used to organise it before conducting a qualitative approach to the data.

Description of the case

Theo is a nine-year-old boy with DS. He has some important learning difficulties and limited language. However, the client can clearly express what he wants/does not want through the words "yes" and "no" and expresses himself with clear body language and sounds. He mirrors everyone around him both

emotionally and in movement. For this reason, he is challenged when engaging in social interactions. He has difficulty understanding the social rules. This often causes him to be overstimulated, resulting in him reacting violently towards the other children.

In class he is influenced by the moods of the other children. If another child is angry and reluctant and does not want to participate in the lesson, he mirrors this and becomes unwilling. He is also challenged in his fine motor skills and is sensitive to sensory stimuli – especially concerning the tactile sensory system. Because of his sensorial difficulties, he can find two pieces of a puzzle and place them correctly next to each other but cannot put them together himself. He loves music. He sings along and makes gestures when songs with gestures are sung. The first author of this article is the therapist of the case.

The project investigates the impact of the relationship between the music therapist and the client on the client's development. By relationship, the authors mean initiative, turn-taking, and joint attention related to connections as described above. Selected sequences from four different sessions are used. The four video sequences consist of the same activity with a balloon. This activity was first introduced to the client in session two and was used each time in the remaining six sessions of the music therapy process. Except for the video sequence from session 3, the activity begins with the song "Jeg er en lille blå ballon" [I am a little blue balloon] which is described in the selection of data later in this article. The song is seen as the longest mark in the video sequences in the following transcripts. Session 3 begins with turn-taking, where the music therapist and the client take turns pulling the uninflated balloon and saying words and sounds such as "yes, yes" and "no" before singing, and the activity begins.

Earlier, the category system was described that forms the basis for the choice of video sequences. This development takes place over the four sessions and consists of the following actions in each session:

Session 2: The client does not want to pick up the balloon but points to it, takes the music therapist by the hand and has the music therapist pick it up. Furthermore, he touches the balloon briefly afterwards but quickly drops it again as he does not like how it feels to touch the balloon.

Session 3: The music therapist cues the client to pick up the balloon by pretending she cannot reach it.

Session 4: The client picks up the balloon himself. The music therapist cues him by looking at him, then at the balloon, and then at him again.

Session 5: The client picks up the balloon himself when the song is finished and without the music therapist doing anything to make him pick it up.

Analysis methods and design

Ethnographic descriptive approach to video microanalysis

The ethnographic approach, together with video microanalysis, is a good tool for investigating and contextualising interactions and small communication expressions, especially with clients who are

communicatively limited (Holck, 2007). This analytical tool is particularly well suited to describe what is happening between the client and the music therapist and can help to make therapists and students aware of which interactions are taking place partially or completely outside the music therapist's awareness (Holck, 2007). Holck's method follows four basic steps:

1. Data selection,
2. Transcription,
3. Pattern generalisation – horizontal and vertical analysis,
4. Interpretation.

Plahl's video microanalysis

Plahl (2007) has developed a microanalysis model for analysing aspects of preverbal communication, such as joint attention, emotional signalling, and behavioural regulation in children with different developmental disorders. Through video microanalysis of music therapist's and client's communicative performance, it is possible to describe and analyse what works in music therapy and understand why it works or does not (Plahl, 2009). In Plahl's (2009) video microanalysis, there are five essential steps:

1. Constructing a category system
2. Defining and selecting the sample of sequences (time sampling, event sampling)
3. Choosing the program of analysis and the technique of coding
4. Training application of category system and assessing reliability (inter-, interrater)
5. Analysing different parameters on a micro level (frames, seconds, minutes)

(Plahl, 2007, p. 43).

ELAN

The computer software ELAN version 6.3 (2022) is a tool that can be used to record and transcribe both audio and video recordings. It allows you to add notes and comments in words, phrases, descriptions, or translations for various parts or sequences of the exact recording (ELAN, 2022). ELAN also creates different layers or levels that provide an overview of the coding and the other focus points (ELAN, 2022).

Analysis design

The analysis of the four video sequences was inspired by Holck's (2007) and Plahl's (2007) methods of analysis, and they were carried out by the music therapist of the case (first author). The idea of having the therapist in charge of the video analysis was to be more pragmatic and closer to the real life of the music therapy practice. Inspired by these analysis models, the study of this project was based on the following points:

Category system (focus points)

First, a system of categories is developed in terms of definitions of behaviours (phenomena/variables) and their meaning (Plahl, 2007). The focus points of the analysis for the observation of the video sequences are defined as follows:

- The client responds to the music therapist's initiative: the focus of attention, the client responding to the music therapist's initiative, is when the client mirrors the music therapist and/or acts on the music therapist's ideas through verbal, non-verbal, auditory, and visual cues.
- Client's initiative: the client's initiative is when the client spontaneously tries to create or initiate something.
- Joint attention: it is when the client and the music therapist have a shared focus on an object or a point, e.g., a balloon.
- Turn-taking: it is taking turns interacting through verbal, non-verbal, auditory, or visual cues.

Selection of data

This point is inspired by both Holck's (2007) first step of her video microanalysis model and by Plahl's (2007) second step of her analysis model. It is based on a specific musical activity which is introduced in session 2 and repeated in all the following sessions including the eighth and final session. The activity begins with the song "Jeg er en lille blå ballon" [I am a little blue balloon]. The song begins by singing about the balloon and its colour, which can vary from session to session. It continues by singing that there is no air in the balloon and that if you want air in it, you must blow it up yourself. Towards the end, "blow" is sung three times. After each sung "blow" the music therapist blows a little air into the balloon, and after the three blows the balloon is completely inflated. Then the music therapist holds out the balloon and sings "until it bursts with a..." whereafter the client is encouraged to hit the balloon. As the client hits the balloon, the phrase is completed by singing "bang!" and the music therapist releases the (untied) balloon so it flies across the room. Hereafter the client must try to find the flat balloon and afterwards it is to be picked up as part of the activity. Of these eight sessions, seven are recorded on video, giving video material of a total of 4 h., 16 min. and 53 sec. A sequence has been selected from sessions 2, 3, 4, and 5, with each sequence lasting between 46 sec. and 1 min. and 2 sec. depending on the duration of the activity in that session. These four sessions/time sequences have been chosen because the target behaviours started from the activity introduced in session 2 and occurred over the subsequent three sessions. It means that the same activity is assessed in all the selected sessions and the time duration will depend on the duration of the target activity. Therefore, analysing this development at a micro-analytical level is relevant for investigating what is happening.

Transcription

Plahl's (2007) third step of the analysis model deals with the coding technique for the analysis. In this project, the coding technique that was developed was inspired by Holck's (2007) second step of the analysis model. The use of ELAN was also included. In this study, a narrative notation is used in which the music therapist describes the observations in her own words.

Analysis of the data

The project is inspired by Plahl's (2007) method of analysis, especially concerning the presentation of the analysis. Based on a horizontal (Holck, 2007) and a quantitative organisation, the data is presented based on transcriptions performed in ELAN. Here, what happens in the video sequences is narrated and patterns are searched for. Finally, the findings of the analysis are interpreted through a discussion of the results.

First, a narrative notation was made through a horizontal transcription of the four video sequences. The horizontal transcription was performed using the computer software ELAN (2022) (see section above). The y-axis shows the different codes and selected focus points for the music therapist and the client, respectively. The focus points presented on the y-axis are client responding to music therapist's initiative, client's initiative, joint attention, and turn-taking, divided into two to mark when the music therapist takes a turn and when the client takes a turn. To see when the client responds to the music therapist's initiative, the music therapist's initiative is also marked in the analysis. In addition, the verbal communication and sounds of the music therapist and the client are noted to provide an overview of what is being said between the music therapist and the client and to get an idea of how it influences the other focus points.

The x-axis shows the temporal evolution of the session over time. The markings for the music therapist are shown as red boxes, the client markings as green boxes, and the markings for both are shown as purple boxes.

Ethics

Based on the General Data Protection Regulation (GDPR) rules and in order to protect personal data, the place of internship and the client are anonymised in this article and its case. Before the music therapy session, consent was obtained from the client's guardian as the client is not of legal age. In this consent, the client's guardian has permitted the video recordings of the music therapy sessions and further use of the video material in the current project. The case that gave rise to the analysis presented here is derived from a clinical process carried out during the internship of the first author. This case was used in her bachelor's thesis, which was transformed into this article. For this reason, the authors only obtained the informed consent of those responsible for using the data presented here.

RESULTS

This section describes the different results according to the different sessions. The results also include some figures that help in the description of the different findings.

Session 2

Session 2 lasts 33 min. and 38 sec. Of these, a video sequence from 23:20-24:12 in the session has been selected lasting 52 sec. Below is the horizontal transcription of these 52 secs. (Figure 1).

The client responds to the music therapist's initiative: first, the video sequence begins with an extended response from the client to the music therapist's initiative, with the music therapist singing the song, 'I'm a little blue balloon,' and the client singing along shortly after. After this, the transcription

shows that the client reacts to most of the initiatives music therapist takes, with reactions of different lengths. The client does not respond to six of the music therapist's initiatives.

Client's initiative: the figure shows that the client takes the initiative twice. In the figure, these initiatives are seen as a substitute for a reaction by the client to the music therapist's initiative.

Joint attention: in the middle of the video sequence, joint attention occurs between the music therapist and the client. It is observed that the first time this joint attention occurs, it is relatively short. By the end of the session, the joint attention lasts longer.

Turn-taking: after the song is finished, some turn-taking between the music therapist and the client occurs. It is seen that the music therapist initiates the turn-taking twice and ends them both times.

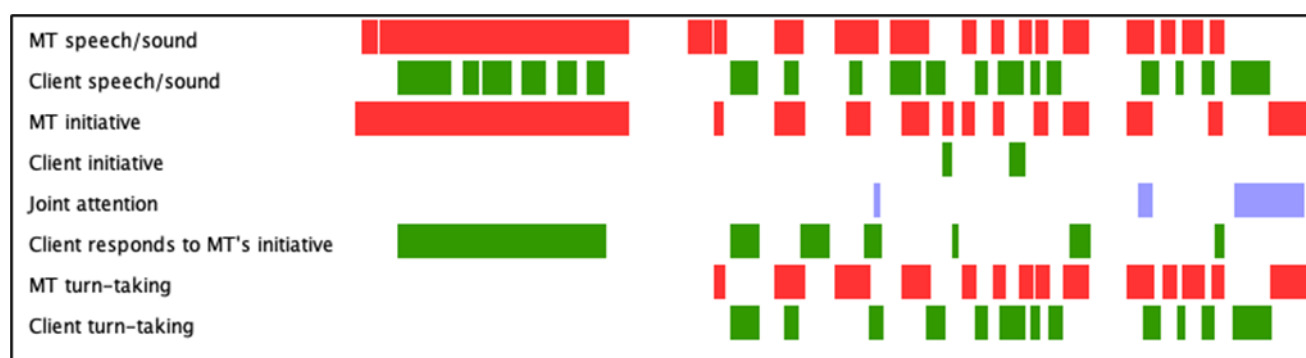


Figure 1: Horizontal transcription of session 2

Session 3

Session 3 has a duration of 35 min. and 38 sec. The video sequence has the time code 13:21-14:18 in the session and lasts 57 sec. Below is the horizontal transcription (Figure 2).

The client responds to the music therapist's initiative: in this sequence, it is seen that the client responds to all of the music therapist's initiatives. The response is staggered by the music therapist's initiatives, and there is an extended response in the middle of the sequence where the song is sung.

Client's initiative: the transcription shows that the client takes the initiative himself twice while responding to an initiative from the music therapist. However, it should be added that in Figure 2, the client takes the initiative two times when the music therapist does not develop a new initiative.

Joint attention: There is joint attention from the beginning of this sequence. It is only interrupted a few times but is otherwise present for most of the session. However, the length of joint attention becomes shorter towards the end of the sequence.

Turn-taking: in this sequence, there is also a lot of turn-taking. The first turn-taking interaction is initiated by the music therapist but completed by the client. The second turn-taking interaction is both created and conducted by the music therapist. In this interaction, there are also two times where the client does not take turns; therefore, the music therapist takes turns twice in a row before the client takes his place in the turn-taking pattern again.

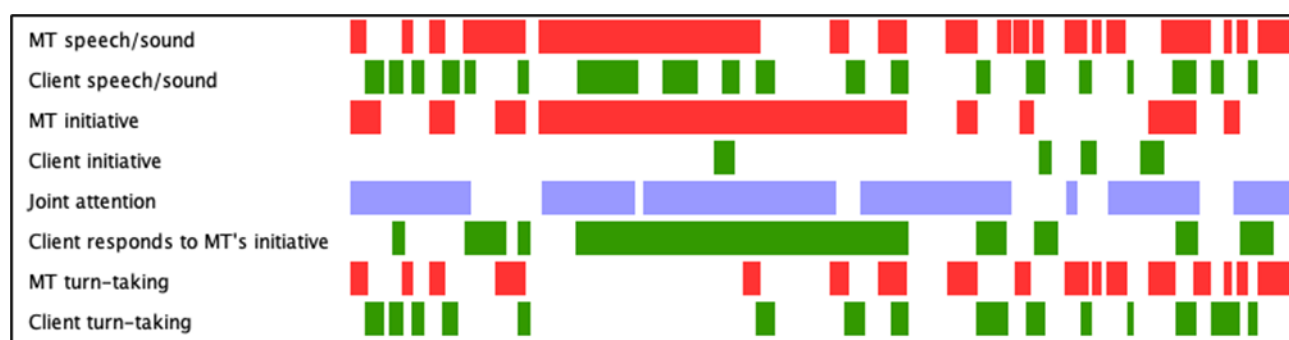


Figure 2: Horizontal transcription of session 3

Session 4

Session 4 is 40 min. and 56 sec. long. The video sequence is from the middle of the session from time code 22:47-23:49. The sequence has a duration of 1 min. and 2 sec., and the horizontal transcription is shown below (Figure 3).

The client responds to the music therapist's initiative: In this sequence, the client responds to all of the music therapist's initiatives. However, the music therapist does not take the initiative as often in this sequence, and in addition to the long initiative with the song, there are only three more initiatives to which the client can respond.

Client's initiative: the client briefly shows initiative during the song and a more extended initiative at the end of the sequence.

Joint attention: toward the end of the song, joint attention is created and continues for a while after the song has ended. Brief joint attention occurs a few times toward the end of the sequence.

Turn-taking: in this sequence, there is turn-taking, but less frequently than in the previous two sequences. The communication is initiated and completed by the music therapist.

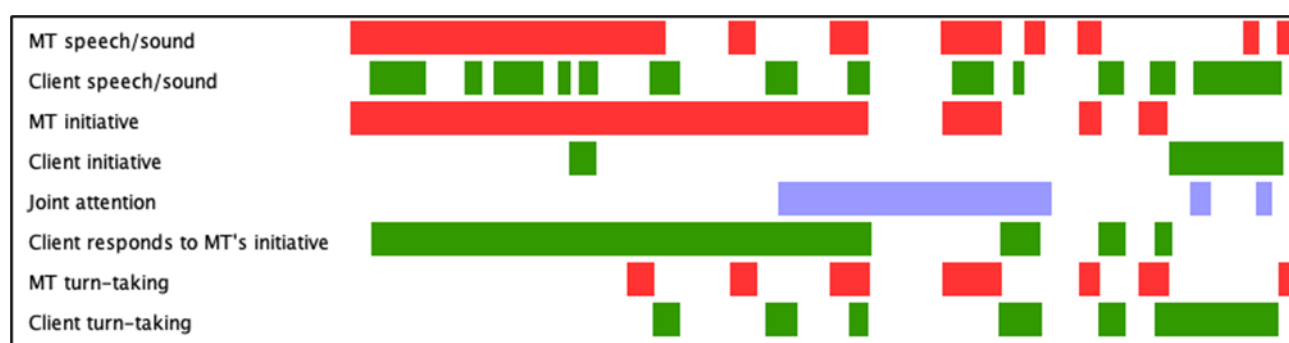


Figure 3: Horizontal transcription of session 4

Session 5

Session 5 has a duration of 35 min. and 2 sec. The video sequence is selected shortly after the beginning of the session from 8:41-9:27. The sequence has a length of 46 sec., and its horizontal transcription is shown below (Figure 4).

The client responds to the music therapist's initiative: the client responds to all but one of the music therapist's initiatives. There is one extended response, three short ones, and one long response.

Client's initiative: the client shows initiative during the song. Then there is a pause, after which the client shows initiative three times in a row. First, one that lasts for a while, followed by two short ones.

Joint attention: here, joint attention only occurs towards the middle of the sequence. Then the joint attention increases in length, and joint attention occurs twice. At the end of the transcription, it is seen that the joint attention becomes twice as long as the previous one.

Turn-taking: the first turn-taking interaction is initiated and completed by the music therapist. The client responds or does not respond to two of the music therapist's attempts to pass the turn. However, the client initiates the second turn-taking interaction and completes it.



Figure 4: Horizontal transcription of session 5

Quantitative organisation

The data from the horizontal transcription are inserted in a table to provide an overview of the frequency of the different focus points in the four video sequences. On the left of Table 1 are the focus points and on the right are the number of times each focus point occurs in the video sequence from that session.

Client responds to the music therapist's initiative: in session 2, the music therapist initiates thirteen times of which the client responds to seven of them. There are thus six initiatives that do not trigger a reaction from the client. In sessions 3 and 4, the client responds to all the music therapist's eight and four initiatives respectively, whereas in session 5 the client reacts to five out of six of the music therapist's initiatives.

Client's initiative: from session 2 to session 3, the client's initiative increases twofold from two initiatives to four. This pattern holds from session 4 to session 5 where it also goes from two to four times.

Joint attention: in sessions 2, 4, and 5 there is joint attention three times, while in session 3 there is joint attention seven times.

Turn-taking: In sessions 2, 3, and 5 the music therapist has the turn twice as much as the client, while in session 4 it is only once. When comparing the tables, there is an association between the music therapist's turn-taking and the client's turn-taking. It seems that the more turn-taking the music therapist presents, the more turn-taking the client demonstrates.

Focus points	Frequency of focus points per session			
	<i>Session 2</i>	<i>Session 3</i>	<i>Session 4</i>	<i>Session 5</i>
Music therapist's initiative	13	8	4	6
Client responds to music therapist's initiative	7	8	4	5
Client's initiative	2	4	2	4
Joint attention	3	7	3	3
Turn-taking	14	17	7	7
Client turn-taking	12	15	6	5

Table 1: Frequency of the focus points in session 2, 3, 4 and 5

Summary of the results of the analysis

The four focus points for the analysis were:

- Client responds to the music therapist's initiative
- Client's initiative
- Joint attention
- Turn-taking

Looking at sessions 2 and 3, it is noticed that the music therapist initiates many things in the activity and is very keen to get the client to participate. This is seen in the number of times the music therapist takes the initiative and in the number of times turn-taking occurs. In sessions 2 and 3, it is also the music therapist who initiates the turn-taking every time. This can be interpreted as the client mirroring or copying the music therapist's expression and therefore just following along during the session. This is, hence, a reaction to the music therapist's initiatives.

In sessions 4 and 5, the music therapist takes less initiative and the number of episodes decreases when compared to the first two sessions. Even though the frequency of the client taking the initiative is similar when looking at sessions 2 and 3, the length of the client's initiative increases significantly. The length of the initiatives in sessions 4 and 5 increase to double, if not triple, when compared to the first two sessions. Common to sessions 3, 4, and 5 is that the client shows initiative when the music therapist pauses. This indicates that the more the music therapist gives space to the client, the more prolonged the client's bouts of initiative become.

In three of the four video sequences, joint attention occurs three times. In session 3, however, there is an important difference as joint attention occurs seven times and almost extends over the entire activity. In sessions 3 and 4, there is a lot of joint attention compared to sessions 2 and 5, where the length of joint attention is the same. Overall, joint attention occurs when the object (balloon) is in motion and needs to be picked up.

Finally, a correlation between the music therapist's and the client's initiatives is observed. When the music therapist takes a lot of initiative and engages in frequent turn-taking, the client responds to this most of the time, showing only minimal initiative. But when the music therapist takes less initiative, initiates less turn-taking, and gives more space, the client takes more initiative. The joint attention also occurs towards the end of the activity when the balloon flies around and must be picked up before the activity can start again.

DISCUSSION

Discussion of results

The analysis results show that the music therapist takes a lot of initiative and initiates the turn-taking in sessions 2 and 3. This seems to cause the client to react to these initiatives and take less initiative himself. This may reflect that it is early in the music therapy process and that the activity is new. Therefore, there are still a lot of new impressions for the client to relate to, and as the client is challenged with DS, this client group is also characterised by learning difficulties. From the case description above, it is understood that the client needs predictability and a good, safe environment. Being with a new person in a completely new environment, the client is pulled out of the safe and usual environment. In the first sessions, the client is burdened with all the new impressions he must process. This might cause him to take less initiative because his focus is on so many other things in addition to the activity presented. One can imagine that this could be why the client responds to most of the music therapist's initiatives, because it is a play rule he knows from his everyday life where he mirrors others and because it is more accessible or tangible for him. This fits well with LaGasse's (2017) explanation that music can be used to train social skills. Here it is seen that the client's social behaviour is trained through imitation of the music therapist's initiatives and that he responds to what his interaction partner produces.

Another point of view is that the relationship between the music therapist and the client is strengthened during the sessions. In the first sessions, the client must learn who the music therapist is, what the music therapist does, how the interaction with the music therapist is, how the music therapist reacts, and what the boundaries are when the client is with the music therapist. These are just some of the many things involved in forming a new relationship, and one can imagine that it can easily become overwhelming on top of the many other new experiences. The goal of DIRFloortime is to "understand the challenges of each unique child and facilitate their development through a tailored process to reach their full potential" (Carpente, 2009, p. 7). The music therapist is active in the first sessions because the new activity needs to be introduced. By repeating the activity over and over during each session, the music therapist creates predictability for the client regarding what will happen and what the music therapist does. As with DIRFloortime, she tailors the activity to the client, allowing the activity to be repeated and meeting the client at his level while allowing the client to develop. This is also seen through the activities where there is a development from the client not wanting to pick up the balloon and touch it to him voluntarily picking it up. This development occurs against the background of the music therapist using techniques in music therapy such as cueing, gaze, repetitions, and pauses to meet the client where he is and, at the same time, challenge him to promote

his development. As the client experiences predictability and recognisability in the activity and the music therapist's actions concerning the activity, it can provide more space for the client to dare to explore and detach more from the music therapist.

The third perspective suggests the emergence of a relationship is characterised by the establishment of boundaries and limits, as well as the establishment of familiarity and predictability. Rather than using energy and focusing on the environment, the client can have the energy to focus on what is happening in the moment. Similar to many children who require time to feel comfortable in new surroundings, the same applies to the client. Looking at the analysis results of the client's own initiative-taking, it appears that the client feels more liberated to respond to his own impulses. A solid foundation and safe environment have been established, allowing space for exactly what he brings forth to be acknowledged and accepted as it is.

The results of joint attention, which were broadly similar, coincide with the theory that children with DS may be challenged with their attention abilities. However, it should be noted that there was only one camera to film the music therapy interaction. Therefore, there may have been several moments of joint attention that were not apparent because the camera angle needed to allow both the music therapist's and client's faces to be seen.

Discussion of results in relation to new theory

This section discusses the results of the analysis in the light of different theories. Dorothea Pienaar works as a music therapist in New Zealand and has published an article on music therapy for children with DS (Pienaar, 2012). Her article was based on a questionnaire given to persons who care for or work with persons with DS. She explains how infants communicate through song and music by imitating, hitting notes, singing along, and creating a melodic duet with the person they are interacting with (Pienaar, 2012). She further explains that children with DS have good nonverbal skills from infancy but that this ability develops slowly (Pienaar, 2012). Pienaar explains:

They have more interest in people and do not respond in a typical way to interactions which involve a person and an object. This lack of referential eye-contact (moving the eyes from person to object and back again) leads to reduced opportunity for a caregiver to name an object and talk about it. (Pienaar, 2012, p. 38)

Pienaar's (2012) point of view about the challenge of creating joint attention between the child with DS, another person, and an object may explain why the analysis indicates that there is not a significant amount of joint attention occurring in the video sequences. Pienaar (2012) describes that it can be challenging for a caregiver to focus on an object and talk about it, as the child has an impaired ability to shift gaze from a person to the object and back to a person again. Thus, there may be an impaired capacity of what Bakeman & Adamson (1984) call coordinated joint attention, where the child only sees the object that the other person is moving but does not see the person behind the movement. Bakeman & Adamson (1984) distinguish between passive joint engagement and coordinated joint attention, but the question is whether one can distinguish these two forms of joint attention. These

two forms of joint attention cannot be distinguished based on the analysis results. Although the client does not seem to participate in joint attention during the actual singing in the activity, joint attention occurs when the object (balloon) moves around the room. However, the client stays connected with the music therapist and shifts his attention to the music therapist when the balloon has fallen to the ground. Therefore, this joint attention occurs only briefly. Rather than running after the object and picking it up immediately, the client stays in the relationship with the music therapist. They stand laughing together for several seconds before the object is picked up.

Some common characteristics exist between an infant's communication skills and a child with DS, such as imitation. This seems evident and frequent in the analysis of the first two video sequences, which could be an expression of the early communication patterns, as children with DS cognitively typically correspond to half their age.

Pienaar (2012) explains that one of the strengths of music therapy for children with DS is that it can support those linguistically challenged children because music therapy can help the child's expression through music, dance, and song. She further believes that "music is used as a communication tool in music therapy sessions, and relationships are pivotal in these sessions" (Pienaar, 2012, p. 38). So, does this mean that success in music therapy sessions cannot be achieved if relationships are poor? According to Carpente (2009), relationships are essential for a child's development, and the more the child trusts and feels at ease with the music therapist, the more likely he is to engage in the music therapy process and make progress. Pienaar (2012) believes that while relationships are essential for the child to use music as a means of communication, sessions can still be successful even if the relationship is not yet fully developed or is just beginning. The session can be successful on many levels and with different focus points. However, based on Carpente's (2009) and Pienaar's (2012) views on the importance of relationships in the development of music therapy, it can be argued that the higher the quality of the session, the better the relationship between the music therapist and the client is. This could be related to the clients' feeling more comfortable in the sessions and, on that basis, showing more initiative.

Kim (2006) conducted a study of ASD children in which she defines "initiation of engagement" as when the child spontaneously requests or initiates an interaction with the music therapist. This definition is like the project's focal point, "client's initiative." However, Kim (2006) believes that initiation of engagement has a further dimension which she adds to her definition, referring to when the child changes the way it plays with the music therapist with the anticipation that the music therapist will follow the child, or when the child initiates a shift in the interaction. Kim's (2006) definition clarifies what initiative itself entails, while simultaneously providing a more precise framework for defining what constitutes the child's initiative. This makes it easier for the reader to understand the concept and identify more precisely when the child takes the initiative.

On the other hand, it can be difficult to distinguish whether the child initiates by creating a change in play or is unable to imitate or respond in the same way as the music therapist, resulting in the child displaying behaviour that can be mistaken for initiating change. In that case, it would be more tangible to provide examples of gestures, such as pointing, which clearly indicate the initiation of an action, to avoid confusion about whether it is defined as initiative or not. However, the initiative has many aspects and ways it can be shown because people are different. It can therefore take time to produce a precise definition.

Kim (2006) also adds that initiation of engagement is a rare behaviour in children with ASD. As some cases of DS might have some behavioural similarities with the ASD, this may be a relevant factor to relate to the findings of the analyses of the client's initiation, which occurred only a few times during the video sequences.

Comparison of results

Kim (2006) found that improvisational music therapy effectively promotes joint attention in children. As our proposal was not focused on improvisational music therapy, an exact comparison with Kim's findings is not possible. However, both proposals (our proposal and Kim's publications) found out that it is possible to achieve forms of joint attention focusing on the interaction with the client. Kim (2006) also found that more prolonged eye contact, joy, emotional synchronicity, and initiation of engagement occurred in improvisational music therapy. This is partially different from the findings of this project. No development in eye contact, joy, and emotional synchronicity was found because these focus points were not included in this project. However, this project has in common with Kim's (2006) study that development in taking the initiative was found and that the length of the initiatives became longer throughout the sessions.

Plahl (2007) examines preverbal communication in a case of a five-year-old boy with ASD and developmental disabilities. The boy is developmentally equivalent to a 20-month-old child. She uses the category system KAMUTHE (KAtagoriensystem MUSikThERapie), which she developed (Plahl, 2007). In her study, she categorises three types of behaviour in music therapy: musical, verbal, and non-verbal (Plahl, 2007). She focuses on the child's gaze, play/musical activity, vocalisation, and gesture. In addition, she has used these categories with both the music therapist and the child adding subcategories such as looking at an object, playing with an object, and laughing (Plahl, 2017). Some of these subcategories differ from the focus points of our project, such as the focus on speech and singing and an overall focus on the music therapist's behaviour (Plahl, 2017). However, these studies have in common that the subcategory of the child looking at an object may be similar to this project's focus point on joint attention if the music therapist is also looking at the thing simultaneously.

In terms of computer software, Paulsen (2021) uses a program called INTERACT® in her bachelor's thesis to micro-analyse her data. This program is somewhat like ELAN and is used to analyse behaviour in video recordings, but it has some different features than ELAN. In INTERACT®, the other focus points of the microanalysis are coded, which gives an overview of what is happening in the session. Paulsen (2021) has also complemented this microanalysis with a transcription of the conversation between the music therapist and the client in the video sequences. This is different from this project's analysis, as no conversation transcription was done because the client has limited speech.

Finally, a comparison is made with Popescu's (2021) master's thesis, in which she examines the behaviour and patterns of a seven-year-old boy with ASD who receives improvisational music therapy. The results show that the boy's behaviour and patterns are changed, and even new ones emerge through the musical stimuli. A trustful relationship is built through music, where the client can explore and engage in musical activities (Popescu, 2021). These findings might address the client's development and a trustful relationship between the music therapist and the client, and this is

precisely what this project investigates. Even though Popescu's study is based on a case of a child with ASD, the common denominator for the projects is that a study of a child with neurodevelopmental disorders is proposed where a change in the child's behaviour is seen in the analysis.

Discussion of the study methodology

The analysis method for the project has been developed continuously throughout the analysis process. Holck's (2007) analysis method and Plahl's (2007) analysis method has therefore served as inspiration and an example of how the analysis could be carried out in the best way possible and end up with the best possible results. Holck's (2007) four points of analysis (data selection, transcription, pattern generalisation, and interpretation) have provided a clear guide through the analysis process. It has served as a recipe for what is important to mention in the microanalysis of the video recordings. Plahl's (2007) analysis method has also provided a clear overview during the analysis process, especially in terms of how to present and organise the information for the reader. Plahl's (2007) method of analysis has also served not only as an elaboration of Holck's (2007) method, but also as a motivation and inspiration to develop an analysis method that worked well for this project.

During the transcriptions of the video sequences, it was discovered that the focus points (see analysis design) could have been even clearer to be sure that the author and the reader of the project would have the same understanding of these. Furthermore, it was noticed that some of the focus points could have been divided to create an even better understanding for further analysis. For example, one could have divided initiative into verbal and nonverbal. This would result in the initiatives being shown even more clearly.

The selection of data was quite straightforward as it was based on a specific activity. This activity was relatively short and it, therefore, seemed obvious to select approximately one minute from each session for further analysis. The video sequences from each of the four sessions made it manageable to work with the data and use the data for further analysis. However, the data material was selected on the basis that there was a development over the four sessions. Had the sequences been randomly chosen instead of the development within one activity, the results may have been more "real."

Microanalysis of the video sequences has been a good tool to work in depth with verbal and nonverbal behaviour and to investigate its meaning at a micro level. Through transcription in ELAN, an overview of this behaviour was created, and the interactions and reactions of the music therapist and the client were clarified. ELAN is an easy-to-use program with many more features than those used in the present project. Although other computer software could have performed the transcription task at the same level or perhaps even better, ELAN's visual presentation of the transcriptions was satisfactory and made it easy to examine interaction patterns between the music therapist and the client.

As the music therapist of the case also acts as an author of this article, she is naturally affected by bias. It also means that the role of the head of the project is less objective than if the study had been conducted by a researcher who had not been in the situation and experienced the client. The head of the project is influenced by having been the music therapist in the music therapy process with the client herself because she knows him and his expressions. During the transcription of the video

sequences, there is a risk that she may have interpreted the client's expression as, e.g., initiative when in fact it may have been a reaction to the music therapist's initiative. This may also have been the case for some of the other focus points.

As a music therapist working on your own case, you want to see a development in the work you have done. This desire can influence the results as one can force a development that may not have existed in an objective perspective of a researcher who had no relation to the case. On the other hand, being present in the situation and the same room as the client also plays a role. There are a lot of aspects that cannot be captured on camera, and what you feel and sense in the situation as the music therapist is as important as what you see. Especially when working with relationships, one can analyse and draw on theories about the importance of, e.g., eye contact or physical contact for the relationship, but a relationship is also about chemistry and sensing each other, and this is not captured on the camera. Therefore, the fact that the head of the project is the same as the case's music therapist can also be an advantage because this contributes to dimensions of the interaction that could otherwise not be seen but which are important to create a holistic picture of the interaction. Having said that, it coincides with the role of the phenomenological researcher, where the researcher tries to understand a given phenomenon from his/her own experience and understanding of the event. It also means that different researchers could get different results from the same event.

CONCLUSIONS

Based on the results, it is concluded that building a relationship between the music therapist and the client is essential in music therapy, as the relationship is a crucial prerequisite for the client's development through the music therapy interaction. The therapeutic relationship between the music therapist and the client allows the client to practice his communication skills. The client's tendency to mirror is reduced while the client's ability to take initiative increases. Based on this, it is concluded that the client's communicative skills are developed and strengthened due to the relationship.

Based on the secure relationship formed in this case between the music therapist and the client, it is concluded that the client takes more initiative and becomes more independent as the relationship is strengthened through the sessions. In the first sessions, it is seen that the client's participation in music therapy stems from the music therapist's initiatives. The client's involvement, therefore, decreases in frequency throughout the sessions but increases in intensity as his reactions and initiatives last longer. It is therefore concluded that the development of the music therapy sessions increases as the relationship between the music therapist and the client becomes more secure. Finally, it is concluded that the relationship has a positive effect on the client's development, e.g., the client overcomes his tactile hypersensitivity. He goes from not wanting to touch the balloon to picking it up on his initiative. The relationship helps to motivate the client to move from needing help to pick up the balloon to picking it up voluntarily.

IMPLICATIONS OF THE STUDY

This project has drawn attention to the importance of building a good and secure relationship between music therapists and their clients and that this helps to create good preconditions for the client's

development. It is essential to be aware of not only the client's expressions, but also that the client has so much potential that a music therapist must learn to identify and recognise to promote the client's strengths and address the areas that may be challenging.

During the work with this project, it has been shown that it is difficult to find literature on music therapy for people with DS. No literature could be found in Danish, only a little in English, and a little more in various other languages. The hope of this article is to contribute to the literature on music therapy with people with DS and to contribute to people recognising the many possibilities of music, as this article shows the results of change happening with this target group through music therapy.

It can be difficult to incorporate music therapy as a treatment option on par with physiotherapy, speech therapy, and occupational therapy. Hopefully, in the future, it will be possible for music therapy to become a treatment option in day care centres and schools working with children with developmental disabilities. Music therapy has enormous potential for children with physical and psychological disabilities, and the future will bring even more experiences and research in this area.

REFERENCES

- Bakeman, R., & Adamson, L. (1984). Coordinating attention to people and objects in mother infant and peer-infant interaction. *Child Development*, 55, 1278-1289. <https://doi.org/10.2307/1129997>
- Boston Children's Hospital (n.d.). Down syndrome. <https://www.childrenshospital.org/conditions/down-syndrome>
- Carpente, J. A. (2009). *Contributions of Nordoff-Robbins music therapy within a developmental, individual-differences, relationship-based (DIR®)/Floortime™ framework to the treatment of children with autism: Four cases studies* [Doctoral dissertation, Temple University].
- Centers for Disease Control and Prevention (CDC) (2021). Facts about down syndrome. <https://www.cdc.gov/ncbddd/birthdefects/downsyndrome.html>
- Centers for Disease Control and Prevention (CDC) (2022). Important milestones: Your baby by four months. <https://www.cdc.gov/ncbddd/actearly/miles-tones/milestones-4mo.html>
- Den Danske Ordbog (n.d.). Initiativ [initiative]. <https://ordnet.dk/ddo/ord-bog?query=initiativ>
- ELAN. (2022). EUDICO Linguistic Annotator (Version 6.3) [Computer software]. The Language Archive. <https://archive.mpi.nl/tla/elan>
- Gómez Scarpetta, R. Á., Durán Arismendy, L., Cabra Sosa, L. J., Pinzón Vargas, C. T., & Rodríguez Becerra, N. R. (2012). Music therapy to control dental anxiety in children with Down syndrome. *Hacia la Promoción de la Salud*, 17(2), 13-24.
- Holck, U. (2004). Turn-taking in music therapy with children with communication disorders. *British Journal of Music Therapy*, 18(2), 45–54. <https://doi.org/10.1177/135945750401800203>
- Holck, U. (2007). An ethnographic descriptive approach to video microanalysis. In T. Wosch & T. Wigram (Eds.), *Microanalysis in music therapy* (pp. 29-40). Jessica Kingsley Publishers.
- Husserl, E. (2014). *Ideas: General introduction to pure phenomenology*. Routledge.
- Jackson, N. A. (2016). Phenomenological inquiry. In K. Murphy & B. Wheeler (Eds.), *Music therapy research* (pp. 885-906). Barcelona Publishers.
- Kim, J. (2006). *The effects of improvisational music therapy on joint attention behaviours in children with autistic spectrum disorder*. [Doctoral dissertation, Aalborg University].
- LaGasse, A. B. (2017). Social outcomes in children with autism spectrum disorder: A review of music therapy outcomes. *Patient Related Outcome Measures*, 8, 23–32. <https://doi.org/10.2147/PROM.S106267>
- Mössler, K., Gold, C., Aßmus, J., Schumacher, K., Calvet, C., Reimer, S., Iversen, G., & Schmid, W. (2019). The Therapeutic Relationship as Predictor of Change in Music Therapy with Young Children with Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders*, 49(7), 2795–2809. <https://doi.org/10.1007/s10803-017-3306-y>
- Mössler, K., Schmid, W., Aßmus, J., Fusar-Poli, L., & Gold, C. (2020). Attunement in music therapy for young children with autism: revisiting qualities of relationship as mechanisms of change. *Journal of Autism and Developmental Disorders*, 50(11), 3921-3934. <https://doi.org/10.1007/s10803-020-04448-w>
- Mundy, P., & Newell, L. (2007). Attention, joint attention, and social cognition. *Current Directions in Psychological Science*, 16(5), 269–274. <https://doi.org/10.1111/j.1467-8721.2007.00518.x>
- Murphy, K. (2016). Interpretivist case study research. In K. Murphy & B. Wheeler (Eds.), *Music therapy research* (pp. 1135-1146). Barcelona Publishers.
- O'Donoghue, J. (2017). The observed experiences of music therapy on parent-child interaction for families with children with Down syndrome. *Voices: A World Forum for Music Therapy*, 17(2). <https://doi.org/10.1584/voices.v17i2.892>
- Paulsen, A. (2021). "Mere end et grin." *Et fænomenologisk casestudie, der undersøger fænomenet latter som glæde og forsvarsmekanisme i et musikterapiforløb med et barn med cerebral parese* ["More than a laugh." A phenomenological case study that investigates the phenomenon of laughter as joy and defense mechanism in music therapy with a child with cerebral palsy] [Bachelor's Thesis, Aalborg University].

- Pienaar, D. (2012). Music therapy for children with Down Syndrome: perceptions of caregivers in a special school setting. *Kairaranga*, 13(1), 36–43. <https://eric.ed.gov/?q=down+syndrome+music&id=EJ976663>
- Plahl, Christine. (2007). Microanalysis of preverbal communication in music therapy. In T. Wosch & T. Wigram (Eds.), *Microanalysis in music therapy* (pp. 41-53). Jessica Kingsley Publishers.
- Popescu, M. (2021). *Let me play a song for you: A qualitative single case study: Can improvisational music therapy with a boy with autism spectrum conditions make a difference in opening new windows of opportunities?* [Master's Thesis, Aalborg University]. Det digitale projektbibliotek. https://projekter.aau.dk/projekter/files/414766323/Masterthesis_Musictherapy_Monique_Popescu_May_2021_DigitalEksam.pdf
- Robson, C., & McCartan, K. (2016). *Real world research*. Wiley.
- Stake, R. E. (1995). The unique case. In R. E. Stake (Ed.), *The art of case study research* (pp. 1-13). Sage.

Ελληνική περίληψη | Greek abstract

Χτίζοντας σχέσεις στη μουσικοθεραπεία: Μια μελέτη περίπτωσης με ένα αγόρι με σύνδρομο Down βασισμένη σε μια υπερβατική φαινομενολογική ανάλυση

Rikke L. Højvang Christensen | Gustavo Schulz Gattino

ΠΕΡΙΛΗΨΗ

Βασισμένο στην πράξη, αυτό το άρθρο προήλθε από την εμπειρία κατά τη διάρκεια του έκτου εξαμήνου πρακτικής άσκησης σε ένα δημοτικό σχολείο στη Δανία με ειδικά μαθήματα για παιδιά με μαθησιακές δυσκολίες. Ο πελάτης σε αυτήν την περίπτωση είναι ένα αγόρι εννέα ετών με σύνδρομο Down. Η παρούσα ποιοτική μελέτη περίπτωσης ερευνά την επίδραση των σχέσεων στη μουσικοθεραπεία και πώς μπορούν να επηρεάσουν την εξέλιξη της θεραπείας. Η μελέτη διερευνά πώς η σχέση μεταξύ ενός μουσικοθεραπευτή και ενός πελάτη με σύνδρομο Down επηρεάζει το θεραπευτικό αποτέλεσμα και την ανάπτυξη και συμμετοχή του πελάτη στη μουσικοθεραπεία. Αυτή η μελέτη προήλθε από μια ποιοτική μελέτη περίπτωσης, με υλικό που προέκυψε από τις τέσσερις συνεδρίες μουσικοθεραπείας χρησιμοποιώντας ακολουθίες βιντεοσκοπήσεων. Με βάση μια φαινομενολογική προσέγγιση, το υλικό αναλύθηκε μέσω μικροανάλυσης χρησιμοποιώντας θεματική κωδικοποίηση, οριζόντια ανάλυση και ποιοτική ανάλυση. Τα αποτελέσματα της έρευνας υποδεικνύουν ότι οι σχέσεις είναι το κλειδί της ανάπτυξης στη μουσικοθεραπεία. Ο πελάτης εκδηλώνει μεγαλύτερη πρωτοβουλία και αποκτά περισσότερη ανεξαρτησία κατά τη διάρκεια των συνεδριών. Τέλος, η μελέτη υποδεικνύει ότι οι επικοινωνιακές δεξιότητες του πελάτη και η εξέλιξη των μουσικοθεραπευτικών συνεδριών βελτιώνονται καθώς βελτιώνεται η σχέση μεταξύ του μουσικοθεραπευτή και του πελάτη.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, σύνδρομο Down, σχέση, φαινομενολογική προσέγγιση

ARTICLE

Safe and Sound: A mixed-methods study to explore relationships between special education classroom practitioners and autistic students through music therapy consultation

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ABSTRACT

This study investigated the accessibility and viability of the *Safe and Sound* music therapy consultation protocol for classroom practitioners seeking to optimise relationships with students in a UK school providing specialist education for autistic children. Winnicott's theory of the holding environment provided the framework for an original evaluation instrument, which underpinned an autism-focused staff development programme. Five participants evaluated their usual musical interaction with a student (pre-intervention). Following the development programme (intervention), participants undertook six filmed music sessions with the same individual (post-intervention). Two self-chosen extracts, pre- and post-intervention, were self-rated against the evaluation instrument. Participants then reflected on their experiences in interviews. The same ten randomised video extracts were similarly rated by 18 UK music therapists. Qualitative results evidenced participants' learning during the study as enabling them to attune to the student and hold them in mind. Quantitative results showed the realisation of this in adaptation to the student through concrete musical skills. The study indicated that Winnicott's theory of the holding environment could support the optimisation of classroom practitioner-student relationships. The small sample prohibits outcomes generalisation and further research is needed to explore wider protocol viability.

KEYWORDS

music therapy
consultation,
autism spectrum,
Winnicott,
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INTRODUCTION

Responding to a locally identified need, music therapy consultation speaks to a growing focus on collaborative and interdisciplinary professional practice (Maclean & Tillotson, 2019; Steele et al., 2020; Strange et al., 2017). Research demonstrates that classroom practitioners with no formal musical

training can be supported by a music therapist to facilitate music sessions with children with special educational needs to enhance development and learning (Clough & Tarr, 2021; Margetts, 2022; Tomlinson, 2020).

The present study was motivated by the outcomes of the author's doctoral music therapy consultation research at a Development Centre for children with complex needs in Belarus (Margetts, 2022). A key finding showed that participating classroom practitioners required support to maintain two levels of awareness in this work—the internal process of change in perceiving and empathising with the student, which then underpinned the development of concrete musical interactional skills. In accordance with the Centre's request, results evidenced a significant qualitative shift in practitioner-student relationships with a positive impact on educational outcomes. Furthermore, potential transferability of the research protocol to wider contexts was indicated.

Central to that intercultural doctoral research was a new staff development programme designed for classroom practitioners working with children with complex needs (Margetts et al., 2020). The structure and processes of this first iteration are published elsewhere (Margetts, 2022). This present study investigated the accessibility, relevance and applicability of an autism-focused adaptation of that programme in a UK school. This second iteration has been named *Safe and Sound*. A structured, taught staff development programme specifically designed to support classroom practitioners seeking to optimise relationships with autistic students represents a currently unexplored area of music therapy research.

LITERATURE REVIEW

Research suggests that 1.2 million children and adults in England are on the autism spectrum (O'Nions et al., 2023). In a society which privileges neurotypical ways of being, autistic children can experience significant challenges in navigating social interaction and building relationships, with consequences for the individual's mental health and engagement with education.

The Cochrane Database for Systematic Reviews has evaluated the overall efficacy of music therapy for autistic children compared to other interventions (Geretsegger et al., 2022). Studies using a variety of methodologies have shown that engagement in co-improvised music-making within a therapeutic relationship can support the development of joint attention and focus, motivation, reciprocity, verbal and non-verbal communication and social interaction (Kim et al., 2009; Rickson, 2016; Tomlinson, 2020; Vlachová, 2022). This can increase emotional regulation and facilitate creative and accessible ways of being with others (Rickson, 2021).

Writing and research concerning collaboration between music therapists and classroom practitioners in school settings is increasing (Rickson, 2012; Skewes McFerran et al., 2017; Steele et al., 2020; Strange et al., 2017). Music therapists use their skills to collaborate with and support the work of their colleagues in schools (Strange, 2021), principally through developing capacity for music-making with individual students (Margetts et al., 2020; Tomlinson, 2020) and in the classroom (Arns & Thompson, 2019; Clough & Tarr, 2021; Steele et al., 2022).

Presenting a critical and interpretive review of literature concerned with music therapy consultation, Steele and colleagues (2020) found that sustaining positive outcomes of this work typically posed a significant challenge. Commonly encountered reasons included a staff team's

dependence on one passionate practitioner for maintenance of musical activities (McFerran et al., 2017) and situation-specific challenges such as timetabling and staff availability (Coombes & Tombs-Katz, 2017; Maclean & Tillotson, 2019). Sustainable outcomes have been found to be strengthened where the primary focus is on the professional needs of classroom practitioners rather than on the needs of students addressed through the upskilling of staff. Steele and colleagues (2022) subsequently devised and interrogated a professional learning programme, *Music for Classroom Wellbeing*, in which individual teachers were supported to use music to optimise inclusive practice in their classrooms. Practitioners foregrounded emotional wellbeing as a primary need, to which this individually tailored programme was found to contribute.

Research that evidences the importance of the teacher-student relationship in schools has increased in the past decade (Aspelin et al., 2021; McGreery, 2016). Teaching is a complex profession in which daily emotional challenges can arise from occupational, relational and societal interactions (Adams et al., 2016; Glover Gagnon et al., 2019; Muenchhausen et al., 2021; Poulou, 2020). Teachers generally wish to build positive relationships with their students that support professional motivation and provide essential emotional foundations of learning, including the ability to operate within boundaries, self-regulate, and focus (Glover Gagnon et al., 2019). The affective quality of individual teacher-student interactions may vary considerably across a classroom. Sustained experience of challenging emotional encounters with students has been identified as a predictor of teacher stress (Koenen et al., 2019). This can lead to emotional exhaustion and a reduced sense of self-efficacy (Brunsting et al., 2014), both of which are causal factors of burnout (Skaalvik & Skaalvik, 2007; Muenchhausen et al., 2021). Positive teacher-student relationships moderate stress (Glover Gagnon et al., 2019; Hopman et al., 2018), improve the teaching and learning experience and outcomes (Muenchhausen et al., 2021), and can be a protective mechanism for at-risk students (Aspelin et al., 2021).

The *Safe and Sound* music therapy consultation protocol is framed by Winnicott's (1960) theory of the *holding environment*. Founded within the natural processes of caregiver-infant interaction, Winnicott presented the holding environment as comprising mutually supportive processes of identification and adaptation. *Identification* describes the process whereby the primary caregiver's love enables attunement with and holding in mind of the infant's emotional state. *Adaptation* represents an active awareness and instinctive emotional and physical matching of that feeling state (Levinge, 2015). Through reliable experience, the infant can begin to take for granted that what is needed will be provided. Winnicott (1971) theorised that, through this process, the child's inner world is able to find an incentive for contact with the external world and so they will naturally begin to play. Conversely, without a good enough caregiver-infant relationship, playfulness cannot grow with potential consequences for healthy development.

Aspects of the caregiver-infant relationship have been identified that link to those in the classroom, prompting increased awareness of the role of attachment in meeting students' needs (Delaney, 2017; Riley, 2011; Rose et al., 2019). Where teaching staff can respond empathetically to each student, a school may offer a holding environment that supports self-regulation, self-agency and a sense of belonging (Hyman, 2012).

These principles lie at the centre of the *Safe and Sound* music therapy consultation protocol. Accordingly, the centrality of the relationship between classroom practitioner and student and between consultant and staff team in effective practice is foregrounded (Margetts, 2022; Rickson, 2012; Steele et al., 2022; Twyford & Rickson, 2013). Participants are supported to connect with potentially natural parenting skills in developing live, reciprocal relationships with autistic students. The process of becoming able to attune to a student takes place on an emotional as well as a cognitive level and underpins the development of correspondingly sensitive ways of relating based in musical interaction.

RESEARCH QUESTIONS

Research question 1: To what extent and in what ways might the *Safe and Sound* programme, framed by Winnicott's (1960) theory of the holding environment, as realised through musical interaction, be accessible, relevant and applicable to UK classroom practitioners in relation to their work with autistic children?

Research question 2: What is the impact of participants' learning, in terms of identification with and adaptation to autistic students through musical interaction, on the nature of classroom practitioner-student relationships?

RESEARCH CONTEXT

The setting for the study was part of the not-for-profit organisation Autism Unlimited, with whom the researcher has been employed for four years. The school provides specialised education for 110 students between the ages of 4 and 19 who are diagnosed as being on the autism spectrum. The school prioritises child-centred approaches in accordance with the UK's Ofsted's Education Inspection Framework (2019). A comprehensive Therapy Team works closely with educational staff to support students' individual learning journeys.

Participants

Following a presentation to a whole school staff meeting, five classroom practitioners volunteered to participate in the study: two teachers (T1, T2), two integrated support leaders (ISL1, ISL2) and one teaching assistant (TA). None of the participants had received formal musical training. Each practitioner worked with one student (not currently accessing music therapy) throughout. The students, four boys and one girl between the ages of seven and 10 years, used predominantly non-verbal communication methods. The participants suggested them in agreement with the children's class teachers.

RESEARCH METHOD

The study employed a convergent mixed-methods pre- and post-test design (Creswell, 2015). To answer the research questions, a pragmatic approach facilitating the exploration of a real-world context through both quantitative and qualitative information was adopted (Rickson et al., 2016). Winnicott's (1960) theory of the holding environment provided the framework for an evaluation instrument (Appendix), adjusted in accordance with the outcomes of the researcher's doctoral study (Margetts, 2018). This then underpinned the structure of the autism-focused staff development programme, integrating theoretical teaching, experiential work, observation and listening exercises, musical activities and spaces for reflection.

During six weekly group seminars, the programme aimed to support the development of existing understanding of behaviour as communication of feeling state, observation and listening skills and confidence in accessing creativity and playfulness. Each taught session corresponded to the core domains of the evaluation instrument, as shown in Table 1.

The points that the *Safe and Sound* programme would not be a music therapy training and that the researcher would not be working with the group as a therapist were emphasised throughout. Participants were encouraged to bring material from their classroom practice to group discussions, promoting a culture of dialogue. Individual supervision sessions and a training manual supported participants' learning processes, together with the researcher's availability via Autism Unlimited internal email system.

Prior to the staff development programme (pre-intervention), participants conducted ten minutes of musical interaction with a student, seeking to address the question: *"How can I engage this student in a playful musical interaction?"* A selection of musical instruments and a static video camera were provided. Participants were advised to aim to play with the student in their usual way in the classroom. Following engagement with the staff development programme (intervention), participants were supported to transfer their learning into six self-filmed music sessions with the same student (post-intervention). Self-monitoring of their work through reflective engagement with these videos was encouraged (Bishop et al., 2015). Continuing this process, participants then chose two extracts from the beginning of each pre-intervention and one post-intervention session, as a consistent point of comparison. These extracts were self-rated against the 10 descriptors of the evaluation instrument (Appendix) using a 10-point Likert scale where 1 denoted 'Strongly Disagree' and 10 'Strongly Agree'. A separate option of 'Don't Know' was also available. Participants then reflected in semi-structured interviews on their experience with the student. The transcriptions of these interviews were returned to participants for verification and comment prior to analysis. To provide triangulation, those same 10 pre- and post-intervention video extracts were randomised and rated in the same way by 18 UK music therapists. In accordance with the convergent mixed-methods design (Creswell, 2015), quantitative and qualitative data sets were analysed separately and then integrated to form a joint display (Figure 1).

Session format	Session outline
Training day (6 hours)	Introduction to the programme • Hopes and fears for learning • The importance of the teacher/pupil relationship • Why we are all musical • Attachment and children on the autism spectrum • Introduction to waiting, listening and looking • Group discussion • Musical activities throughout the day
Twilight session 1 (2 hours)	Individualising physical space (core domain 1) • Managing and moderating the environment for the child • Observation using elements 1-3 of the evaluation instrument • Group discussion • Musical activities
Twilight session 2 (2 hours)	Waiting, listening and looking (core domain 2) • Listening and observation in musical interaction • Video observation using elements 4-6 of the evaluation instrument • Group discussion • Musical activities
Twilight session 3 (2 hours)	Matching and adapting (core domain 3) • Matching and adapting in musical interaction • Video observation using points 7-9 of the evaluation instrument • Group discussion • Musical activities
Twilight session 4 (2 hours)	Playfulness • Secure attachment and playfulness • Video observation using the complete evaluation instrument • Group discussion • Musical activities
Twilight session 5 (2 hours)	Reflection and preparation • Reflective exercises • Preparation for music sessions • Introduction to the training manual • When is it time to refer to music therapy? • Musical activities

Table 1: Outline of the *Safe and Sound* programme

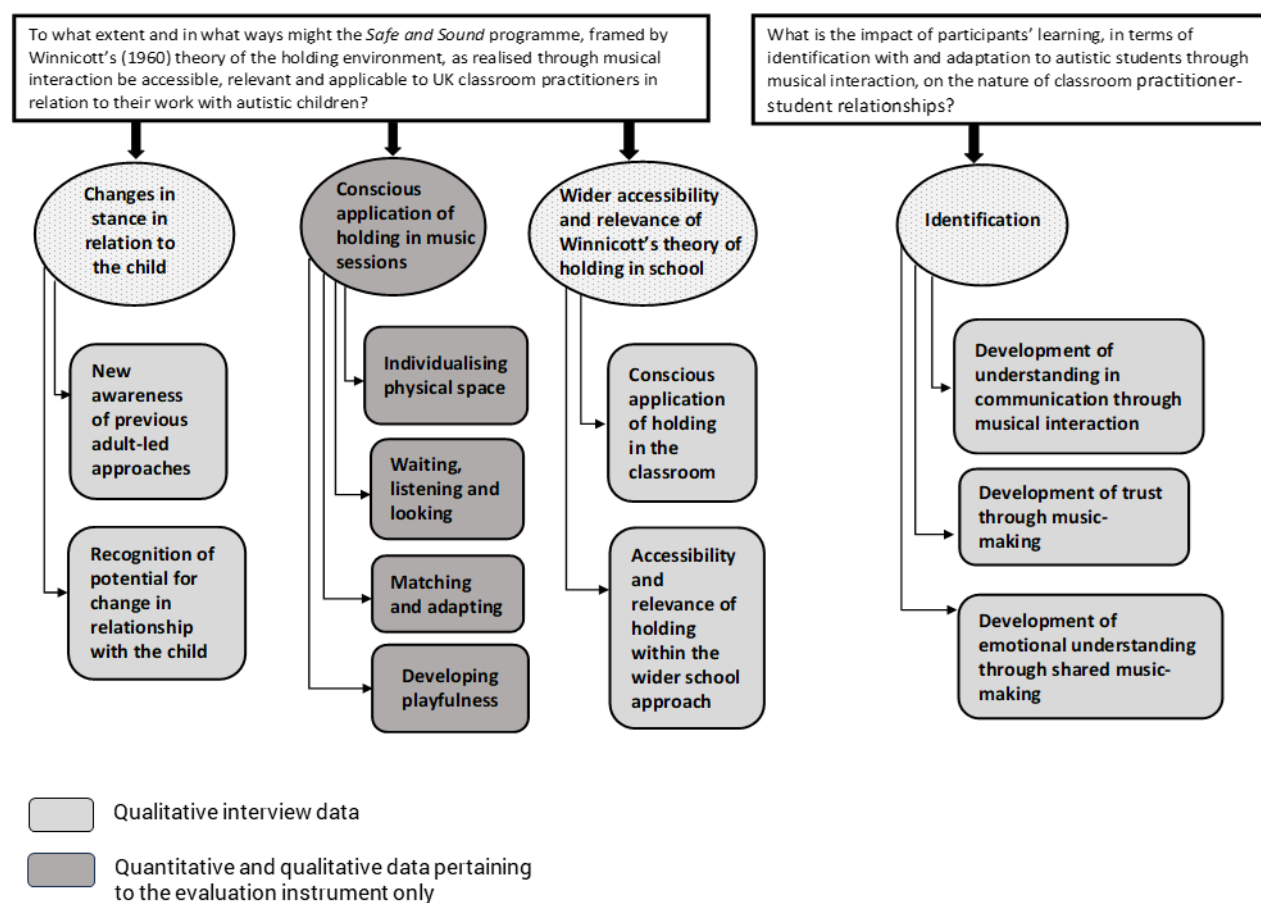


Figure 1: Thematic map derived from quantitative and qualitative data sets

RESULTS

Framed by the two research questions, an otherwise inductive thematic analysis of classroom practitioner participants' (N=5) verbatim interview data (Braun & Clarke, 2013) produced themes 1, 3 and 4, each with between 2 and 3 sub-themes. Verbatim data items were allocated once only.

Continuing to answer research question 1, quantitative and qualitative analysis was undertaken of data collated from five classroom practitioners and 18 UK music therapists pertaining directly to the 10 descriptors of the evaluation instrument. These results are shown in Table 3.

Research question 1 asked: To what extent and in what ways might the *Safe and Sound* programme, framed by Winnicott's (1960) theory of the holding environment, as realised through musical interaction, be accessible, relevant and applicable to UK classroom practitioners in relation to their work with autistic children?

Theme 1: Changes in stance in thinking about and relating to the student

New awareness of previous adult-led approaches

Four participants spontaneously recognised the extent to which they had led the pre-intervention music session for the student.

I think in my first session, I was just so keen for [the student] to ... essentially do something with the instruments there ... it was very much me guiding it rather than me allowing him to create and explore (T2).

I was just desperate to try and get her attention back and to bring her back in the room ... and try and do what we do in the classroom, which is make everything exciting for her (TA).

I was talking a lot more and I was leading a lot of it ... I also wanted him to sit instead of moving around the space (ISL1).

I felt like I sort of led it and I couldn't believe that actually (T1).

Recognition of potential for change in the relationship with the student

All participants recognised the potential for positive change in their relationship with the student.

Before ... the thing about our relationship that wasn't healthy was that he was so dependent on me. Whereas now he's not completely dependent on me, but we still have the relationship, which is nice (T2).

And it got to the point where he then wanted me in his world ... that was a *huge* step (T1).

Theme 2: Conscious application of Winnicott's (1960) theory of holding in music sessions

As described, classroom practitioners (N=5) self-rated their self-chosen pre-and post-intervention session extracts against the evaluation instrument descriptors using a 10-point Likert scale where 1 was 'strongly agree' and 5 'strongly disagree.' Results are shown in Table 2.

Owing to the small sample size, descriptive statistical analyses were undertaken of the five pairs of scores for each descriptor. The total percentage change for each is shown as *CP % change* in Table 3.

Eighteen UK music therapists similarly rated the same 10 now randomised pre- and post-test video extracts against the ten descriptors of the evaluation instrument. The larger sample enabled the use of an unpaired t-test to compare the means of pre- and post-test results, denoted as *MT t-test* in Table 3.

Next, a further unpaired t-test compared the means of the two combined sets of pre-test (N=888) and post-test (N=888) scores returned by the UK music therapist participants. The mean pre-test score was 6.4, with a standard deviation of 2. The mean post-test score was 7.3, with a standard deviation of 1.93.

The mean of pre-test minus post-test equals -0.92951200 with 95% confidence interval of this difference: From -1.11258261 to -0.74644139 and with a standard error of difference of 0.093. The t-statistic was 9.97, with df = 1775 ($p < .0001$). By conventional criteria, this change is considered to be extremely statistically significant.

Classroom practitioner self-rated scores											
Core domains	Rated elements	Pre-intervention					Post-intervention				
		P1	P2	P3	P4	P5	P1	P2	P3	P4	P5
Individualised physical space	1. Has set up the room appropriately for the child.	4	6	5	5	7	7	9	8	9	8
	2. Has structured the session appropriately for the child.	3	7	4	4	6	7	10	7	9	9
	3. Sets boundaries of acceptable behaviour according to the child's needs.	7	7	5	7	6	6	9	8	9	9
Waiting, listening and looking	4. Is able to wait and allow space for the child according to their individual needs.	4	2	6	4	6	7	10	9	8	8
	5. Observes the child closely and consistently.	8	7	7	5	7	7	10	9	9	9
	6. Listens to the child closely and consistently.	7	7	6	6	7	7	10	9	9	9
Matching and adapting	7. Is able to time and pace musical responses appropriately.	6	7	5	3	7	5	9	8	8	8
	8. Responds sensitively to all communications from the child: Musical and non-musical.	7	7	1	3	6	6	10	8	8	8
	9. Matches musical elements with the voice and/or an instrument.	6	7	5	2	6	7	10	7	8	9
Playfulness	10. The adult and the child together are able to enjoy creative and flexible musical play.	3	6	3	7	7	9	10	10	10	10

Table 2: Classroom practitioner self-rated scores

Core domain	Rated elements	Classroom practitioners (CP) qualitative data results	CP (N=5) % change	MT t-test
Individualised Physical Space	1. Has set up the room appropriately for the student	T1. So [the student] came in, he had room to move, he had space. The instruments were around for him to explore, him to lead, and I copied by finding instruments that were similar. T2. I think the setup with the drums in the middle on the red mat worked really well, because [the student] does like to walk around the room so much but having sort of that focal point in the middle, that in itself I think he found quite grounding. TA. [The student] loved the piano. She then would play other instruments but then wait for me to respond on the piano and that became our song. It was 'Pia pia piano.' She loved that. So yes, I think setting up the room where she was allowed to use the piano really helped her just <i>flourish</i>.	52% increase	Pre-test N=89 M = 7.03, SD = 1.72 Post-test N=87 M = 7.50, SD = 1.58 $t(85) = 1.9146$ $p = .0589$
	2. Has structured the session appropriately for the student	TA. I think I tailored it more to what [the student] needs, so relating each musical instrument to a song she likes, which then engages her. She has something to relate to. ISL1. I've got a structure, so there's a clear beginning, there's a clear part where he can do whatever, and then there's a clear goodbye. T2. And with my Phase 3 session it's why it was so clear that he'd got used to the structure because he started singing along with the goodbye song straight away. Whereas the [Phase 1] session was just kind of, "here are some instruments. Let's make some noise. OK, it's finished". There was no sort of preparation or a wind down or anything.	75% increase	Pre-test N=87 M = 6.58, SD = 1.77 Post-test N= 87 M = 7.09, SD = 1.88 $t(84) = 2.0411$ $p = .0444$
	3. Sets boundaries of acceptable behaviour according to the student's needs	T1. A couple of times he would perhaps stand on an instrument ... but then I would break the silence and I'd say, "we don't do that". And then he would go back to playing them appropriately or I'd model it. T2. So seeing actually how quickly he respected the boundary that I put in place was really nice and it was kind of, he's tested me. He knows what I now expect.	28% increase	Pre-test N=83 M = 7.15, SD = 1.63 Post-test N=84 M = 7.48, SD = 1.56 $t(78) = 1.5739$ $p = .1196$

Waiting, Listening and Looking	4. Is able to wait and allow space for the student according to their individual needs	TA. When it was post intervention then I'm waiting for her to choose and if she doesn't do anything for a while, that's fine. T1. With the fact that I realized I needed to allow [the student's] freedom of movement and of expression, his frustration reduced massively because he knew when he came in here he wasn't going to have any pressures and he wasn't going to have anything hold him back. ISL2. I think the training's definitely given me the urge to wait ... I've learned from here, from [the student] especially, just every child is different and sometimes some children do need that little longer to respond. ISL1. I wait a lot more. There's a lot of more silence from me, and then I wait for him. Then the last video ... He was really quiet for really long time, and I was really quiet. T2. Whereas now I look at it and I know that actually he needs that space, he needs to have the waiting, he needs to request what he wants in his own way and allow space for him to decide what he wants to do ...	90% increase	Pre-test N=90 M = 6.19, SD = 2.08 Post-test N=90 M = 7.50, SD = 1.87 $t(89) = 4.5022$ $p = <.0001$
	5. Observes the student closely and consistently	ISL1. I think in the [phase 1 video] I was kind of just watching that he wasn't going to throw something or stand on anything or hurt himself. Whereas this [phase 3 video] because he knows the room, I'm just kind of watching his body language more, seeing how <i>he</i> is. ISL2. So I tried to always make sure that I would move with him to follow him with my eyes.	30% increase	Pre-test N=90 M = 7.14, SD = 1.78 Post-test N=90 M = 8.30, SD = 1.48 $t(89) = 4.8021$ $p = <.0001$
	6. Listens to the student closely and consistently	ISL1. I also see just him in general, because I realized that there's certain pitches in his voice... vocalizers that when he's upset it's really really high pitch. ISL2. He'd just look me straight in the face and just make vocal noises at me and wait for my response ... It was like we were talking ... Yes, I think that was my favourite moment!	33% increase	Pre-test N=90 M = 6.42, SD = 1.95 Post-test N=90 M = 7.84, SD = 1.81 $t(89) = 5.4982$ $p = <.0001$

Matching and adapting	7. Is able to time and pace musical responses appropriately	ISL1. I know we've got sometimes half an hour, sometimes 15 minutes, depending on the time he gets in, but I don't think he feels rushed. ISL2. And I just was waiting for [the student] to do something and then just trying to react to him to see what I could get back. T1. I think for [the student] it was sort of his time to express himself in the way he wanted to. T2. When he would first come in and we do the Hello song and then just sort of a steady pulse because, no matter when in the process he was coming through, he'd always come in and just need a few minutes to pace and ready himself.	36% increase	Pre-test N=90 M = 5.96, SD = 1.91 Post-test N=90 M = 7.07, SD = 2.04 $t(89) = 3.8800$ $p = .0002$
	8. Responds sensitively to all communications from the student	ISL2. He needed to get his tapping experiences out like his sensory needs or his vocal needs of the "ba ba ba" ... And I think I think it definitely regulated him. Upon leaving he was always very calm. ISL1. Sometimes he's running around and climbing the chairs and coming back ... and then I match his pace. T1. The pulling me up, the eye contact and then ... he would make a noise to see me make a noise. Or he'd play an instrument for me to [play it]. And sometimes he'd come over and be like, "this is what I want".	66% increase	Pre-test N=90 M = 5.79, SD = 2.09 Post-test N=90 M = 6.78, SD = 2.07 $t(89) = 3.5689$ $p = .0006$
	9. Matches musical elements with the voice and/or an instrument	TA. I think I tried to match mainly based on pitch ... [the student] was on the cymbal and I tried to match the sound on the keyboard ... where I was sat, instead of getting up and running over to something else to try to do that and volume as well. ISL2. I was kind of mimicking his noises and his sounds and the noises he was making on the instruments. I was just trying to match him, so he knew that I was, you know, answering him back almost. ISL1. And then he just started really quiet and we just built up and up and up, which was really nice. And some [sessions] he just comes in and he's loud and we're loud together, so I think that's really good. T1. I talked a lot less, I mimicked his noises, and then I had that more communication because I was getting on his level. I was communicating his way and I had so much more eye contact.	58% increase	Pre-test N=90 M = 5.60, SD = 2.23 Post-test N=90 M = 6.74, SD = 2.27 $t(89) = 3.6233$ $p = .0005$

Table 3: Joint display of quantitative and qualitative results pertaining to the research evaluation instrument

Theme 3: Wider accessibility and applicability of Winnicott's (1960) theory of holding in school

Conscious application of holding in the classroom

All participants valued the secure framework for *Safe and Sound* that was Winnicott's (1960) theory of the holding environment, as well as the programme's approach that integrated theory and practice.

The theory was very important ... I don't think we would have got the amount of progress without this holding environment. Because I do think this is what's really worked (T1).

You taught us quite a lot before we'd even done the sessions. And then obviously we practised during the training as well (ISL2).

Each participant articulated ways in which their learning had impacted on their classroom practice.

But I think because of *this*; knowing [the child's] vocalisation pitch when he's happy, in class I feed back, "oh he's really happy ... this is what it sounds like in the Safe and Sound sessions." But then, when there's like screeching, really, really high pitch, then I'm like, "no, this is him upset" (ISL1).

I think the whole waiting and allowing for space. Not just sort of physical space, but also the silence and all of that has been probably one of the things that's really changed my practice the most (T1).

The way you teach, it changes once ... you've learned a bit more about the Winnicott theory ... I have learned ... just get down to the child's height and sit and let them know that you're fully there (ISL2).

I've applied it into the swimming pool and we've gone from a boy who would barely let go to now jumping in! Just because we allowed him that space and that time (T1).

Just waiting. Giving them the process time. Because [the student's] processing time is quite long (TA).

Accessibility and applicability of Winnicott's (1960) theory of holding within the wider school approach

All participants agreed that their learning about Winnicott's (1960) theory of the holding environment fitted with wider school approaches with benefits for both staff and students.

Using this in my practice has been hugely beneficial and I don't see why this can't be used throughout the whole school (T1).

And I liked as well how much of the theory was based on parent-child relationships. Because I think obviously being in the school we're in, everything we do is mirroring that parent-child relationship (T2).

I think it would be great if there were more people doing music sessions with their students. So many students here could benefit and really enjoy it (ISL2).

Research Question 2 asked: What is the impact of participants' learning, in terms of identification with and adaptation to autistic students through musical interaction, on the nature of classroom practitioner-student relationships?

Theme 4: Identification

Development of understanding in communication through musical interaction

This theme described ways in which participants began to make an emotional connection with the student. All participants agreed on their developing understanding of the student's communication and the student's understanding of them as a dialogue partner in music sessions.

I think he learned to wait for me as well ... I remember he would say a sound and then wait a little bit and he was looking like, "it's your turn!" (ISL1).

And I remember when we were halfway through, and we had a breakthrough where he actually looked at me and ... did his noises and he wanted that [interaction]. And then after that I saw, "oh, I'm actually speaking his language now. We've got that to and fro" ... A massive difference (T1).

I think that eye contact was a big thing because as he was walking around freely, he would always look to see if I'm looking. So I think that is important (ISL2).

I'm not in here, just playing an instrument as well. I'm in here playing something based off what she's done. And I think she's smiling a lot more. She's interacting with me a lot more. She's coming to sit on my lap for the piano, and she knows that this is something we do together (TA).

He would be wandering around, and I'd just be sat still in one place. And then he looked at me from wherever he was at in the room, and he'd walk straight to me and either take my hand or put his hand to my face (T2).

Development of trust through music-making

All participants stated that trust had grown in their relationship with the child.

Whereas now it's almost as if he knows, this is our time together. This is what we do (T2).

We would sing that she's in the music room and then she'd come in. Near the end of the sessions, she came into school singing that song because she knew. And she'd only ever sing it on a Tuesday (TA).

Participants agreed that allowing space for the student in music sessions was central to the development of trust, together with the practitioner's focused attention, patience and responsiveness.

So he knows that I'm a safe space and I'm going to allow him that time and space (T1).

So yes, tailoring [the session] towards her and just waiting, pausing, listening to her ... I think she maybe felt that she had the space to explore and it wasn't restricted (TA).

And with the waiting and the patience of him having a turn, me having a turn, I think we both felt a bit more relaxed because he was feeling that I was calm and that was giving him vibes to be calm (ISL2).

I know in the training we talk about mother and child bond, maybe that has sort of led [the student] to think, "oh I have a relationship with her now. She gets me, she plays my music, she listens, she looks at me, she waits" (TA).

Three participants described how this trust was generalised into the classroom.

I think now if I go into his class and work with him, I feel like he knows me. That he feels like I'm a safe person because he will just come up to me now if I'm in the class and make noises with me and rock and want that reaction back (ISL2).

I think he accepted me a lot quicker than maybe the other teaching assistants ... It's almost like he feels more safe with me, which is nice (ISL1).

All participants described a process of learning from and about the child, supported by the one-to-one time together in music sessions.

You learn so much with them being in here, one on one and it just takes you into a whole new world of what they're trying to tell you, what they're thinking (ISL2).

I feel like I thought I understood him really well, but since doing this, I understand him a lot more and ... I think he understands me a lot more as well (T1).

I've also found from the [Phase 1] video when I was on my knees, I was taller than [the student] and he kept moving away ... Because it is quite a domineering thing if someone is towering over you ... where I ... stayed sat down, he felt quite free to go around (ISL1).

Development of emotional understanding through shared music-making

All participants described an increased understanding of the student's emotional states during music sessions and in the classroom. Three participants found that this sometimes produced uncomfortable feelings of 'not knowing.'

That's probably been a challenge of mine trying to work out if he's just going to touch the door, or whether he's actually trying to indicate to me that he wants to go (ISL2).

But I would worry, I suppose, about is she going to be ready for this today? Is it going to be asking too much of her? (TA).

And I think my worry about him not wanting to spend time with me was also partly me projecting that on to him and actually me potentially not wanting to spend time with him because we've not seen each other for so long (T2).

Three participants reflected on positive changes in the student's engagement with staff and classmates that they attributed to the trusting relationship developed during music sessions.

[The student] is getting so much better at sharing and waiting ... So potentially that's because she is sharing instruments in here with me and she's waiting for my response (TA).

And sometimes he'll be saying something and the students will copy him. And then he's like, "oh! She's copying me too!" (ISL2).

[The student] is not just running away from [staff]. He's taking himself out and waiting, and "this is what I need right now" ... I like to think the sessions have really supported that (T2).

DISCUSSION

This study interrogated the accessibility, relevance and applicability of the *Safe and Sound* music therapy consultation programme for five classroom practitioners working with autistic students in a UK school. The discussion of outcomes is framed by the research questions.

Research question 1

The extent to and ways in which the *Safe and Sound* protocol, framed by Winnicott's (1960) theory of the holding environment as realised through musical interaction, might be accessible, relevant and applicable to UK classroom practitioners in relation to their work with autistic children was evaluated from integrated quantitative and qualitative data sets (Creswell, 2015). These comprised scores and interview data returned by Autism Unlimited participants and 18 UK music therapists, which pertained directly to the evaluation instrument used throughout the study (Appendix). This was then further informed by inductive thematic analysis of participants' interview data (Braun & Clarke, 2013). Results showed agreement that Winnicott's (1960) holding theory provided a vital foundation for practitioners' music sessions with the students and in the classroom, and that the approach held for the wider school environment. A clear shift from practitioner-led to student-led approaches and broadening of awareness of student behaviours as communication of feeling state were foregrounded.

Quantitative results returned by classroom practitioners (n=5) showed positive percentage increases between pre- and post-intervention self-chosen video extracts for each evaluation descriptor (Table 3). Particularly substantial change in both quantitative and qualitative data was recorded for element 4, 'Is able to wait and allow space for the student' (90%) and element 10, 'The adult and the child together are able to enjoy creative and flexible musical play' (88%). Participants were unanimous as to the importance of waiting and allowing space for the student's spontaneous gestures in facilitating the development of playfulness in music sessions and in their teaching practice.

ISL1 stated that “the training I got ... was you really taking yourself out and being patient. There’s power in waiting. And I’ve found that in the classroom.” T1 agreed. “I’ve seen ... I call them little miracles throughout my [teaching] sessions ... And I didn’t realise that if you just give [students] that, again, holding environment, that space, that time, they really do flourish.”

There was a similar consonance concerning this key area in qualitative results relating directly to the evaluation instrument. Participants clearly described learning from individual students as to the time and space they needed to maintain self-regulation, initiate, and engage in an interaction. TA summarised: “I’m waiting for [the student] to choose, and if she doesn’t do anything for a while, then that’s fine.” This comment also illuminated a change in participants’ capacity to manage silence. T2 realised: “[the child] needs to request what he wants in his own way and allow space for him to decide what he wants to do.” These findings resonate with literature which foregrounds child-led educational approaches, such as allowing time and space for the child to make choices (Kossyvaki et al., 2012; Rushton & Kossyvaki, 2020).

Statistical results obtained from UK music therapists (n=18) were predominantly similarly positive. Change in respect of eight out of ten rated elements was assessed as statistically significant (Robson, 2011). Two elements that did not reach a statistically significant level were concerned with element 1 (individualised environment) and element 3 (behavioural boundaries). This could partly reflect the available view of the session space in the short video extracts and that no behaviours of concern were observed. Six elements showing a particularly statistically significant level of change were concerned with core domain 2 (waiting, listening and looking) and core domain 3 (matching and adapting). This may be seen as evidence of participants’ growing capacity for identification with and musical adaptation to the students (Levinge, 2015).

Research question 2

The impact of learning on the nature of practitioners’ relationships with both the individual students in music sessions and the classroom was evaluated from thematic analysis of participants’ qualitative interview data.

Theme 4 described ways in which participants became able to identify with individual students. Winnicott’s (1960) holding theory describes ‘identification’ as the caregiver’s capacity to tune into the child’s emotional state and constantly hold them in mind. All participants felt that their ability to attune to the student’s needs had significantly increased. T1 reflected: “I’ve learned ... that we can get into each and every child’s world. We just need to find the right key. And that’s huge!” There was agreement that increased understanding of the student’s communication, involving waiting, listening and observation, supported this process. ISL 1 explained: “I also just see him in general. Because I realised that there are pitches in his voice ... that when he’s upset it is really, really high pitch.”

Results revealed a shift in each participant’s experience of the student as their music sessions together progressed. Tension between them eased and trust developed. T1 explained: “I feel like we have a kinship where he knows that I’m going to support him.” Genuine enjoyment in musical shared play grew exponentially. Participants increasingly looked forward to the sessions. All emphasised positive change in the ongoing relationship with the student as the most enjoyable outcome. ISL1 reflected: “When I see him he’ll still come hold my hand or he’ll still sit next to me in class ... He’s

a great boy. I do think he's cool." T2 added: "Now I'm obviously sad it's ending. I don't want it to."

These findings correlate with the literature review. Authentic enjoyment in playing with the child is, Winnicott (1971) maintains, essential to live, responsive relationships. In the classroom, this reduces stress and promotes conducive and enjoyable teaching and learning (Hopman et al., 2018). Poulou (2020) further posits that teachers need to feel emotionally held and supported if they are to be able to form these relationships. Towards the end of the study, the *Safe and Sound* group members described the research group sessions as "a space just for us" within which they felt safe to share work experiences together and engage in musical play.

Glover Gagnon and colleagues (2019) emphasise the need for interventions specifically designed to support teachers to understand and navigate their relationships with their students. The present research found that Winnicott's (1960) theory of the holding environment, based on natural caregiving processes (Phillips, 2007) and realised within musical interaction, offered an appropriate framework to support optimisation of classroom practitioner-student relationships. The *Safe and Sound* programme supported participants in the processes of identification with the students and adaptation to their needs through the development of concrete, responsive musical skills.

The literature emphasises sustainability as fundamental to music therapy consultation (Bolger & Skewes McFerran, 2020; Margetts, 2022). Choice of orientation, genuine collaboration based on respect for local context and an exchange rather than a help approach have supported maintenance of the positive outcomes of *Safe and Sound* in the classroom. As T1 summarised: "Let's learn [the students] before we try to teach them something!"

LIMITATIONS OF THE STUDY

Mixed-methods research can be particularly vulnerable to bias (Robson, 2011), partly owing to closer researcher-participants relationship than is typical of experimental methodologies. The researcher's sustained employment at the school and degree of familiarity with participants appeared to enable reflection on challenges as well as positive outcomes encountered in music sessions.

All aspects of the study were undertaken with the researcher. It was impossible to remove all corresponding potential factors for bias, including the researcher's gender, age, personality, knowledge, skills and experience. Sustained professional experience, supervision and peer support enabled maintenance of appropriate boundaries. However, participants' responses to the researcher would inevitably have influenced their attitude to and engagement with the research process.

Triangulation used to offset bias and support methodological rigour included employment of quantitative and qualitative data sources, different research methods, and peer review of participants' self-selected video examples by 18 UK music therapists.

FUTURE RESEARCH

Although not a formal area of enquiry during qualitative interviews, participants nonetheless spontaneously detailed their affective responses to their experiences with the students during and following the research. The substantial volume of post-intervention material generated particularly concerned participants' increased sense of self-efficacy and reduced levels of stress (Muenchhausen et al., 2021) and was sufficient to warrant a third corresponding research question. This will be

explored in a future publication.

Music therapy consultation has been described as a unique practice that requires new knowledge and skills (Rickson, 2012). The *Safe and Sound* programme has been integrated into the annual training programme offered to classroom practitioners at Autism Unlimited. As the protocol has, to date, been developed and researched by the author, there is scope to interrogate its efficacy when offered by other music therapists in the schools in which they work. Future research could also usefully and formally evaluate outcomes for students engaging in *Safe and Sound*.

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ETHICAL CONSIDERATIONS

The research for this project was submitted for ethics consideration under the reference EDU 20/ 189 in the School of Education and was approved under the procedures of the University of Roehampton's Ethics Committee on 04/02/2020.

REFERENCES

- Aigen, K. (2005). *Music-centered music therapy*. Barcelona Publishers.
- Adams, J., Dudenhöffer, S., Claus, M., Kimbel, R., Letzel, S., & Rose, D.M. (2016). Coping patterns in special school staff: Demographic and organisational factors. *Occupational Medicine*, 66, 138-142. <https://doi.org/10.1093/occmed/kqv157>
- Arns, B., & Thompson, G.A. (2019). Music therapy teaming and learning: How transdisciplinary experience shapes practice in a specialist school for students with autism. *Australian Journal of Music Therapy*, 30, 31-52.
- Aspelin, J., Östlund, D., & Jönsson, A. (2021). 'It means everything': Special educators' perceptions of relationships and relational competence. *European Journal of Special Needs Education*, 36(5), 671-685. <https://doi.org/10.1080/08856257.2020.1783801>
- Bishop, C. D., Snyder, P. A., & Crow, R. E. (2015). Impact of video self-monitoring with graduated training on implementation of embedded instructional learning trials. *Topics in Early Childhood Special Education*, 35(3), 170-182. <https://doi.org/10.1177/0271121415594797>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.
- Coombes, E., & Tombs-Katz, M. (2017). Interactive therapeutic music skill-sharing in the West Bank: An evaluation report of project Beit Sahour. *Approaches: An Interdisciplinary Journal of Music Therapy*, 9(1), 67-79. <https://doi.org/10.15845/voices.v11i1.291>
- Creswell, J. R. (2015). *A concise introduction to mixed methods research*. SAGE.
- Delaney, M. (2017). *Attachment for teachers: The essential handbook for trainee teachers and NQTs*. Worth Publishing.
- Geretsegger, M., Fusar-Poli, L., Elefant, C., Mössler, K.A., Vitale, G., & Gold, C. (2022). Music therapy for autistic people. *Cochrane Database of Systematic Reviews*, 5, CD004381. <https://doi.org/10.1002/14651858.CD004381.pub4>
- Glover Gagno, S., Huelsman, T. J., Kidder-Ashley, P., & Lewis, A. (2019). Preschool student-Teacher relationships and teaching stress. *Early Childhood Education Journal*, 47, 217-225. <https://doi.org/10.1007/s10643-018-0920-z>
- Hopman, J. A. B., Tick, N. J., Van der Ende, J., Wubbels, T., Verhulst, F. C., Matas, A., L D Breeman, L. D., & Van Lier, P. A. C. (2018). Special education teachers' relationships with students and self-efficacy moderate associations between classroom-level disruptive behaviours and emotional exhaustion. *Teaching and Teacher Education*, 75, 21-30. <https://doi.org/10.1016/j.tate.2018.06.004>
- Hyman, S. (2012). The school as a holding environment. *Journal of Infant, Child, and Adolescent Psychotherapy*, 11, 205-216. <https://doi.org/10.1080/15289168.2012.700793>
- Kim, J., Wigram, T., & Gold, C. (2009). Emotional, motivational and interpersonal responsiveness of children with autism in improvisational music therapy. *Autism*, 13, 389-409. <https://doi.org/10.1177/1362361309105660>
- Koenen, A-K., Vervoort, E., Kelchtermans, G., Verschueren, K., & Split, J. L. (2019). Teachers' daily negative emotions in interactions with individual students in special education. *Journal of Emotional and Behavioural Disorders*, 21(1), 37-51. <https://doi.org/10.1177/1063426617739579>
- Kossyvak, L., Jones, G., & Guldberg, K. (2012). The effect of adult interactive style on the spontaneous communication of young children with autism at school. *British Journal of Special Education*, 39, 173-184. <https://doi.org/10.1111/1467-8578.12001>
- Levinge, A. (2015). *The music of being: Music therapy, Winnicott and the school of object relations*. Jessica Kingsley Publishers.
- Maclean, E., & Tillotson, C. (2019). How do music therapists share? Exploring collaborative approaches in educational settings for children with autism spectrum conditions. In H. Dunn, E. Coombes, E. Maclean, H. Mottram & J. Nugent (Eds.), *Music therapy and autism across the lifespan: A spectrum of approaches* (pp. 197-226). Jessica Kingsley Publishers.
- Margetts, L. (2022). *Intercultural music therapy consultation research. Shared humanity in collaborative theory and practice*. Routledge.

- Margetts, L., Ockelford, A., Hargreaves, D., & Sutton, J. (2020). Potential spaces: Supporting the development of relationships between classroom practitioners and children with complex needs in Belarus through music therapy consultation. *Nordic Journal of Music Therapy*, 30(4), 338-356. <https://doi.org/10.1080/08098131.2020.1806913>
- McGreery, M. (2016). Temperament as a behavioural construct: Assessing the classroom environment and student-teacher relationship. *Intervention in School and Clinic*, 51(4), 238-245. <https://doi.org/10.1177/1053451215589176>
- Muenchhausen, Sv., Broenig, M., Pfeifer, R., Görtz, A. S., Bauer, J., Lahmann, C., & Wuensch, A. (2021). Teacher self-efficacy and mental health – their intricate relation to professional resources and attitudes in an established Manual-Based Psychological Group Program. *Frontiers in Psychiatry*, 12(510183). <https://doi.org/10.3389/fpsy.2021.510183>
- Ofsted, (n.d). *Education Inspection Framework 2019: Inspecting the substance of education*. <https://www.gov.uk/government/consultations/education-inspection-framework-2019-inspecting-the-substance-of-education/education-inspection-framework-2019-inspecting-the-substance-of-education>
- O'Nions, E., Petersen, I., Buckman, J. E.J., Charlton, R., Cooper, C., Corbett, A., Happé, F., Manthorpe, J., Richards, M., Saunders, R., Zanker, C., Mandy, W., & Stott, J. (2023). Autism in England: assessing underdiagnosis in a population-based cohort study of prospectively collected primary care data. *The Lancet Regional Health – Europe*, 29(100626). <https://doi.org/10.1016/j.lanepe.2023.100626>
- Pasiali, V. (2014). Music therapy and attachment relationships across the lifespan. *Nordic Journal of Music Therapy*, 23(3), 203-223. <https://doi.org/10.1080/08098131.2013.829863>
- Phillips, A. (2007). *Winnicott*. Penguin Books.
- Poulo, M. S. (2020). Students' adjustment at school: The role of teachers' need satisfaction, teacher-student relationships and student wellbeing. *School Psychology International*, 41(6), 499-521. <https://doi.org/10.1177/0143034320951911>
- Rickson, D. (2012). Music therapy school consultation: A unique practice. *Nordic Journal of Music Therapy*, 21(3), 268-28. <https://doi.org/10.1080/08098131.2012.654474>
- Rickson, D. (2021). Family members' and other experts' perceptions of music therapy with children on the autism spectrum in New Zealand: Findings from multiple case studies. *The Arts in Psychotherapy*, 75(101833). <https://doi.org/10.1016/j.aip.2021.101833>
- Rickson, D. (2022). *Music Therapy with Autistic Children in Aotearoa, New Zealand: Haumanu ā-Puoro mā ngā Tamariki Takiwātanga i Aotearoa*. Palgrave Macmillan.
- Rickson, D., Castelino, A., Molyneux, C., Ridley, H., & Upjohn-Beatson, E. (2016). What evidence? Designing a mixed-methods study to investigate music therapy with children who have autism spectrum disorder (ASD) in New Zealand contexts. *The Arts in Psychotherapy*, 50(119-125). <https://doi.org/10.1016/j.aip.2016.07.002>
- Riley, P. (2011). *Attachment theory and the teacher-student relationship*. Routledge.
- Robson, C. (2011). *Real world research*. Wiley
- Rose, J., McGuire-Snieckus, R., Gilbert, L., & McInnes, K. (2019). Attachment aware schools: The impact of a targeted and collaborative intervention. *Pastoral Care in Education*, 37(2), 162-184. <https://doi.org/10.1080/02643944.2019.1625429>
- Rushton, R., & Kossovaki, L. (2020). Using musical play with children with profound and multiple learning disabilities at school. *British Journal of Special Education*, 47(4), 489-509. <https://doi.org/10.1111/1467-8578.12334>
- Skaalvik, E. M., & Skaalvik, S. (2007). Dimensions of teacher self-efficacy and relation with strain factors, perceived collective teacher efficacy and teacher burnout. *Journal of Educational Psychology*, 99(3), 611-625. <https://doi.org/10.1037/0022-0663.99.3.611>
- Skewes McFerran, K. S., Crooke, A. H. D., & Bolger, L. (2017). Promoting engagement in school through tailored music programs. *International Journal of Education and the Arts*, 18(3). <http://ijea.org/v18n3/>
- Steele, M., Crooke, A. H. D., & Skewes McFerran, K. (2020). What about the teacher? Synthesis on literature describing music therapist teacher support programmes. *Voices: A World Forum for Music Therapy*, 20(1). <https://doi.org/10.15845/voices.v20i1.2839>
- Steele, M., McFerran, K. S., & Crooke, A. H. D. (2023). Shifting the focus to teachers: A new approach for music therapists working in schools. *Music Therapy Perspectives*, 41(1), 10-18. <https://doi.org/10.1093/mtp/miac020>
- Strange, J. (2021). Improvised music to support Intensive Interaction for children with complex needs: A feasibility study of brief adjunct music therapy. *British Journal of Music Therapy*, 35(2), 43-52. <https://doi.org/10.1177/13594575211028038>
- Strange, J., Odell-Miller, H., & Richards, E. (Eds.). (2017). *Collaboration and assistance in music therapy. Roles, relationships, challenges*. Jessica Kingsley Publishers.
- Tarr, J., & Clough, N. (2022). *Addressing issues of mental health in schools through the arts: Teachers and music therapists working together*. Routledge.
- Tomlinson, J. (2020). Music therapist collaboration with teaching assistants for facilitating verbal and vocal development in young children with special needs: A mixed methods study. *British Journal of Music Therapy*, 34(2), 95-107. <https://doi.org/10.1177/1359457520971815>
- Twyford, K., & Rickson, D. (2013). In their element! Student responses to the work of a music therapist in music therapy school consultation. *Music Therapy Perspectives*, 31, 1217-136. <https://doi.org/10.1093/mtp/31.2.127>
- Vlachová, Z. (2022). Means of musical dialogues and reciprocity: Improvisational music therapy for social interaction of a pre-school child with autism spectrum disorder. *Voices: A World Forum for Music Therapy*, 22(2). <https://doi.org/10.15845/voices.v22i2.3191>
- Winnicott, D. W. (1960). The theory of the parent-infant relationship. In D. W. Winnicott (1990), *The maturational processes and the facilitating environment* (pp. 37-55). Hogarth Press.

APPENDIX: SAFE AND SOUND EVALUATION INSTRUMENT WHAT TO LOOK FOR IN THE ADULT'S RESPONSES

Increasing the Student's sense of Emotional Safety	The Student's Behaviours are Understood and Responded to as Potentially Communicative				2
	CD	Elements	Adult's Observed Responses	Possible Interpretation of Responses	
	Individualised Physical Space	1. The room and the instruments are set up for the individual student in advance	The adult is able to allow the student to enter in their own time. Can take into account the student's individual needs, (for example, visual or positioning), in organising the session space. The student is able to access the instruments safely, spontaneously and freely.	Setting up the room specifically for the student potentially demonstrates that they have been held in mind and remembered.	
		2. The session is structured appropriately for the student	Is able to structure the session through thinking about the student's individual needs, taking into account any sensory difficulties and/or restricted movement, and capacity to tolerate proximity in considering the nature of the musical activities to be offered.	Flexible structuring of the session specifically for the student demonstrates the adult's sustained thinking about the student's responses and needs in advance of and during each session.	
		3. Boundaries of acceptable behaviour are set	Is able to maintain safe and appropriate behavioural boundaries for the student in accordance with their needs.	The adult seeks to understand the student's behaviour as communication of their feeling state and considers session boundaries accordingly.	
Waiting, watching and Listening		4. The adult is able to wait, and to allow space for the student according to their individual needs.	Is able to wait for the student to initiate an interaction, musical or non-musical. Is able to stay with silence, remaining quiet but visible, or may create a musical atmosphere designed to be enabling (e.g. vocalising a phrase in the rhythm of the student's breathing). Is able to think about, rather than react to possible rejection of their availability.	The adult is focused on the student, who is the centre of the experience, potentially supporting the student to begin an interaction using sounds and non-verbal communication. A reflective approach to the student's presentation is demonstrated.	
		5. The adult observes the student closely and consistently	Is able to closely observe non-verbal communication. Is able to notice fleeting moments of potential connection (eye contact, movement) and respond to them using appropriate instrumental and/or vocal sounds, gestures, movement and looking behaviour.	The adult is taking in something of the student and responding accordingly using sounds and silences. This communicates to the student that the adult is observant, responsive and accepting.	
		6. The adult listens to the student closely and consistently	Is able to listen to the student's sounds or silence. Is able to notice fleeting moments of potential connection (instrumental and/or vocal sound) and respond to them using appropriate instrumental and/or vocal sounds, gestures, movement and looking behaviour.	The adult is taking in something of the student and responding accordingly using sounds and silences. This communicates to the student that the adult is listening, receptive and interested in them.	

Increasing the Student's sense of Emotional Safety	The Student's Behaviours are Understood and Responded to as Potentially Communicative				a
	CE	Elements	Adult's Observed Responses	Possible Interpretation of the Adult's Responses	
	Matching and Adapting	7. Timing and pace in musical responses	Is able to show an awareness of timing and pace in adapting their musical responses flexibly to those of the student.	Tuning in to the student's pace inspires further confidence in the student that they are being listened to and thought about. Timing of give and take in the interaction may indicate familiarity and trust.	
		8. Responding sensitively to all the student's communications	Is able to remain attentive and to recognise and sustain capacity to respond to all of the student's communicative attempts: gaze, movement, silences, instrumental and/or vocal sounds.	The adult's focused attention communicates to the student that they are being listened to and thought about, together with a sustained interest in the shared interaction.	
		9. Matching musical elements with the voice and/or an instrument	Is able to match the student's sounds and musical ideas with their own: for example, in terms of sound quality, pitch, loudness, duration, shape and intensity.	Further demonstrates to the student that their sounds are heard, accepted, and interesting to the adult, who may feel increasingly included in, and energised by the interaction.	
	Playfulness	10. Is able to sustain creative and flexible musical play	The adult and student together are able to enjoy creative and flexible musical play. May constitute warmth, liveliness, fun, humour, give and take, trying things out, challenge.	Sufficient emotional safety has been established in relationship. Student and adult are able to sustain engagement in shared musical play.	

Ελληνική περίληψη | Greek abstract

Safe and Sound: Μια μελέτη μικτών μεθόδων για τη διερεύνηση των σχέσεων μεταξύ εκπαιδευτικών ειδικής αγωγής και αυτιστικών μαθητών μέσω μουσικοθεραπευτικής διαβούλευσης

Lisa Margetts

ΠΕΡΙΛΗΨΗ

Αυτή η μελέτη διερεύνησε την προσβασιμότητα και την βιωσιμότητα του πρωτοκόλλου της μουσικοθεραπευτικής διαβούλευσης *Safe and Sound* για τους εκπαιδευτικούς της τάξης που επιθυμούν να βελτιστοποιήσουν τις σχέσεις με τους μαθητές σε μια σχολική μονάδα του Ηνωμένου Βασιλείου που παρέχει εξειδικευμένη εκπαίδευση για αυτιστικά παιδιά. Η θεωρία του Winnicott για το περιβάλλον κρατήματος πρόσφερε το πλαίσιο για ένα πρωτότυπο εργαλείο αξιολόγησης το οποίο υποστήριξε ένα πρόγραμμα ανάπτυξης προσωπικού με επίκεντρο τον αυτισμό. Πέντε συμμετέχοντες αξιολόγησαν τη συνηθισμένη μουσική τους αλληλεπίδραση με έναν μαθητή (πριν την παρέμβαση). Μετά το πρόγραμμα ανάπτυξης (παρέμβαση), οι συμμετέχοντες πραγματοποίησαν έξι βιντεοσκοπημένες συνεδρίες μουσικής με το ίδιο άτομο (μετά την παρέμβαση). Δύο αυτοεπιλεγόμενα αποσπάσματα, πριν και μετά την παρέμβαση, αξιολογήθηκαν από τους ίδιους με βάση το εργαλείο αξιολόγησης. Στη συνέχεια, οι συμμετέχοντες αναστοχάστηκαν σχετικά με τις εμπειρίες τους μέσω συνεντεύξεων. Τα ίδια δέκα τυχαιοποιημένα αποσπάσματα βίντεο αξιολογήθηκαν αντίστοιχα από 18 μουσικοθεραπευτές στο Ηνωμένο Βασίλειο. Τα ποιοτικά αποτελέσματα έδειξαν την εκπαίδευση των συμμετεχόντων κατά τη διάρκεια της μελέτης, επιτρέποντάς τους να συντονίζονται με τον μαθητή και να τον κρατούν στο μυαλό τους. Τα ποσοτικά αποτελέσματα έδειξαν την πραγματοποίηση αυτού μέσα από την προσαρμογή προς τον μαθητή μέσω συγκεκριμένων μουσικών δεξιοτήτων. Η μελέτη έδειξε ότι η θεωρία του Winnicott για το περιβάλλον κρατήματος θα μπορούσε να υποστηρίξει τη βελτιστοποίηση των σχέσεων εκπαιδευτικού-μαθητή στην τάξη. Το μικρό δείγμα αποτρέπει τη γενίκευση των αποτελεσμάτων και απαιτείται περαιτέρω έρευνα για τη διερεύνηση της ευρύτερης βιωσιμότητας του πρωτοκόλλου.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, διαβούλευση, φάσμα αυτισμού, Winnicott, σχέση μαθητή-επαγγελματία, έρευνα μεικτών μεθόδων

ARTICLE

A qualitative pilot study examining Tibetan bowls and monochord sound meditation with adults with mental health conditions and intellectual disabilities

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ABSTRACT

Tibetan bowls and monochords are millennia-old instruments used for spiritual and therapeutic purposes. In the last few decades, there has been growing interest in the use of these instruments in meditation and therapeutic settings. Nevertheless, they are still rarely used in music therapy in the Western world, either because of technical difficulties or musical or cultural biases. The purpose of this pilot study was to examine the experiences of adults with mental health conditions and intellectual disabilities during sound meditation sessions using Tibetan bowls and a monochord. In this qualitative pilot, a group of six psychiatric inpatients participated in seven weekly sound meditation sessions over eight weeks that implemented Tibetan bowls and the monochord combined with meditation. Semi-structured interviews were conducted after each session to capture participants' reflections on their experiences. The interview data was analysed using thematic analysis. Three main themes emerged: physical sensations, experiences of emotions, and visual experiences. The sounds of the Tibetan bowls and the monochord helped participants relax and evoked a wealth of emotions and mental imagery. These findings suggest that using these instruments with adults with mental health conditions and intellectual disabilities can foster relaxation, as well as heighten their awareness of physical sensations, feelings, and previous life events. Music therapists can thus integrate Tibetan bowls and the monochord into their skillset and use them during treatment sessions.

KEYWORDS

Tibetan bowls,
singing bowls,
monochord,
sound meditation,
sound therapy,
vibrational sound,
sound bath,
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disabilities

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INTRODUCTION

Between music and sound

There is considerable research on the benefits of meditation as a way to achieve relaxation and tranquillity (Burns et al., 2011; Young, 2011). Meditation is known to influence many aspects of life and contribute to reducing multiple physiological and psychological impairments, especially those linked to anxiety and stress (Burns et al., 2011). Several ancient cultures combine meditation with music or sounds to achieve deeper states of consciousness that are considered to lead to a more profound healing process (Goldman, 1996; Torri, 2011). These ancient techniques have gradually been incorporated into modern popular and therapeutic practices.

In music therapy, a number of receptive methods combine listening to recorded or live music with other approaches such as meditation and guided imagery (Bruscia & Grocke, 2002). These combined modalities have been shown to stimulate and have a range of psychological, physical, cognitive, and spiritual benefits (Grocke & Wigram, 2007). However, few make use of sound instruments such as TBs or the monochord (MC), which like gongs, crystal bowls, and tuning forks, are associated with sound therapy (Crow & Scovel, 1996), or sound healing (Bruscia, 1998). This pilot study implemented a combination of TBs and MC with meditation. The use of these instruments or other monochrome musical instruments¹, when associated with meditation and/or relaxation techniques, is alternatively termed sound therapy, sound bath, or sound meditation (Goldsby et al., 2022). These techniques primarily involve sound vibrations, not only as auditory stimuli, but also as physical sensations (Bartel & Mosabbir, 2021).

Sound therapy principles: Resonance and entrainment

Resonance and entrainment are thought to account for the therapeutic value of most types of sound therapy. Both derive from the basic musical element of rhythm, which holds a substantial factor in balancing and survival mechanisms (Davis, 2004). Sound also manifests as a rhythmic cycle that can be measured in Hertz (Hz) (Goldman, 1991).

Resonance is the natural frequency at which an object vibrates. When one object vibrates at the same frequency as another object, they both resonate harmoniously (Davis, 2004). Entrainment occurs when a strong rhythmic vibration affects a weaker rhythmic vibration to cause synchronisation. Whereas resonance is a passive process that corresponds to the natural frequency of an object, entrainment is an active process that changes the object's rhythmic pattern (Goldman, 1991). The principle of entrainment is universal (Thaut et al., 2015). In the human body, breathing is entrained by the rhythmic pattern of the heart and vice-versa. Music can also entrain various physiological systems (Juslin et al., 2010). Different ways of using sound can entrain rhythmic patterns in breathing, circulation, and brainwaves (Fachner, 2011).

¹ "Monochrome sounds are monotonously played sounds with a characteristic timbre" such as those found in monochords, gongs, or singing bowls (Schmucker, 2007, p. 174).

Sound therapy as a medium for change

Physiological change

The relaxation response, a term coined by Benson and Klipper (1975), is one of the underlying mechanisms in sound-based techniques. By engaging in a repetitive mental or physical activity such as breathing techniques, yoga, mantras or sound, deep relaxation and a calming of the mind and body can be achieved (Benson & Klipper, 1975; Moberg, 2003).

Body-mind unity

One of the main characteristics of monochrome musical instruments is their ability to transmit vibrations. Vibrations can be felt by either placing the instruments on the body, being in contact with a surface of the instrument or being very close to it. Different positions generate different sensations and physical experiences. The idea of body-mind unity as conceptualised in therapeutic uses of sound draw on the notion that human beings are a unitary whole (Mate, 2011). Pert (1997) discussed the interconnectedness between emotional and physiological manifestations. She suggested that neuropeptides may convey information from the nervous system to the immune system. These enzymes may carry emotional information and affect the body by connecting with cell receptors. The gut in particular is rich in neuropeptides. More recent work suggests that neuropeptides, which play a role in regulating stress, can facilitate crosstalk between the nervous system and the immune system (Deng & Chiu, 2022).

Another physiological mechanism that may give rise to affective responses are the mechanoreceptors, especially the Pacinian Corpuscles (PC). These mechanoreceptors are crucial for proprioception, sensitive to vibrations and resonate with sounds. They are located in the skin, tendons, bones, several organs in the abdomen, and the genitals (Koelsch, 2015). Afferent impulses from the PC travel through the nervous system and reach different areas in the brain, including the limbic system. PC is primarily located in the mesentery and inner organs (Sigurdardóttir, 2019).

Altered states of consciousness

Another important feature of sound as a medium that impacts the human body is the way it affects brainwaves (Huang & Charyton, 2008; Wahbeh et al., 2007). People who engage in meditation, play, or music listening often experience a change in their subjective awareness of themselves and their surroundings, or in their state of consciousness (Garcia-Romeu & Tart, 2013). States of consciousness that represent a departure from “normal” states are referred to as altered states of consciousness (ASC), and can be characterised by subjective experiences, physiological and neurological responses (Vaitl et al., 2005). In meditation and other relaxation-inducing techniques, the predominant measured EEG patterns are alpha and theta wave bands (Williams & Gruzelier, 2001; Vaitl et al., 2005).

There are numerous age-old approaches, methods, and media for inducing ASC (Garcia-Romeu & Tart, 2013). In ancient traditions, shamans used various techniques, including monochrome sound instruments to elicit ASC in themselves and others (Winkelman, 2011). This enabled shamans to evoke imagery in their listeners designed to expand their consciousness and provide an outlet for internal pressures caused by personal conflicts and issues (Moreno, 1995). In old shamanic traditions and

modern music therapy approaches, music or sound is used to reach an ASC to promote healing, with or without evoking imagery (Kovach, 1985).

Imagery

Images that come to mind unconsciously are comparable to symbols that represent certain aspects of individuals' inner psychological states. Similar to a dream, these symbols may represent difficult or repressed emotions or life events (Bruscia, 2015). Images evoked by music in a therapeutic process are used in Guided Imagery and Music (GIM). These experiences can activate inner reflections, memories, and feelings to promote greater well-being and health (Bruscia & Grocke, 2002). Ballan and Abraham (2016) discussed the role of sensory integration when experiencing imagery and suggested that input from several senses result in a stronger response in the nervous system. For example, when an auditory input is too weak, simultaneous visual or somatosensory input may enhance the auditory response and strengthen the therapeutic process.

Tibetan bowls and the monochord as sound therapy instruments

Tibetan bowls (TBs), also known as singing or Himalayan bowls, probably originated in China around the 6th century BC (Jansen, 1992) and were historically used for religious purposes. This instrument gradually became a therapeutic tool in various cultures in East Asia, such as the Bon tradition in Tibet (Humphries, 2010; Price, 2001). The shaman used sound as a tool for altering states of consciousness and entering into a meditative state.

The MC is also an ancient instrument dating back to around the 6th century BC. It originally consisted of one to three strings and was used for scientific purposes, such as probing the mathematical relationships governing musical intervals (Creese, 2010). In the past few decades, monochords (MCs) with more strings and a variety of shapes and sizes have been used for both music and therapy. One type of MC commonly mentioned in studies is the body MC, a modern development designed for therapeutic use (e.g., Jungalberle & Altieri, 2002; Sandler et al., 2017). Built like a massage bed, it is composed of a resonance box with up to 60 strings tuned to the same pitch. Players usually sit beside the instrument and use their fingers to strum the strings continually. In this manner, overtones begin to emerge and can be differentiated.

A number of empirical studies on the therapeutic value of TBs, MCs, and other monochrome sound instruments have been reported in the last three decades, mainly in German (e.g., Oelmann, 1993; Rose & Weis, 2008; Strobel, 1988). One of the first to research the therapeutic features of monochrome sound instruments was Wolfgang Strobel (1988). Strobel developed the *sound-guided trance* method where monotonous playing is used to enable individuals to enter into an ASC so that repressed content can become conscious, thus fostering therapeutic processes which potentially allows healing to occur (Shmucker, 2007).

Monochord sound research

Several studies have indicated that MC sounds have a positive impact on perceived anxiety and relaxation. These studies show prominent experiences of ASC as well (Jungalberle & Altieri, 2002; Sandler et al., 2017). Sandler et al. (2017) compared a treatment with body MC to listening to a relaxing CD in a sample of individuals with psychosomatic disorders. The results showed that participants with higher depression and anxiety scores tended to experience the CD music as less emotionally positive.

Experiences of the MC sounds can also manifest as physiological changes in perception (Fendel et al., 2018), such as changes in the temperature of the hands and feet, and have an effect on breathing, inner calmness, and inner warmth. In that study, participants compared the vibrations to a waterfall or a river, although unpleasant sensations such as exhaustion or restlessness were also reported. Another study investigated the effects of the table MC and found different physiological changes in perception as well as pleasant emotions (Kearl, 2017). Studies that have compared the effects of MC sounds to Progressive Muscle Relaxation² (PMR) reported increased relaxation, although without a significant difference between interventions (Gaebel et al., 2017; Lee et al., 2012). Both interventions induced positive feelings in the patients and were not experienced as threatening.

Studies that have investigated the impact of MC sounds on EEG signals have reported inconsistent results (Bhattacharya, 2016; Fachner and Rittner, 2005; Sandler et al., 2008). Bhattacharya (2016) compared the neurological effects of MC sounds to those induced by PMR and found a significant theta band effect induced by MC sounds. Sandler et al. (2008) also observed an increase in intensity of theta activity in participants exposed to MC sounds. By contrast, Fachner and Rittner (2005) found no increase in theta band activity. However, this study only investigated two participants. Both had different EEG scans and both reported imagery content.

Tibetan bowls sound research

Sound vibrations can have a physiological effect and are shown to lead to relaxation in muscle tone, lower blood pressure, and slower respiration, which can enhance blood flow and metabolism (Halstead & Roscoe, 2002). Landry (2014) found that using TBs in meditation lowered blood pressure and heart rate. Bidin et al. (2016) explored TBs treatment in oncology patients and found that it contributed to a decrease in skin conductance, indicative of a decrease in anxiety and stress. Similarly, participants' EEG data indicated reduced arousal and lower levels of mental exhaustion as shown by a decrease in beta waves. There was a decrease in alpha waves and no significant change in theta waves. Other anecdotal reports showed beneficial health effects of TBs, especially with respect to relaxation (Gaynor, 2002; Jansen, 1992).

Sound meditation research

To the best of our knowledge, only two studies have used a sound meditation approach similar to the one implemented in this study. Rose and Weis (2008) showed that MC and other monochrome sound instruments such as TBs can have a positive impact on mood. In their study, which was conducted

² PMR is a relaxation technique that involves alternating tensing and relaxing of the muscles (Jacobson, 1938).

over a period of three weeks in a rehabilitation center, there were significant changes in the patients, who reported feeling more balanced, less nervous, and less exhausted. Goldsby's (2017) study on the effects of sound meditation primarily via TBs also found a significant increase in positive mood and well-being. The participants reported significantly less tension, anger, fatigue, and depressed mood.

In a comprehensive systematic review of several TBs studies, Stanhope (2020) indicated that using TBs show some evidence of a beneficial impact on human health. Nevertheless, there is a substantial need for more research. There are few English-language studies on the effects of MCs, TBs, and other monochrome sound instruments over an extended period, let alone in a psychiatric setting. To respond to this need, this pilot study examined how psychiatric inpatients experienced group sound sessions of TBs and MCs combined with meditation.

There are a number of issues when conducting a TBs and MC study on a sample of individuals with intellectual disabilities and mental health conditions. Researchers have cautioned about the use of monochromatic musical instruments, such as gongs, with individuals who have schizophrenia (Wigram & De Backer, 1999). This is due to the potential of these sounds to evoke images or emotions that might become overwhelming. Goldberg (1994) highlighted the possibility of relapse when working with people with schizophrenia, although she also cited the possible positive outcomes of doing this kind of work in a group setting. This pilot study was designed to explore the potential benefits of using these instruments in group sessions to better understand the potential outcomes and therapeutic effects of this approach.

Based on the review of the literature, the research questions were as follows: (1) what was the nature of participants' physical and psychological experiences? (2) Did participants experience ASC and if so, how? (3) Were there any visual experiences during the sessions and if so, what sort of images were involved?

METHOD

This pilot study employed a qualitative research design to explore participants' experiences during sound meditation sessions using TBs and MC. Semi-structured interviews were conducted, and all sessions including the interviews, were recorded and transcribed. The first author also maintained a research diary (RD) containing reflections and observations. The analysis process involved thematic analysis (Braun & Clarke, 2006).

Participants

Six participants took part in this pilot study. The psychiatric hospital director, together with the music therapist recruited participants from that hospital. The inclusion criteria were: (a) relatively good verbal capabilities and a stable mental condition; (b) aged 20-50; and (c) a lack of or moderate tendency toward behaviours destructive to self or others. Pseudonyms are used below to ensure confidentiality. Table 1 lists the participants' demographics.

Pseudonym	Gender	Age	Diagnosis
Ronit	F	38	Borderline personality disorder: factitious disorder with predominantly psychological signs and symptoms.
Oren	M	41	Personality change due to a known physiological condition and mild intellectual disabilities from childhood.
Abraham	M	27	Personality change due to a known physiological condition and mild intellectual disabilities.
Ilia	M	34	Psychosis with delusions due to a known physiological condition and mild intellectual disabilities.
Idit	F	43	Personality change due to a known physiological condition and mild intellectual disabilities.
Dina	F	34	Schizophrenia and mild intellectual disabilities.

Table 1: Demographics

Ethical considerations

Participants were given a complete verbal explanation of the study by the first author. It was made clear to them that their participation was voluntary and that they could leave the pilot study at any time without jeopardizing their treatment or otherwise. In addition, participants' guardians were provided with a written explanation about the procedure and signed a written informed consent form. The participants also gave their consent to be part of this pilot study. This pilot study was approved by the Ethics Committee of the University of Haifa, Israel.

Data collection

This qualitative pilot study was based on semi-structured interviews (Kvale & Brinkman, 2009) and the participants' reflections at the end of each session and during the listening phase. In addition, the first author kept a research diary (RD), consisting of his observations, thoughts and impressions during and after each session. The interviews were conducted by the first author at the end of the study.³

Procedure and setting

The participants took part in seven weekly group sound sessions lasting approximately one and a half hours each, over a period of eight weeks. The sessions were led by the first author, who was at the end of his Master of Arts (MA) degree in music therapy. Prior to his MA, he worked as a Shiatzu therapist, took part in several sound therapy workshops, and incorporated TBs and the MC in his Shiatzu sessions. Each session was audio recorded and the first author's reflections were written in a diary (RD). After the last session, the participants were interviewed.

The sessions were conducted in a multi-sensory room (i.e., a Snoezelen room) in the hospital. White mattresses were placed on the floor. The room was also equipped with several lighting and audio instruments. To ensure a "clean" environment and prevent overstimulation, the lighting equipment and audio instruments were not used during sessions. To minimise any risks related to participants' mental state, several precautions were taken. Firstly, the sessions included the hospital

³ See Appendix A for the semi-structured interview schedule.

music therapist as a passive participant to ensure that participants' needs were addressed and to reduce any anxiety participants might experience. At times, the hospital music therapist played a more active role during the sessions by mediating certain instructions or providing additional support to some of the participants. Secondly, the sounds of the instruments were presented gradually by incorporating self-playing in the first few sessions. This made it possible to get a preliminary impression of how participants reacted to the sounds. In addition, it served as a way of establishing trust and a bond between the first author and the participants.

The sessions involved the following instruments: nine TBs of various pitches and sizes consisting of two large bowls measuring 9.5-10.5 inches in circumference and weighing 3-5kg, 5 medium bowls measuring 6.5-7.5 inches in circumference weighing 2-2.5kg, and two small bowls measuring 4-5 inches and weighing 0.5-1kg. The MC used in this pilot study was a 60-inch long resonance box with 25 strings. It had a movable bridge which allowed for one pitch on either side. During the sessions, it was tuned to have a perfect fifth between two pitches. The TBs were played by either striking or rubbing around the rim of the bowls.

Each session was composed of four stages:

(1) Preparatory (10-20 mins). Presenting the instruments and/or providing the participants with general guidelines, as well as explaining the session structure. The first author informed the participants that they would have the chance to experience the sounds of the instruments and they could also feel the vibrations of the TBs on their bodies if they wanted to. The participants were reminded that they could move around as they liked during the session. However, the emphasis was on being attentive to their individual experiences and minimizing conversations during the listening phase. The participants were also encouraged to share any thoughts or concerns, either related to the ongoing session or from the previous session.

(2) Meditation (5-10 mins). This stage was characterised by different techniques over the course of the study. In the first two sessions, a combination of movement, listening, and striking the TB were used. This strategy aimed to reduce anxiety and build trust between the participants and the facilitator (the first author). The following sessions incorporated a few minutes of relaxation, using breathing techniques with prolonged verbal guidance.

(3) Listening (30-45 mins). Participants were guided to listen to the sounds created by the first author and to notice any effects they might experience in the process. At times, verbal guidance was given by the first author to encourage participants to explore their experiences.

Although the music was improvised, the order of playing was almost identical. Firstly, the TB sounds were gradually introduced with pauses between the strikes. Then the sounds of the MC were introduced and the overall intensity gradually increased by adding the TBs to enhance the richness of sounds. Towards the end of this phase, the sounds gradually became softer and quieter.

The listening phase unfolded as follows: (a) TB improvisation, from the largest to the smallest TBs; (b) playing the MC; (c) MC+TB improvisation; and (d) placing some TBs on the participant's stomachs or backs while playing other TBs in the room. During this phase (d), the first author walked around the mattresses where the participants were lying and asked whether they wanted to have a TB placed on their bodies. A medium-sized TB was positioned on each participant who requested it. Participants told the first author to put the TB on their stomach or back. While the TBs were resting on

their bodies, they were gently struck with a mallet, occasionally accompanied by striking other TBs positioned on the mattress.

(4) Closure (15-25 mins). The first author provided verbal guidance to achieve an awakened state by raising the participants' awareness of the sensations in their entire body. After awakening⁴, the participants were invited to reflect on their experiences and share whatever came up while experiencing the sounds with the group.

Data analysis

The session recordings and interviews were transcribed. To identify research themes and subthemes, we followed the principles of thematic analysis which consists of familiarisation with the data, generating initial codes, searching for themes, reviewing, and defining and naming themes. We grouped the data and compared our findings by returning to the transcripts and the first author's reflections. Throughout this process, the first author maintained intersubjectivity by consulting with the second author. Ultimately, the overarching themes were generated, reviewed, and selected based on their relevance to the research questions.

RESULTS

This section presents the participants' experiences as shared in the semi-structured interviews and the participants' reflections during and at the end of each session. The sessions are indicated by their ordinal number (S1-7) and the data from the interviews by (I). Data from the RD are also discussed in relation to the associated themes.

Three main themes generated from the data analysis: physical sensations, experiences of emotions, and visual experiences.

Theme 1: Physical sensations

This theme deals with participants' experiences related to a sense of calmness and relaxation, as well as negative or positive, pleasant or unpleasant physical sensations as described by the participants.

1.1 Calmness and relaxation

During the sessions, most of the participants reported a sense of relaxation or calmness. According to Oren "it calms the whole body, there was quiet everywhere" (S2). Other participants confirmed this feeling: "I felt calmness, I felt serenity" (Abraham, S2); "Fun, calmness, like meditation" (Idit, S2); "It really relaxes" (Ilia, S4).

Both Oren and Abraham mentioned the prolonged effect of calmness: "It helped me in general, for two weeks... I am now very relaxed. Whatever you did with the TBs got me into a state of concentration" (Oren, I); "I was calm a lot, for one month" (Abraham, I). Idit also mentioned the continued effect of calmness in one of the sessions: "All day I feel quiet and calm and don't make any trouble; I don't shout or threaten anyone" (S5).

⁴ Some of participants were alert during the sessions and reflected on their experiences during the listening phase.

Observations that were documented in the RD also suggested a process of gradual increase in calmness and relaxation. Idit, who typically sat leaning against the wall, began to lie down in the fourth session (RD, 29.1.2017). Abraham also claimed he had difficulty falling asleep. In the initial sessions, he would usually lie down with his eyes open. From the third session onward, he seemed to become more relaxed as he would shut his eyes and sometimes fall asleep (RD, 22.1.2017). During the sessions, some of the participants appeared to experience a calming effect and showed an improvement in muscle tone, which became looser (RD, 5.2.2017). During the instrumental part of the last session, Ilia fell asleep for the first time (RD, 26.2.2017).

1.2 Sensation of currents

One of the main experiences that participants shared was a current-like sensation. Some described it as being like an electric current and others as a kind of ticklish vibration: "I feel currents all over my body" (Oren, S3). "When you stroked the bowl, I felt an electric current and what characterised it is not the difficulty but the strength" (Omer, S6); "Currents all over the body, really a pleasant sensation, calmness, quiet, everything is positive... I feel positive currents. It tickles me... I feel vibrations all over my body" (Idit, S5).

In the interviews, Oren and Idit mentioned certain body parts where they felt the sensation and also related it to a positive experience: "I felt it in my legs, hips, hands and head, in the skull... I wouldn't call it a negative current but a positive current" (Oren, I). "When you placed bowls on my back, I felt currents from my head to my feet and also when you placed one on my stomach... Positive currents" (Idit, I).

As the sessions progressed, two of the participants, Oren and Idit, enjoyed the sensations more and wanted more TBs to be placed on them for longer periods (RD, 19.2.2017).

1.3 Unpleasant sensations

Some participants also described unpleasant sensations including physical pain, although it was unclear whether this was due to the sounds or whether the pain was already present. Others mentioned a mixture of unpleasant and pleasant sensations: "My stomach hurts.... I have a lot of bowel movements... It was fun when you placed a bowl on me... It was pleasant" (Dina, S3). Oren mentioned a stomachache as well: "I have had pain in my stomach since last Sunday, I ate a lot, and maybe if you put a bowl on me it will help" (S4).

Theme 2: Experiences of emotions

Several participants shared experiences related to emotions. In some cases, the participants could not specify any particular emotion, but classified what they felt as "positive" or "negative".

2.1 "Positive" emotions

The participants expressed various emotions related to enjoyment and satisfaction and used words such as "good," "fun," and "positive" to describe how they felt: "It was good" (Dina, S2); "[The sessions] took away the negative qualities and brought in the positive ones" (Oren, S3); "I felt positive and not

negative sensations. I felt great and it was fun" (Idit, S3); "I felt great" (Abraham; S3); "I felt good, it's good with you" (Ilia, S2); "It was nice, fun, calming, made you calm, with a good sensation in your heart" (Ilia, S7).

2.2 "Negative" and ambivalent emotions

There were also expressions of "negative," unpleasant, or difficult emotions: "After the session, sometimes I had feelings that were not good... I have a lot of frustration in me. I wanted this session to continue to calm me down" (Oren, S5).

Some emotions were ambivalent like Ronit's: "I don't feel comfortable here... it's good for my spirit; you calm me down... I don't feel good [starts to cry] I don't want to quit... I want to get out... I'm sorry, I'm not calm" (S4). Ronit then exited the group. At the same session, Idit also expressed an ambivalent emotion after placing a TB near her legs: "I felt sadness and joy" (S4). Oren was also ambivalent: "I felt both sorrow and happiness, but in a profound way... I had positive thoughts at first but when the negative thoughts appeared, all went away" (Oren, S4). Idit and Oren expressed ambivalent emotions when certain memories of their deceased family members emerged: "I felt a longing for my grandfather... I felt sadness when I thought about him and... I felt calmness at first and then sadness" (Oren, S5). "I had pleasant sensations with the bowls but I thought about my father and felt sadness" (Idit, S5).

Towards the end of the sessions, all of the participants were very disappointed that the program had come to an end. Ilia, for example, had an intense emotional response in the last session. He put his head on the first author's lap and began to cry, saying he did not want the sessions to end (RD, 26.2.2017).

Theme 3: Visual Experiences

This category deals with the content of the participants' mental imagery evoked during the sessions. The images related to memories of family members, places, life events, water, dialogue, trips, and human interactions.

3.1 Previous group homes

Abraham and Oren mentioned their previous group homes more than once: "The group home in Ramla appeared in my mind; leaving it was a mistake" (Abraham) (S2); "When I was lying down, I felt I was dreaming of three group homes that could have advanced me" (Oren) (S2).

3.2 Deceased family members

Ilia and Idit saw images of their deceased fathers: "I was dreaming that I was at a Purim⁵ party with my stepmother and my father who were alive" (Ilia) (S6); "I was thinking of my deceased father, it's been two years since he died, I remember exactly when it happened" (Idit) (S2). Oren shared imagery of his deceased mother: "I felt my mother touching me, telling me: son, be with me up above because this is where our life's at" (Oren) (S4).

⁵ A Jewish holiday where people wear costumes.

3.3 Water imagery

Water imagery was experienced in different ways by three of the participants. Oren described an experience of flowing water: “The TBs gave me a flowing sensation like water, but inside of me there is Coke, like a shower” (S3); “I felt a wave of water, like water from a well that draws me out to the sea... It felt negative and positive, like I was drifting in the water and people came to rescue me” (S6). When Oren was asked during the interview about what he felt when the TB was placed on his body, he talked about water again: “The water was flowing, it was like going into the water and a strong current flowed over me”. Abraham and Idit also mentioned the sea: “It reminds me of the sea” (Abraham) (S4); “It reminds me of a quiet sea” (Idit) (S4).

3.4 Travelling

Oren had several mental images related to trips and transitions to other places: “When you did the meditation with the instruments I felt like I was in another world, a world of music, a very important world of dancing. I felt very positive about it” (S2). “When you placed a bowl on my stomach or on my back I felt like I was getting on a train and travelling to my former group home” (S5).

During the interview, Ilia mentioned several types of seafaring vessels when the TBs were played: “I felt good, like a ship, water, a boat”. Once he imagined that the bowl was being played in India: “I was imagining that you are in India” (S2).

3.5 Human interactions

Some of the participants had images that can be described as interactions with others, or between other people. Oren saw himself speaking and interacting with several figures:

The minute you switched bowls, I felt different things happening to me, and that I was succeeding in life. For example, someone wanted to give me a job and I couldn't take it then, and he said never mind you can come tomorrow and I felt good about it. (S3)

Abraham mentioned a promise he had made to his brother several times: “I recalled my brother who said to me: If you won't burst out for a whole year, I'll take you on a trip to Paris” (S4).

DISCUSSION

This pilot study examined a sound therapy intervention that focused on the use of TBs and MC within a group psychiatric setting consisting of six adults with mental health conditions and intellectual disabilities. It examined the participants' physical and psychological experiences as well as their ASC and visual experiences. The results suggest that the participants had a variety of experiences in several domains.

Sounding the body: Physical, mental , and emotional responses

All participants experienced a number of physical sensations in different parts of their body, regardless of whether the instruments were listened to or in contact with their bodies. These physical effects may be explained in terms of sound vibrations. Using sound instruments such as TBs in a therapeutic setting may cause participants to experience various sensations. The TBs can be placed on different parts of the body and act as both a tactile and auditory instrument. Thus, the participants' experiences varied from physical sensations to mental, cognitive, and emotional responses.

Each participant responded differently to a different set of sounds. One of the main experiences was an electric current or tickling, which was mentioned by three participants in their reflections after the sessions or in their interviews. These experiences were usually associated with calmness, relaxation, or other positive sensations. These sensations were also experienced while the TBs were placed on their body.

Calmness and relaxation

Several participants experienced a sense of calmness and relaxation when the TBs or MC were played. Sound vibrations can have a physiological effect since they lead to a relaxation of muscle tone and a decrease in circulatory and respiratory rates (Halstead & Roscoe, 2002). These findings correspond with the effects of the relaxation response (Benson & Klipper, 1975), where sound can act as the repetitive vessel.

Idit and Oren frequently said that the MC in particular had a calming effect, more than the sounds of the TBs. One possible explanation for this effect may be connected to the repetition and continuous type of sounds produced by the MC which creates a grounding effect. Playing the MC in a steady, slow pattern (60-70 bpm) acted as rhythmic grounding. Slower tempos induce slower respiratory and heart rates, and thus help the individual achieve a more relaxed state and reduce anxiety (Halstead & Roscoe, 2002). This technique can support feelings of physical and psychological safety and stability (Bruscia, 1987).

The relaxation and sense of safety that Ilia experienced during the sound sessions were very apparent. In the first session, he was talkative and fidgety, but gradually became more relaxed and even fell asleep during the final session. This gradual process of relaxation suggests that the sounds had a calming effect on him. The relaxation effect of the MC sounds as presented in this pilot study supports other studies that described a similar effect (Lee et al., 2012; Sandler et al., 2017).

Most participants reported that the physical sensations were enjoyable and pleasant, although in some instances, unpleasant sensations also emerged. Three participants experienced physical pain during some of the sessions. Oren and Dina experienced a stomachache and Ilia had chest pain. Although Oren and Dina mentioned that they also felt discomfort beforehand, the sound experiences could have evoked some pain. Physical pain can also be caused by repressed emotions that present as a psychosomatic reaction (Ventegodt & Merrick, 2005).

Given that sounds stimulate mechanoreceptors in the body through vibrations and that emotions are linked to our biological essence through the concept of body-mind unity, it is likely that different vibrations on different parts of the body can evoke different emotions depending on where certain

emotions are more present in the body at a given moment. For example, because the abdomen contains a high concentration of Pacinian corpuscles (Sigurdardóttir, 2019) and neuropeptides (Pert, 1997), pleasant or unpleasant sensations in this area may be more prominent.

Emotional experiences

The interconnectedness of body and mind emerged clearly in the participants' descriptions of their emotional experiences. The participants often used general words such as "positive" or "negative" to describe how they felt during sessions. This mode of expressing emotions is common among individuals with developmental disabilities, for whom identifying and labelling emotions can be difficult. Hatton (2002) reported that these individuals often use simplified emotional labels and broader categories such as "happy" or "sad."

Most participants experienced positive emotions and used words such as "happy," "good," "nice," and "fun." Conversely, some participants expressed unpleasant emotions. This variety of emotional responses indicates that the sounds had a broad emotional impact on the participants.

Another interesting finding was the parallel presence of both positive and negative emotions. At times, there was a positive emotion followed by a negative one, or vice-versa. These cases might indicate deep emotional processes. When one of the participants experienced a negative emotion, it might have been related to a release of repressed emotions. This in turn might have contributed to psychological relief that was translated into a positive emotion. Gaynor (2002) discussed the affective responses to TB sounds, where sound can transform emotions, particularly negative ones, into a state of calmness and composure that can affect physiology.

There were two instances where an experience of mixed emotions was reported. Oren related to an experience of mixed emotions of sorrow and joy to an image he had and said that at first, he had positive thoughts, but then negative ones appeared and "made the positive ones go away." Ronit had an intense emotional experience where she felt both calmness and stress. An experience of emotional duality can be therapeutically beneficial, as the client learns, at a physical and emotional level, that it is possible to experience both positive and negative or contain the good and the bad at the same time (Yalom, 1983).

In music psychology, the experience of mixed emotions is usually related to listening to music which has contrasting musical features⁶ (Hunter et al., 2008; Ladinig & Schellenberg, 2012). However, in the current pilot study, the nature of playing was relatively monotonic across sessions, with no apparent changes that might imply a conflicting cue. This raises questions regarding the differences in vibrational sound experiences versus listening to music in evoking emotions. This kind of intervention, which is receptive and monotonic, may elicit a more spontaneous emotional response. However, the participants' mental health condition may have contributed to their experiences of emotional fluctuation. More research is needed on this topic.

In this context, the emergence of unpleasant emotions or sensations may have been related to leaving the group. Two participants left the group during the pilot study. Dina left after the third session and Ronit attended the first and fourth sessions but did not return after that. The reason for Dina's

⁶ Such as a fast tempo and a minor mode, or a slow tempo with a major mode.

departure was unclear. During the third session, she mentioned having a stomachache, but also mentioned having had bowel movements prior to the session and experiencing a pleasant sensation at the same time.

Visual imagery

Another possible explanation for the participants' emotional experiences may have been related to their visual imagery. Visual imagery is considered to be one of the underlying mechanisms that evoke emotions (Juslin et al., 2010). The listener may be influenced by the images and experience different emotions. The content of mental imagery is affected by emotional state and imagery experiences can elicit further emotions.

Different modalities in music therapy often use musical structure as an important element for evoking certain emotions or psychological states (Sloboda & Juslin, 2011). Although the first author's playing was relatively monotonous in this study, multiple emotions, physical reactions, and mental visualisations were evoked.

The participants frequently mentioned the elicitation of visual content, including figures and scenes or events from their lives. According to Juslin et al. (2010), music can induce an emotion in the listener that evokes a personal memory or specific event in the listener's life. Many of the participants' visual experiences involved memories of deceased family members and past life events or locations. This may have significant therapeutic value. Moe (2002) suggested that music can help individuals understand themselves and their lives through a nonverbal narrative model. The sounds of the instruments in this pilot study mediated the external and internal worlds, thus providing a conduit into the participants' memories and emotions. Over time, these experiences may strengthen the sense of self, particularly for individuals with schizophrenia (Moe, 2002). The participants' visual experiences appeared to be connected to their biographical selves, as though their unconscious selves were trying to bring unresolved issues to consciousness (Schmucker, 2007). This may have been the case for Oren and Ilia, who experienced images of conversations or interactions with their deceased fathers. According to Hübner (2007), sounds can bring blocked or lost elements from the subconscious to the surface, thus allowing them to be processed and integrated.

The participants used various words to describe the images that seem to have unconscious meaning for them. These images can be thought of as symbols representing certain aspects of their internal psychological state. Similar to dreams, these symbols may reveal repressed emotions or events from the past (Bruscia, 2015). Jung (1964) described the emergence of symbols as a process that gives form and progression to certain energies in the unconscious. The sounds of the TBs and MC may have induced a trance-like state in some of the participants, allowing imagery to arise. Previous research has also found that MC sounds can have this effect (Sandler et al., 2017).

In the participants' experiences, water and travel-related words were commonly mentioned. These words can be interpreted as symbolic expressions of the participants' inner state. Water-related images may be connected to the participants' sensations of physical vibrations, whereas travel experiences may symbolise a deeper state of consciousness, access to certain areas of the psyche, or a journey through the subconscious.

Altered states of consciousness

It was difficult to determine the extent to which the participants experienced ASC in this pilot study, as it did not include EEG screening or measures of physiological parameters. In addition, it was difficult to gather information about their subjective experiences through interviews, due to their limited ability to express themselves. ASC are typically characterised by marked changes in subjective experiences (Vaitl et al., 2005). In this pilot study, the participants reported changes in mood and a sense of relaxation. Moreover, some of the participants also experienced imagery, which is usually associated with ASC (Winkelman, 2011). However, no experiences related to a change in body perception or sense of time was reported. It is noteworthy that some of the participants remained alert during the sessions and sometimes talked about their experiences during the listening phase.

Limitations, practical implications, and recommendations for future research

The procedures during the preliminary phase differed slightly from one another. Furthermore, the way TBs were played was improvisational and varied in terms of the order and dynamics across sessions. The sample was small and there were only a few sessions. In addition, only four of the six participants participated until the end. Future studies could expand upon the current findings by conducting sessions with a larger sample size. Another limitation is the participants' relatively limited verbal abilities, which may have hindered their ability to fully express their insights and experiences from the sound sessions. Alternative methods of communication, such as drawing or cards, could be used in future studies to address this limitation. Furthermore, the first author was the one who facilitated the sessions and conducted the interviews with the participants, which could have introduced a potential bias in the results.

In terms of practical implications, the sound work described in this paper may be helpful for individuals with mental health conditions and intellectual disabilities in reducing anxiety and addressing stressful issues. It is important to note, however, that extra care and safety measures should be taken when using TBs with this population. The placement of bowls on the body should be done gradually, with a constant evaluation of whether it is pleasant or not for the client.

Music therapists could benefit from incorporating monochrome sound instruments such as TBs and MC when working with clients from different backgrounds and when using a range of approaches. For example, therapists could combine TBs with relaxation techniques over an entire session or as a single intervention during a session. In addition, certain principles that are more closely associated with sound therapy such as resonance, entrainment, and ASC could be implemented in music therapy training programs. Learning about these principles could broaden future music therapists' approach to the use of sound or music in therapy. Gaining a deeper understanding of the mechanisms underlying the effects of sounds could help music therapists apply and adapt other receptive sound therapy techniques more effectively to optimise the therapeutic benefit of their interventions for their clients.

Our findings demonstrated that TBs and MC in a group setting were beneficial for some participants in various domains. Primarily, most felt more relaxed during or after the sessions – an important therapeutic benefit for this population that often suffers from high levels of anxiety and nervousness (Fletcher et al., 2016). Future quantitative research could consider exploring the

physiological effects of sound therapy on relaxation and sleep, and its impact on the need for anti-anxiety medication. Therapists working in different environments such as hospitals and nursing homes could use TBs to induce relaxation. The fact that the participants reported enjoying the sensation of vibrations from the TBs on their bodies suggests that this type of therapy may be particularly effective for clients who have an aversion to direct physical contact.

Instruments such as the MC and TBs may help therapists evoke emotions in their clients. The unique characteristics of TBs may also contribute to the client's sense of body-mind unity by strengthening their connection to emotions and physical experiences. Monochromatic sounds, which are not commonly used in Western music, may offer listeners a more passive experience and induce significant changes in ASC (Hübner, 2007). All the participants in this pilot study experienced some form of mental imagery, thus pointing to the potential of monochromatic sound instruments in evoking mental imagery. One advantage of using these instruments in therapy is that they are often new to clients, so they may be less conditioned or influenced by past experiences and attitudes towards the sounds compared to more conventional instruments. The images evoked during sessions can also be used for self-exploration in a therapeutic setting.

CONCLUSION

This pilot study explored the effects of monochromatic sound therapy using TBs and MCs in a sample of individuals with mental health conditions and intellectual disabilities. The results indicated that the sessions led to a sense of relaxation and a reduction in anxiety for the participants, although some also experienced unpleasant sensations. The use of monochromatic sound instruments also evoked a variety of emotions and mental imagery in the participants, thus pointing to the potential of these instruments in evoking emotional responses and facilitating self-exploration in a therapeutic setting. However, the small sample size and the participants' limited verbal abilities suggest the need for further research with a larger sample size and alternative methods of communication to more fully capture the participants' experiences. Despite these limitations, the findings suggest that TBs and MC sound meditation may be a useful tool in the treatment of individuals with mental health conditions and intellectual disabilities.

REFERENCES

- Ballan, H., & Abraham, A. G. (2016). Multimodal imagery in music: Active ingredients and mechanisms underlying musical engagement. *Music and Medicine*, 8(4). <https://doi.org/10.3390%2Fhealthcare9050597>
- Bartel, L., & Mosabbir, A. (2021). Possible mechanisms for the effects of sound vibration on human health. *Healthcare*, 9(5), 597. doi: 10.3390/healthcare9050597
- Benson, H., & Klipper, M. Z. (1975). *The relaxation response*. Harper Collins.
- Bhattacharya, J., & Lee, E. J. (2016). Modulation of EEG theta band signal complexity by music therapy. *International Journal of Bifurcation and Chaos*, 26(01), 1650001. <http://dx.doi.org/10.1142/S0218127416500012>
- Bidin, L., Pigaiani, L., Casini, M., Seghini, P., & Cavanna, L. (2016). Feasibility of a trial with Tibetan Singing Bowls, and suggested benefits in metastatic cancer patients. A pilot study in an Italian Oncology Unit. *European Journal of Integrative Medicine*, 8(5), 747-755. <http://dx.doi.org/10.1016/j.eujim.2016.06.003>
- Burns, J. L., Lee, R. M., & Brown, L. J. (2011). The effect of meditation on self-reported measures of stress, anxiety, depression, and perfectionism in a college population. *Journal of College Student Psychotherapy*, 25(2), 132-144. doi: 10.1080/87568225.2011.556947
- Bruscia, K. E. (1987). *Improvisational models of music therapy*. Charles C Thomas.
- Bruscia, K. E. (1998). *Defining music therapy*. Barcelona Publishers.
- Bruscia, K. E. (2015). *Notes on the practice of Guided Imagery and Music*. Barcelona Publishers.
- Bruscia, K. E., & Grocke, D.E. (Eds.). (2002). *Guided imagery and music: The Bonny method and beyond* (Vol. 1). Barcelona Publishers.

- Creese, D. (2010). *The monochord in ancient Greek harmonic science*. Cambridge: Cambridge University Press.
- Esch, T., Fricchione, G. L., & Stefano, G. B. (2003). The therapeutic use of the relaxation response in stress-related diseases. *Signature*, 9(2), 34.
- Fachner, J., & Rittner, S. (2005). Music and altered states of consciousness (ASC), sound and trance in a ritualistic setting. *Proceedings of the 6th European Music Therapy Congress, Finland*, 6(4), 942-973.
- Fachner, J. (2011). Time is the key—music and altered states of consciousness. *Altering consciousness: A multidisciplinary perspective*, 1, 355-376.
- Fendel, U., Sandler, H., Papachristou, C., Voigt, B., Rose, M., & Klapp, B. F. (2018). Bodily experiences of patients diagnosed with anorexia nervosa during treatment with the body monochord—A modified grounded theory approach. *The Arts in Psychotherapy*, 59, 7-16. <https://doi.org/10.1016/j.aip.2018.03.003>
- Fletcher, R. J., Cooray, S. E., Andrews, T., Bailey, N. M., Devapriam, J., McLaren, J. L., Purandare, K. N., Jaydeokar, S. S., Tasse, M. J., & Wijeratne, A. (2016). Chapter 13 anxiety disorders. In *Diagnostic manual - intellectual disability: A textbook of diagnosis of mental disorders in persons with intellectual disability: DM-ID-2* (2nd ed., pp. 303–328). NADD Press.
- Gaebel, C., Garrido, N., Koenig, J., Hillecke, T. K., & Warth, M. (2017). Effects of monochord music on heart rate variability and self-reports of relaxation in healthy adults. *Complementary medicine research*, 24(2), 97-103. <https://doi.org/10.1159/000455133>
- Gaynor, M. L. (2002). *The healing power of sound: Recovery from life-threatening illness using sound, voice, and music*. Boston: Shambhala.
- Garcia-Romeu, A. P., & Tart, C. T. (2013). Altered states of consciousness and transpersonal psychology. In H. L. Friedman & G. Hartelius (Eds.), *The Wiley-Blackwell handbook of transpersonal psychology* (pp. 121-140). John Wiley & Sons.
- Goldberg, F. S. (1994). The Bonny Method of Guided Imagery and Music as individual and group treatment in a short-term acute psychiatric hospital. *Journal of the Association for Music and Imagery*, 3, 18-34.
- Goldman, J. (1991). Sonic entrainment. In D. Campbell (Ed.), *Music: Physician for times to come* (pp. 217-233). Theosophical Publishing House.
- Goldman, J. (1996). *Healing sounds: The power of harmonics*. Element Books.
- Goldsby, T. L., Goldsby, M. E., McWalters, M., & Mills, P. J. (2017). Effects of singing bowl sound meditation on mood, tension, and well-being: An observational study. *Journal of Evidence-Based Complementary & Alternative Medicine*, 22(3), 401-406. <https://doi.org/10.1177%2F2156587216668109>
- Goldsby, T. L., Goldsby, M. E., McWalters, M., & Mills, P. J. (2022). Sound healing: Mood, emotional, and spiritual well-being interrelationships. *Religions*, 13(2), 123. <https://doi.org/10.3390/rel13020123>
- Grocke, D. E., & Wigram, T. (2007). *Receptive methods in music therapy: Techniques and clinical applications for music therapy clinicians, educators and students*. Jessica Kingsley Publishers.
- Halstead, M. T., & Roscoe, S. T. (2002). Music as an intervention for oncology nurses. *Clinical Journal of Oncology Nursing*, 6(6), 332-336. <https://doi.org/10.1002/14651858.cd006911.pub3>
- Hatton, C. (2002). Psychosocial interventions for adults with intellectual disabilities and mental health problems: A review. *Journal of Mental Health*, 11(4), 357-374. <http://dx.doi.org/10.1080/09638230020023732>
- Huang, T. L., & Charyton, C. (2008). A comprehensive review of the psychological effects of brainwave entrainment. *Alternative Therapies in Health and Medicine*, 14(5), 38-50.
- Hübner, C. (2007). EnTrance: Entrance to wider worlds, or mystification of mere relaxation. *Music Therapy Today*, 8(2), 257-293.
- Humphries, K. (2010). *Healing sound: Contemporary methods for Tibetan singing bowls*.
- Hunter, P. G., Schellenberg, E. G., & Schimmack, U. (2008). Mixed affective responses to music with conflicting cues. *Cognition & Emotion*, 22(2), 327-352. <http://dx.doi.org/10.1080/02699930701438145>
- Jansen, E. R. (1992). *Singing bowls: A practical handbook of instruction and use* (Kindle DX version).
- Jung, C. G. (1964). *Man and his symbols*. Penguin.
- Jungalberle, H., & Altieri, P. (2002). Töne strömen ein. Beiträge zur Musikpsychologie des Monochords [Abstract]. *Musiktherapeutische Umschau*, 24(3), 319-332.
- Juslin, P. N., Liljeström, S., Västfjäll, D., & Lundqvist, L. O. (2010). How does music evoke emotions? Exploring the underlying mechanisms. In P. N. Juslin & J. A. Sloboda (Eds.), *Handbook of music and emotion: Theory, research, applications* (pp. 605-642). Oxford University Press.
- Juslin, P. N., & Sloboda, J. (Eds.). (2011). *Handbook of music and emotion: Theory, research, applications*. Oxford: Oxford University Press.
- Kearl, A. M. (2017). *The Swiss resonance monochord table: Inquiry into the healing complexity and transformative power of sound*. California Institute of Integral Studies.
- Koelsch, S. (2015). Music-evoked emotions: principles, brain correlates, and implications for therapy. *Annals of the New York Academy of Sciences*, 1337(1), 193-201. <https://doi.org/10.1111/nyas.12684>
- Kovach, A. M. S. (1985). Shamanism and Guided Imagery and Music: A comparison. *Journal of Music Therapy*, 22(3), 154-165. doi: 10.1093/jmt/22.3.154.
- Kvale, S., & Brinkman, S. (2009). *Interviews: Learning the craft of qualitative interviewing*. Sage.
- Ladinig, O., & Schellenberg, E. G. (2012). Liking unfamiliar music: Effects of felt emotion and individual differences. *Psychology of Aesthetics, Creativity, and the Arts*, 6(2), 146-154. <http://dx.doi.org/10.1037/a0024671>
- Landry, J. M. (2014). Physiological and psychological effects of a Himalayan singing bowl in meditation practice: A quantitative analysis. *American Journal of Health Promotion*, 28(5), 306-309. doi: 10.4278/ajhp.121031-ARB-528
- Lee, E. J., Bhattacharya, J., Sohn, C., & Verres, R. (2012). Monochord sounds and progressive muscle relaxation reduce anxiety and improve relaxation during chemotherapy: A pilot EEG study. *Complementary Therapies in Medicine*, 20(6), 409-416. doi: 10.1016/j.ctim.2012.07.002.
- Moberg, K. U. (2003). *The oxytocin factor: Tapping the hormone of calm, love, and healing*. Da Capo Press.
- Moe, T. (2002). Restitutional factors in receptive group music therapy inspired by GIM: The relationship between self—objects, psychological defence manoeuvres and restitutional factors: Towards a theory. *Nordic Journal of Music Therapy*, 11(2), 152-166. <https://doi.org/10.1080/08098130209478057>

- Moreno, J. J. (1995). Ethnomusic therapy: An interdisciplinary approach to music and healing. *The Arts in Psychotherapy*, 22(4), 329-338. doi: 10.1016/0197-4556(95)00039-8
- Oelmann, J. (1993). Klang, Wahrnehmung, Wirkung: Zur therapeutischen Arbeit mit Gongs und Tam-Tams in rezeptiver Therapie. *Musiktherapeutische Umschau*, 14(4), 289-305.
- Pert, C. (1997). *Molecules of emotion: The science behind mind-body medicine*. Touchstone.
- Price, N. (2001). *The archaeology of shamanism* (Kindle DX version).
- Rojahn, J., Lederer, M., & Tassé, M. J. (1995). Facial emotion recognition by persons with mental retardation: A review of the experimental literature. *Research in Developmental Disabilities*, 16(5), 393-414. [https://doi.org/10.1016/0891-4222\(95\)00019-j](https://doi.org/10.1016/0891-4222(95)00019-j)
- Rose J. P., Weis, J. (2008). Klangmeditation in der onkologischen Rehabilitation: Pilotstudie zu einer rezeptiven Gruppenmusiktherapie mit dem Monochord. *Forschende Komplementärmedizin*, 15(6), 335-343. doi: 10.1159/000164268
- Sandler, H., Tamm, S., Klapp, B., & Bösel, R. (2008). Das Ganzkörper-Monochord: Wirkungen auf EEG und subjektives Erleben. *Musik, Tanz und Kunsttherapie*, 19(3), 110-120. <http://dx.doi.org/10.1026/0933-6885.19.3.110>
- Sandler, H., Fendel, U., Peters, E., Rose, M., Bösel, R., & Klapp, B. F. (2017). Subjective experience of relaxation – Induced by vibroacoustic stimulation by a body monochord or CD music: A randomised, controlled study in patients with psychosomatic disorders. *Nordic Journal of Music Therapy*, 26(1), 79-98. doi: 10.1080/08098131.2015.1089312
- Schmucker, A. (2007). The sound guided trance according to Wolfgang Strobel. In I. Frohne-Hagemann, (Ed.), *Receptive music therapy: Theory and practice* (pp. 171-188). Reichert.
- Sigurdardóttir, G. A., Nielsen, P. M., Rønager, J., & Wang, A. G. (2019). A pilot study on high amplitude low frequency–music impulse stimulation as an add-on treatment for depression. *Brain and Behavior*, 9(10), e01399. <https://doi.org/10.1002/brb3.1399>
- Sloboda, J. A., & Juslin, P. N. (2011). At the interface between the inner and outer world. In P.A. Juslin & J.A. Sloboda (Eds.), *Handbook of music and emotion: Theory, research, applications* (pp. 73-98). Oxford University Press.
- Stanhope, J., & Weinstein, P. (2020). The human health effects of singing bowls: A systematic review. *Complementary Therapies in Medicine*, 51, 102412. <https://doi.org/10.1016/j.ctim.2020.102412>
- Strobel, W. (1988). Klang - Trance - Heilung. Die archetypische Welt der Klänge in der Psychotherapie. *Musiktherapeutische Umschau*, 9, 119-139.
- Thaut, M. H., McIntosh, G. C., & Hoemberg, V. (2015). Neurobiological foundations of neurologic music therapy: Rhythmic entrainment and the motor system. *Frontiers in Psychology*, 5(1185), 1-6. <https://doi.org/10.3389%2Ffpsyg.2014.01185>
- Torri, D. (2011). Shamanic traditions and music among the Yolmos of Nepal. *Musiké: International Journal of Ethno Musicological Studies*, 5(3), 81-93.
- Vaitl, D., Birbaumer, N., Gruzelier, J., Jamieson, G. A., Kotchoubey, B., Kübler, A., ... & Weiss, T. (2005). Psychobiology of altered states of consciousness. *Psychological Bulletin*, 131(1), 98-127. doi: 10.1037/0033-2909.131.1.98.
- Ventegodt, S., & Merrick, J. (2005). Clinical holistic medicine: Chronic pain in internal organs. *The Scientific World Journal*, 5, 205-210. <https://doi.org/10.1100%2Ftsw.2005.27>
- Wahbeh, H., Calabrese, C., & Zwickey, H. (2007). Binaural beat technology in humans: A pilot study to assess psychologic and physiologic effects. *The Journal of Alternative and Complementary Medicine*, 13(1), 25-32. doi: 10.1089/acm.2006.6196.
- Wigram, T., & De Backer, J. (Eds.). (1999). *Clinical applications of music therapy in psychiatry*. Jessica Kingsley Publishers.
- Will, U., & Berg, E. (2007). Brain wave synchronization and entrainment to periodic acoustic stimuli. *Neuroscience Letters*, 424(1), 55–60. doi: 10.1016/j.neulet.2007.07.036
- Williams, J. D., & Gruzelier, J. H. (2001). Differentiation of hypnosis and relaxation by analysis of narrow band theta and alpha frequencies. *International Journal of Clinical and Experimental Hypnosis*, 49(3), 185-206. <https://doi.org/10.1080/00207140108410070>
- Winkelman, M. (2011). Shamanism and the evolutionary origins of spirituality and healing. *NeuroQuantology*, 9(1), 54-71.
- Yalom, I. D. (1983). *Inpatient group psychotherapy*. Basic Books.
- Young, S. N. (2011). Biologic effects of mindfulness meditation: Growing insights into neurobiological aspects of the prevention of depression. *Journal of Psychiatry and Neuroscience*, 36(2), 75–77. doi: 10.1503/jpn.110010

APPENDIX A

Semi-structured interview schedule

A qualitative pilot study examining Tibetan bowls and monochord sound meditation with adults who have mental health conditions and intellectual disabilities

1. What was your overall experience of the sessions?
After reminding the participant about the different parts of each session:
2. Did you feel more connected to, or prefer a specific part of the sessions?
 - a. Could you elaborate on that? What did you particularly like about this part or instrument?
3. Was there any part or instrumental sounds that you felt you wanted more of?
4. Were there any parts you didn't like?
 - a. Could you elaborate more on why?
5. What can you share about your experience from listening to the sounds of the TBs?
In case he/she had a physical sensation:
 - a. Where in your body did you feel that?
 - b. Was it a pleasant or unpleasant sensation?*If an emotion emerged:*
 - a. How long did it last?
 - b. Do you remember whether you experienced it once, twice, or more during the sessions?
6. What can you share about your experience from listening to the sounds of the MC?
In case he/she had a physical sensation:
 - a. Where in your body did you feel that?
 - b. Was it a pleasant or unpleasant sensation?*If an emotion emerged:*
 - a. How long did it last?
 - b. Do you remember whether you experienced it once, twice, or more during the sessions?
7. Did you experience any physical sensations during the sessions?
If yes:
 - a. Where in your body did you feel that?
 - b. Was it a pleasant or unpleasant sensation?
8. Were there any instances where you felt pain or discomfort during the sessions?
If pain was felt:
 - a. Where?
 - b. How long did it last?
 - c. Was it something that you recognised from the past?
9. How did you feel after the sessions?
 - a. Did this feeling continue for a certain period afterward?
10. Can you remember one experience from the session which was more meaningful to you?

11. Was there a specific emotion that you felt more present during the sessions?
 - a. Did you have any experience of that emotion being present after a session?
12. Did you feel any effect on your state of mind/mood after each session?
13. Do you remember if there were sessions where you fell asleep?
In case the participant reflected on imagery during the sessions, after reminding them a specific imagery they had:
 - a. Do you recall that?
 - b. Could you elaborate regarding that experience?
 - c. Could you recall if there was any emotion attached to this imagery?
 - d. Could you recall if there was any physical sensation attached to this experience?
14. Did you have any negative or unpleasant experience during the sessions?
 - a. How long did it last?
 - b. Was it something that you recognised from the past?
 - c. Did you feel that in your body? Where?
15. Is there anything else you wish to share with me regarding your experience with the sounds and being present in the sessions?

Ελληνική περίληψη | Greek abstract

Μια ποιοτική πιλοτική μελέτη που εξετάζει τον ηχητικό διαλογισμό με Θιβετιανά μπολ και μονόχορδο με ενήλικες με παθήσεις ψυχικής υγείας και διανοητικές αναπηρίες

Harel Gal | Cochavit Elefant

ΠΕΡΙΛΗΨΗ

Τα Θιβετιανά μπολ και τα μονόχορδο είναι όργανα χιλιετιών που χρησιμοποιούνται για πνευματικούς και θεραπευτικούς σκοπούς. Τις τελευταίες δεκαετίες, υπάρχει ολοένα και περισσότερο ενδιαφέρον για τη χρήση αυτών των οργάνων στον διαλογισμό και σε θεραπευτικά πλαίσια. Παρόλα αυτά, εξακολουθούν να χρησιμοποιούνται σπάνια στη μουσικοθεραπεία στον Δυτικό κόσμο, είτε εξαιτίας τεχνικών δυσκολιών είτε λόγω μουσικών ή πολιτισμικών προκαταλήψεων. Ο σκοπός αυτής της πιλοτικής μελέτης ήταν να διερευνηθούν οι εμπειρίες ενηλίκων με παθήσεις ψυχικής υγείας και διανοητικές αναπηρίες κατά τη διάρκεια συνεδριών ηχητικού διαλογισμού που χρησιμοποιούνταν Θιβετιανά μπολ και ένα μονόχορδο. Σε αυτή την ποιοτική πιλοτική μελέτη, μια ομάδα έξι νοσηλευομένων ασθενών σε ψυχιατρική κλινική συμμετείχε σε επτά εβδομαδιαίες συνεδρίες ηχητικού διαλογισμού για οκτώ εβδομάδες κατά τις οποίες εφαρμόστηκαν τα Θιβετιανά μπολ και το μονόχορδο σε συνδυασμό με διαλογισμό. Μετά από κάθε συνεδρία πραγματοποιήθηκαν ημιδομημένες συνεντεύξεις για να καταγραφούν οι αναστοχασμοί των συμμετεχόντων σχετικά με τις εμπειρίες τους. Για την ανάλυση των δεδομένων από τις συνεντεύξεις χρησιμοποιήθηκε θεματική ανάλυση. Τρεις κύριες θεματικές αναδύθηκαν: σωματικές αισθήσεις, οι εμπειρίες των συναισθημάτων, και οι οπτικές εμπειρίες. Οι ήχοι των Θιβετιανών μπολ και του μονόχορδου βοήθησαν τους συμμετέχοντες να χαλαρώσουν, και ανακίνησαν πληθώρα συναισθημάτων και νοερών απεικονίσεων. Από αυτά τα ευρήματα προτείνεται ότι η χρήση αυτών των οργάνων με ενήλικες με παθήσεις ψυχικής υγείας και διανοητικές αναπηρίες μπορεί να συμβάλει στη χαλάρωση, καθώς και στην διεύρυνση της επίγνωσης των σωματικών αισθήσεων, των συναισθημάτων, και παρελθοντικών γεγονότων της ζωής. Ως εκ τούτου, οι μουσικοθεραπευτές μπορούν να ενσωματώσουν τα Θιβετιανά μπολ και το μονόχορδο στις πρακτικές τους και να τα χρησιμοποιήσουν κατά τη διάρκεια των θεραπευτικών συνεδριών.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Θιβετιανά μπολ, ηχογαβάθες, μονόχορδο, ηχητικός διαλογισμός, ηχοθεραπεία, δονούμενος ήχος, ηχολουτρό, ψυχική υγεία, αναπτυξιακές αναπηρίες

ARTICLE

An analysis of caregiver perceptions of early childhood music therapy telehealth groups

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ABSTRACT

Early childhood music therapy research typically examines the effects of music therapy sessions on children, but little research has examined the perspectives of caregivers: parents of the children and classroom teachers/staff. The purpose of this study was to formally analyse the perceptions of both groups of caregivers of the children who received music therapy services in this 12-week programme. Participants included six Parents and Legal Guardians (PLG) and five Early Childhood Professionals (ECP) who voluntarily took part in individual interviews after the 12-week sessions had concluded. The researchers conducted a thematic analysis of the interviews and created codes, categories, and themes. We identified six themes: two specific to PLG experiences and two specific to ECP, alongside two that were similar across all participants. Results indicated that both groups seemed to need more information as to the purpose of music therapy sessions. Secondly, stress from the pandemic may have hindered the capacity of both groups to integrate the information from the music therapy research team over the period of the study. Future goals for music therapy researchers in early childhood education settings regarding their relationships with PLG and ECP are discussed.

KEYWORDS

parents,
caregivers,
early childhood,
telehealth,
research methods,
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INTRODUCTION

Young children form connections to the adults with whom they spend their time, primarily with caregivers in the form of biological, foster, or adoptive parents, and Early Childhood Professionals (ECP, referring to the various levels of professional staff in early childhood settings) if they attend an early childhood care centre of some kind. In the United States (US), a report from the National Center for Education Statistics (NCES, 2024) established that in 2021, 53% of three to five year olds were in some form of half or full-day care, a decrease from a 59%-61% in the years 2012-2019. A variety of ECP interact with children at childcare facilities every day and they play a growing role as more research shows the importance of healthy connection and attachments in early childhood.

This study was situated in a Head Start certified early learning centre. Head Start, a US-based programme for early education administered by the Department of Health and Human Services Administration for Children and Families, is structured around five key domains: approaches to learning, social and emotional development, language and literacy, cognition, and physical development (Families, 2023). Head Start (and Early Head Start for younger children) fund early childhood facilities who provide comprehensive educational environments for families with lower socioeconomic status.

Adults in young children's microsystems

Parents and Legal Guardians (PLG) and ECP have a place in each child's microsystem, according to Bronfenbrenner's Ecological Theory (1979). Social skills development occurs within this microsystem, wherein there is intersubjective relating learned through healthy attachment to caregivers. Music therapists and ECP might also be considered as part of a child's microsystem, along with PLG. Ideally, these adults are united in trying to provide safety and attachment in the relationship while encouraging the child's development in four phases, according to Briggs (1991): reflex (0-9 months, all ages are estimates based on typical neurodevelopment), intention (9-18 months), control (18-36 months), and integration (36-72 months). Using Bronfenbrenner's ecological systems theory, the current research project was conducted to better understand the nature of the microsystem that includes the interactions among music therapists, ECP, and PLG. Oldfield and Flower (2008) provided a variety of case studies that delved into how music therapists navigate their relationships with family members of children across the age and ability spectrum. Music therapists have collaborated with other professionals who work with children, addressing various concerns such as communication disorders (Boster et al., 2021; Devlin & Meadows, 2021) and physical difficulties (Eid et al., 2021).

To date, research suggests that ECP's comfort and competence with using music varies greatly across geographic areas (Kirby et al., 2023). This study seeks to add to the existing body of knowledge by investigating PLG and ECP attitudes toward collaborating with music therapists who provide large group, small group, and individual music therapy sessions via telehealth during the pandemic.

Attachment and early childhood

Attachment theory undergirds much of early childhood development and many have studied methods to improve and increase attachment between young children and the adults who care for them, including PLG and ECP (Wolfgang, 2018). Makridis et al. (2021) summarised early childhood pedagogical approaches and the “investments” that early childhood music engagement may foster, including cognitive and social development. They suggested that “there is ambiguity about exactly how to invest in children” and promoted “evidence that arts and music education is integral for childhood development” (p.14). Head Start actively engages parents in the learning and well-being of the young children they serve (Head Start, 2024). Early childhood music professionals, like educators and music therapists, may be able to educate PLG and ECP about the benefits of music in early childhood development in the context of remote learning. In this study, the focus was on the perspectives of PLG and ECP on the children they cared for who participated in telehealth music therapy group and individual sessions that occurred at an early childhood facility in the Western US. Additionally, there were technological barriers to overcome and questions around whether musical engagement could still provide some key development for the children in the way Makridis et al. (2021) and some music therapy researchers (Furman & Humpal, 2006; Humpal, 2018; Schwartz, 2008) have suggested. This study investigates PLG’s and ECP’s understanding of the benefit of music in early childhood development delivered through telehealth at one early childhood centre.

Music in early childhood settings

Kirby et al. (2022) reported on the uses of music by ECP in educational settings, including the purposes and challenges they face with music. They also suggested that music engagement can be influential for children who are multiple language learners, as was the case for many children in the current study who are primarily from LatinX and/or Hispanic cultures. One challenge for ECP is their lack of training in music, as opposed to a music specialist, such as a music therapist. Kim and Kemple (2011) and Rajan (2017) agreed that ECP’s lack of musical understanding and knowledge prevents them from having more successful connections with young children through music. Hodijah and Kurniawati (2021) claimed, “in general, teachers believe that music has an important role [...] and their attitude has an important role in the process of learning as well” (p.161).

Telehealth music therapy sessions

The study included weekly group music therapy sessions for children at a Head Start facility in the Western US. The Head Start programme director divided the children into various classroom cohorts per spacing and distancing requirements put in place during the COVID-19 pandemic, which included morning and afternoon cohorts. A research team administrator sent the facility a variety of technology for the music therapists to create virtual music therapy sessions with the help of ECP at the facility. However, music therapy, like many professions, did not have a great deal of research on telehealth prior to the pandemic (Wang et al. 2023; WHO, 2010). Vaudreuil et al. (2020) noted this lack of literature in the profession and encouraged music therapists to learn more about audio fidelity when delivering

telehealth music therapy services. Knott and Block (2020) put forward a three-tiered model in virtual music therapy. In the current study, the music therapists practised at tier 3, which entails synchronous music therapy sessions through online video and audio platforms to encourage therapeutic music and movement experiences.

Session structures were created by the music therapists with input from the research team, focusing on the goal areas of social competence and emotion regulation. These goal areas have been investigated by other researchers in music therapy and early childhood, particularly Sena Moore and Hanson-Abromeit (2018). Before the study began, the research team asked the early childhood learning centre programme director to reach out to families to complete demographic surveys and inform them about what virtual music therapy sessions would look like with their children at the centre. The programme director also created a list of children who were more “at-risk” based on their facility assessment and those children were referred to music therapy for individual weekly sessions in addition to group sessions. The research team worked with PLG to schedule individual virtual music therapy sessions from 15-30 minutes once a week. Group sessions were typically around 30 minutes in length. Both individual and group sessions included ritual hello and goodbye songs (to promote social competence), small or large movement (for emotion regulation), and some instrument playing/singing songs that included social stories and worked on goals such as sustained attention.

PURPOSE OF THE STUDY

The purpose of this study was to formally analyse the perceptions of both groups of caregivers of the children who received music therapy services in this 12-week program. There are two unique aspects to this investigation. First, there is scant research on music therapy services in Head Start. Head Start’s focus on involving parents in their child’s learning is an ideal milieu to investigate how music therapists can serve as expert collaborators with ECP and PLG. Second, the pandemic created an environment for us to evaluate telehealth practices, specifically the pros and cons of trying to communicate without face-to-face contact and in-person feel that is found in typical music and movement-based moments.

Our aim as a research team was to better understand the perceptions of the adult participants in this research study. The guiding research questions were:

- 1) What were the experiences of PLG (Parents and Legal Guardians) and ECP (Early Childhood Professionals) during the music therapy research period?
- 2) How did their experiences compare? What were the similarities and differences?
- 3) What were their experiences specific to the telehealth aspect of music therapy service delivery?

METHOD

The research team was contracted with a Head Start facility in the Western US prior to the pandemic to conduct music therapy sessions over 12 weeks to include group and individual sessions by two board certified music therapists. The overall ethnic and cultural makeup of the children/families at

this facility are majority Hispanic/LatinX, which mirrors the ethnic makeup of the community where this facility is located.

The research team included three administrators from a music therapy company who built the relationship with staff at the early childcare facility, two board certified music therapists who facilitated the music therapy sessions, and two board certified music therapists who are the research consultants and authors of this paper. One of the co-authors (AK) conducted the interviews with ECP and PLG, and both co-authors analysed the qualitative data for this dissemination.

Given the above research questions, we employed thematic analysis, as defined by Braun and Clarke (2021), to learn how PLG and ECP understood and made sense of this telehealth music therapy session. Given the parameters of the pandemic, we conducted online video or phone interviews with these two groups of caregivers. None of the PLG had experienced their child in a music therapy group or individual session before and none of the ECP had facilitated any 'virtual' portions of music therapy groups, although some had prior experiences with a weekly in-person group. The music therapy sessions took place in early 2021 over 12 weeks and the interviews took place within three weeks immediately following the final weekly group session.

Intervention

The telehealth intervention was created by the research team to meet the obligation of the initial contract but also adhere to distancing guidelines of the school district that the Head Start facility was under. The intervention consisted of 30-minute sessions once a week, facilitated by one of the two music therapists over a video platform. Some children also received individual or small group services depending on referrals from the facility director. The research team provided the facility with instruments for each child, video and audio equipment to project the image of the music therapist, and any other support that was requested by the ECP and PLG. The research team met weekly initially to develop the session plans for group sessions. The music therapists were responsible for planning individual and small group sessions based on different goals and objectives for the children in those sessions.

Participants

Overall, five ECP and six PLG completed an interview with one of the co-authors for the purposes of this study. The ECP who worked in the two classrooms that received music therapy weekly groups were invited to be interviewed for this study and agreed to make time for an interview of thirty minutes or less. The other group interviewed for this study were PLG of the children who received both group and individual music therapy sessions over the 12-week period.

Response to intervention

The facility director, as part of their typical processes unrelated to this study, conducted a process through Response-to-Intervention (RTI; Brown-Chidsey & Steege, 2011) protocol. RTI (Jimerson et al., 2016) is a systematic method for identifying, defining, and resolving students' academic and/or

behavioural difficulties. RTI most frequently involves a multi-tiered approach to the implementation of instructional modifications (Pierangelo & Giuliani, 2008).

In this facility, there were three tiers used in their assessment procedures. Tier 1 children were seen as needing fewer additional supports throughout each day. Tier 2 children needed moderate supports, such as an occasional one-to-one ECP to help with emotion regulation. Tier 3 children were assessed as needing the most support, as they most frequently struggled with emotion regulation and social skills with other children.

All children in the facility received weekly music therapy groups. Children assessed at RTI levels 2 and 3 were referred to and scheduled for one-to-one 15-20 minute music therapy weekly sessions at times outside of the regular weekly groups. Music therapy was one way the facility could offer additional support to children assessed as tier 3 due to staff shortages related to the pandemic. A total of 92 children began music therapy groups at the facility, but we could not ascertain how many children were additionally enrolled or left the facility by the end of the study.

Interviewing procedure

The PLG were familiar with the music therapists who facilitated the weekly sessions over a video conferencing mobile device app. However, they did not know the interviewer. Therefore, we requested that the programme director partner with us to conduct a purposive sampling procedure. We communicated to find a sample of PLG and ECP that could “provide the relevant information about the topic or setting” (Ary et al., 2018, p. 429). Specifically, we relied on the programme director’s rapport with their staff and PLG to encourage participation, given that the interviewer intentionally maintained detachment to reduce potential social desirability bias. Some interviews with PLG could not be completed because they either did not answer when contacted or did not respond to attempts to reschedule. All interviewees were provided with a consent form, in compliance with informed consent procedures approved by the school district where the facility is located. The form included information about the nature of the research and clarified that the music therapists and other staff from the music therapy company would not have access to the full transcripts of the recorded interviews. This was intended to encourage interviewees to feel comfortable providing an honest impression of music therapy.

Semi-structured interviews

We received ethical approval for the interviews from the school district’s ethics and research review team. The approved list of questions for both PLG and ECP can be found in Table 1. We adopted a semi-structured approach, meaning these interviews are “non-standardized and are often used in qualitative analysis... [which] allows for probing of views and opinions where it is desirable for respondents to expand on their answers” (Gray, 2009, p. 373). The interviews were conducted by phone and audio recorded for transcription and review on a laptop using an audio editing programme. Alternatively, interviews were conducted using online video meeting software, the same used by the music therapists for their sessions, video recorded for transcription. Interviews lasted no longer than 30 minutes to be respectful of the time of each volunteer interviewee.

Questions approved for PLG semi-structured interviews	
1.	Tell me some overall impressions of the music therapy sessions that your child is involved in.
2.	What are some strategies that you see the music therapists employing that are successful?
3.	What kind of carryover from sessions to your home environment have you observed, if any?
4.	Please let me know any remaining thoughts that you wish to be recorded as part of this study.
Questions approved for ECP semi-structured interviews	
1.	Tell me some overall impressions of the music therapy sessions in your classes.
2.	What are some strategies that you see the music therapists employing that are successful?
3.	Do you see relations between music therapy groups and RTI systems? If so, please elaborate.
4.	What kind of carryover from sessions to your general classroom did you observe, if any?
5.	Please share a story about a specific instance where music therapy helped a child or group succeed.
6.	Please let me know any remaining thoughts that you wish to be recorded as part of this study.

Table 1: Semi-structured interview questions approved for asking ECP and PLG

We (the co-authors) used another source of data to assist in preparation for the interviews, although it was not included in the data analysis. Many of the music therapy sessions were recorded, since they took place over an online video conferencing platform that allowed for recording. Therefore, we were able to watch several hours of sessions to observe the ECP and children to get a sense of their interactions with the music and the music therapist implementing the session. Our goals in watching several of the sessions was to help us learn if there were experiences and/or moments of significance that would help us articulate other questions during interviews.

Data analysis

We used only the transcripts from the interviews of ECP and PLG as the core material and used our relationship with the research team to help contextualise the material. We employed an inductive coding approach within thematic analysis. This approach included creating codes from a line-by-line analysis of the transcripts, noting where some codes were no longer needed or could be collapsed into other codes (Braun & Clarke, 2006). We repeated this process until we felt we had a more manageable list of codes to create a coding frame and then converted the frame into categories written as phrases. Our approach to gathering and categorising primary data from two different primary sources (PLG and ECP) was similar to the data analysis procedure employed by Jang (2020).

We completed a first draft of the categories and sent them to the research team for their feedback and potential revisions/corrections. We compiled their feedback and edited the resulting categories which are presented in Figure 1. Table 2 is an outline of our analysis process based on Braun and Clarke (2006, p.96) "15-point checklist of criteria for good thematic analysis."

Process	Number	Criteria
Interview Recording	1	Data recorded from phone or online video interviews
Transcriptions	2	Discussions were transcribed and auto-transcriptions were reviewed and edited for accuracy
Coding	3	Each data item was given attention as a potential code
	4	Codes were collated and categorised thematically
Analysis	5	Analysis and data are matched - themes and codes seem well-aligned
	6	Analyses include quotes/anecdotes as supportive examples
Written Report	7	Researchers claim agency in the iterative and meaning-making process of theme creation

Table 2: Thematic analysis processes

Throughout the thematic analysis, we took steps to ensure trustworthiness (Nowell et al., 2017) using the following steps:

1. Reading and immersion: It was important to take some distance of time and thought between recording each interview, listening back to recordings, creating transcripts, and repeating the listening and reading process until we had a sense of the narrative in each individual account. We did not create codes until we were able to sense the uniqueness of each interviewee's experience before looking for commonalities in coding.
2. Expert checking: We sent the categories and resulting themes to members of the research team who are practicing music therapists, including the two interventionists for this study.
3. Triangulation of data: The analysis of the data was influenced by our interactions with the music therapists who prepared and implemented the sessions, our review of several hours of recorded group sessions, and the transcripts of each interview of ECP and PLG. We were able to probe interviewees about what they meant by certain answers/terms used since we were familiar with the session content and aims.
4. Researcher bias and acknowledgement of the researcher perspective: As members of the research team, we were involved with the entire process of designing and preparing sessions. We did not have any previous relationships or meetings with any of the interviewees and made clear to them that their responses and transcripts would not be seen by other members of the research team with whom they had interacted or may interact with in the future. As music therapists who work in early childhood (EC), we also had to consider the context of our own experiences and our hopes of productive and meaningful results from the 12-week session. We have decades of experience facilitating early childhood music therapy sessions as well as family music classes. Given our extensive experience, we have thought deeply about how we can communicate with the adults in our sessions. For instance, we place a high value on

empowering adults to make music with their children outside of “music time”. Stige et al. (2009) suggested our biases and experiences are integral parts of the reflexive process and self-critique.

5. Negative case analyses and exploration of rival explanations: Interviewees provided valuable insight that challenged the direction of our analysis, resulting in a rich, nuanced understanding of their experience. This informed our understanding of the data. Simultaneously, we had to imagine a rival explanation that would help us understand, particularly with PLG interviewees, what they were referring to with some explanations of their child’s musicality, enjoyment of, or indifference to a music therapy moment, and whether it was an aberration to the norm as they recalled it.

FINDINGS: THEMES AND ASSERTIONS

Based on our analysis, we grouped the codes into three categories: those unique to PLG, those unique to ECP, and those similar for both groups (Figure 1).

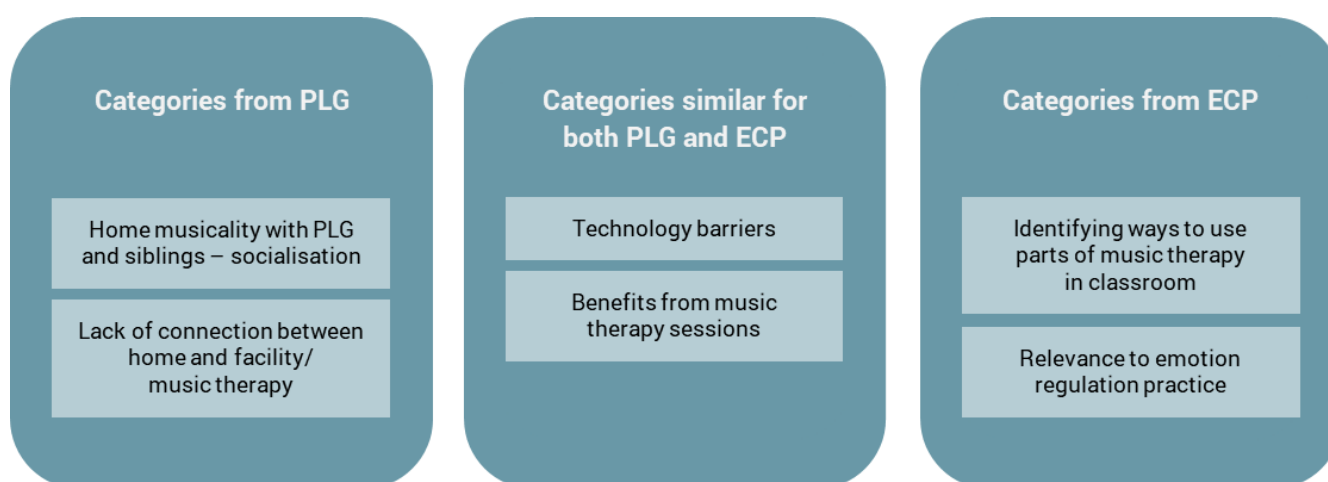


Figure 1: Three groups of categories resulting from codes and coding frame analysis

Each of the six categories above resulted from an iterative process in analysing the coding frames and then receiving feedback from other members of the research team. We sent these data and a link to an anonymous survey where they could provide feedback to add more context, challenge a category or wording, or decide not to participate. This feedback is contextualised below as we explicate the process of converting the categories into broader themes and assertions using quotes from interviewees and observations (Figure 1).

Home musicality with PLG and siblings – socialisation

The COVID-19 pandemic necessarily limited socialisation opportunities for young children. As such, music therapy sessions represented a necessary moment of normalcy for the children. PLG were encouraged to supervise and engage with their child during the learning day. This gave PLG the

opportunity to observe music therapy sessions and formulate opinions regarding the importance or impact of music therapy on their child. One interesting finding is that PLG noted musicality about their child when at home, sometimes in the context of the child making music with PLG and/or siblings, particularly during a time when the pandemic limited most other non-family social contact. There would have been no other way to capture this aspect of musicality at home without the interviews.

One PLG lamented the loss of social activities for their child but commented on the importance of being in school: "It's good that...just being around his friends, his teacher, arts and crafts, he gets to play music, things that he doesn't do at home... he's naturally a social butterfly."

Another mentioned that a lack of social interactions may have stalled progress in the speech domain for their child: "I think socialization was a big part of it... they [ECP and music therapists] provided a really structured routine...We went through music therapy and... what is it? Speech therapy? And now he is back on track." Music therapy may have helped to mitigate some of the skill stagnancy that some young children experienced during the extended shut down.

A third PLG sensed their child was creating more music on her own around the house

maybe because you guys were doing that stuff at school, maybe that built (*sic*) to why she was so active with singing and with her instruments and stuff at home. (Music) really is part of her every day all day, now that I really think about it.

Lack of connection between home and facility/music therapy

During weekly research team meetings, staff and interventionists shared some of the problems in connecting with families to schedule times for individual sessions. Over time, we also learned that connecting over a video conferencing platform was a barrier for some PLG who struggled to get the technology set up for their child in an appropriate environment and sometimes resulted in PLG forgetting about a scheduled session, which meant the child might not be emotionally or cognitively ready if waking from a nap, coming off a diaper change, or part of other plans the family was already engaged in.

Some of the PLG struggled to understand the communication from the research team as delivered through channels at the early childhood facility. This highlighted the difficulty with centre-family communication that may have been exacerbated by the pandemic. A mother of a 3-year-old in the school was not sure why I was calling her at a time arranged by the early childhood programme director.

When she (director) told me you were gonna call I was like, wait, what? Is she in music therapy? Like, I don't even know or are you calling me to see if I want her to be in music therapy? Well if I did (know she was in music therapy) and maybe I missed it, maybe I said 'Yes' and didn't hear anything after that.

One PLG said "initially I didn't even know that (music therapy) was a thing, or what it was for... but I had an idea (of) it being something about teaching coping mechanisms." Another PLG gave

a response that crossed over into the technology category (Figure 1) when asked “What were your impressions of music therapy sessions?” The PLG apologised for the nature of her English-speaking ability which she also noted in her child.

The songs? She (My child) like (*sic*) to dance, like to sing. It (Music therapy sessions) was a little bit complicated because she has troubles with the speech and, um, it's a little bit hard for her to get in contact with the phone or the computer, the session, by internet. I think the last two months she was ok, because we changed the schedule... and she was ok.

Assertion #1

PLG were able to articulate aspects of musicality in their children and see a particular way music is or could be a catalyst for socialisation between their children and siblings. However, a lack of connection between the PLG and the facility staff and research team prevented them from understanding the potential and intentions of music therapy group and individual sessions.

Technology barriers

Technology barriers were mentioned by each ECP, several of the PLG, and were a common topic of the research team. These barriers consisted of a wide variety of issues including stable internet availability during sessions, audio fidelity, physical connections to speakers and projectors, PLG using smaller mobile devices for individual sessions, and lower quality video inputs. Apart from the physical issues, ECP mentioned several issues that impacted the utility of these sessions, including the setup time to complete all connections, troubleshooting audio/video issues during sessions, the general anxiety of these responsibilities while also caring for their cohort of students during sessions, and finally, not having the music therapist there in person impacted the utility of the sessions.

An ECP noted:

It was a little frustrating in the beginning because we would really have to take a while to set everything up and take it down and a few sessions we had more time setting up and tearing down (than) actually doing music.

Benefits from music therapy sessions

An ECP who had experience with a music therapist in their classroom prior to this programme summed up the notion of music therapy benefits by stating that music therapists are “working on so many things all at the same time like language and attention and socialisation and all these things that we are thinking about every day these kids come to us.” So while this ECP had an experienced lens with which to see the efforts of the music therapists in the current program, they were also able to tell the less experienced staff in their classroom what was happening and to feel more comfortable with the expectations that music therapists have of the ECP during sessions. Another ECP synthesised what they saw happening in music therapy groups, particularly with emotion regulation: “They play

music, and it helps them get in a better space, or peace of mind, (they know) that it relaxes them... (helps them) regulate maybe?"

A PLG also articulated some of the goals of music therapy sessions:

They're learning about ways to calm their bodies. Singing or learning an instrument can help them learn to self-regulate... they can get in a place where there is no reasoning with them... so she (the PLG's child) has a list of things on wall that she can do to self-regulate... maybe it can be play (sic) an instrument or sing a song. Sometimes she says, 'Mom I'm doing my breathing, watch!'

Interestingly, the emotion regulation focus came through much more than socialisation and social skills training in the comments from PLG, which could be because the children were still limited by pandemic-based social distancing requirements. It is possible that PLG did not observe groups and so they did not see any elements of social skills practice. It is also possible that ECP associate social skills training primarily with children in proximity with each other, sharing props/instruments, and other similar activities that were not allowed. Thus, music therapists implemented other therapeutic experiences to foster social skills while social distancing, such as singing each other's names and sung social stories.

Assertion #2

Both PLG and ECP expressed some level of frustration in the technology barriers, including stable internet access, tablets, and sound quality, and shared how these issues may have hindered the effectiveness of sessions. However, ECP saw benefits from music therapy sessions and PLG, who did not necessarily have an understanding of the intention of music therapy, were interested in learning more and had suggestions and a desire for music therapy sessions to continue.

Identifying ways to use parts of music therapy in classrooms

Each ECP recalled ways that some of the content of the music therapy session, song lyrics or goals/topics, reappeared outside of the sessions and as part of the early childhood classroom environment. One commented: "Well, some of the songs are pretty catchy, so we'd be lined up to wash hands or something and someone would just start singing a song and change the words to be about hand-washing." Another remarked: "Even with a smaller group of kids, lining up to go outside gets them going so we tried to sing or like, kind of sing or chant some of the lyrics about taking a deep breath."

Relevance to emotion regulation practice

One ECP also added that they also could refer back to the music therapy session to make a point.

One time this boy was having a really hard time just not being so crazy in the classroom and we got to a point where we could, you know, sit together, and I tried to say, like, remember in music when we were trying to give ourselves a hug? So maybe the music helped him remember that.

One ECP seemed to equate emotion regulation with compliance, which was not an approach espoused by the music therapists. They commented: “I think it’s really good when they can follow the directions and calm themselves down between some of the more energising things they do with music.” In this instance, the ECP was likely referring to sung directions to perform actions that were meant to correlate with mindfulness and some sensory prompts from the music therapist. Compliance with the directives as given was not the goal in the case of these moments where they facilitated an experiential on emotion regulation.

An interesting overlap with the technological troubles came about with an ECP who recalled how the staff was trying to help the students regulate themselves while patiently waiting for the issues to get ironed out:

I don’t really know techie stuff, so another teacher was trying to connect or move something around and I was really trying to keep the kids from getting too antsy. We just started trying to rap something or remember a song from last week. Because if they get to a certain point, the music therapy would probably not be too great that day!

Assertion #3

The ECP worked through 2020, despite the increasing dangers of the pandemic. They appreciated that music therapy groups could offer some tools that they were able to bring into non-music therapy instructional time. Specifically, they most easily recognised the music therapists working on emotion regulation and incorporated that content into non-music therapy portions of their school week.

Barriers and limitations

Some of the benefits we found are categorised as environment, social and emotional practice online, and props and tangibles. While all three had the beneficial qualities listed, all three also had drawbacks. For instance, there are benefits to having a music therapist who is able to bring a wider variety of instruments and props to create novelty and use some adapted approaches from music education. Similarly, there are benefits to learning social practices of giving comfortable space to peers, practicing appropriate touch, and other elements of proximity which all contribute to social competence. The need for social distancing and infection control certainly created those barriers that the music therapists struggled to overcome with the online platform. The main barriers and limitations, however, included the interaction of technology and environment, as well as overall therapeutic rapport.

DISCUSSION AND IMPLICATIONS FOR FUTURE RESEARCH

The purpose of the study was to formally analyse the perceptions of both groups of caregivers, PLG and ECP, of the children who received music therapy services in this 12-week program. The members of the research team are unaware of previous literature that delves into these two groups of caregivers and early childhood music therapy via telehealth practices.

In summary, the research team created and implemented a 12-week telehealth music therapy programme for two classrooms at an early childhood learning centre. This programme comprised group and individual sessions for students with higher needs in the latter part of 2020 and early 2021. PLG of students in music therapy groups and ECP who participated in music therapy groups were asked to participate in interviews. We recorded, transcribed, and coded all the interview data and worked to contextualise it with our observations of sessions and recollections of participating in weekly planning sessions with the programme team. The codes were converted into categories and elaborated into themes. After conducting validity checks, we made three assertions:

Assertion #1: *PLG were able to articulate aspects of musicality and ways music could be a catalyst for socialisation between their children. However, a lack of connection between the PLG, the facility staff, and research team prevented PLG from understanding the potential and intentions of music therapy group and individual sessions.*

Assertion #2: *Both PLG and ECP expressed some level of frustration regarding technological barriers, including stable internet access, tablets, sound quality, and how these issues may have hindered the effectiveness of sessions. However ECP and PLG saw benefits from music therapy sessions. ECP noted how music had affected their children positively. PLG were interested in learning more and had suggestions and a desire for music therapy sessions to continue.*

Assertion #3: *Despite the increasing dangers of the pandemic, ECP worked through 2020. They expressed appreciation of the music therapy groups, which offered them tools to bring into non-music therapy instructional time. Specifically, they most easily recognised when music therapists worked on emotion regulation and incorporated that content into non-music therapy portions of their school week.*

Benefits

Overall, the ECP were agreeable to try music therapy via telehealth since some had experience with in-person music therapy services. The added benefit of having music therapists who understood how to implement RTI approaches for individual sessions appealed as well, since music therapy seemed to be a modality that children benefited from anecdotally, regardless of their assessed tier level. In practice, we believed that continued attempts to refine telehealth delivery of music therapy services were in line with non-music therapy-specific conclusions from Huisman Koops and Webber (2021) and worthy of efforts to engage the children and early childhood learning centre staff musically.

Environment

First, children were able to receive music therapy services with some sense of comfort in that they were in familiar confines of the early childhood learning centre (for groups) or home (for individual sessions), instead of a music therapy clinic. While an argument could be made for having young children in a music therapy-centric environment with a wider variety of instruments and acoustic treatment, music therapists have often used itinerant scheduling as private practice clinicians to see service users where they are most comfortable (Wilhelm & Knight, 2020). In addition to this general benefit of a familiar environment for the children, having other adult caregivers take part in music seems to help the non-music therapist adults understand more about the therapeutic process of sessions over time. In groups at the early childhood learning centre, ECP serve as models for

the children, taking an active role, getting the technology set up, and are seen as partners with the music therapists. Some ECP also reported using songs from music therapy sessions in non-music therapy instructional times to help with arousal regulation and classroom rituals. For individual sessions at home, some PLG reported how frequent their child received music therapy services, what their child was most interested in doing during sessions, and how long their attention was sustained on different musical stimuli. When these children are in their typical early childhood learning centre, PLG may not be as attentive to how often their child received “pull-out” tier 3 services because they were required to schedule sessions and prepare their child physically and mentally for the session. It also made PLG aware of the kinds of musical stimuli already existing in their home environment: instruments, “found sound” (household items that could be used musically), and radio/video/toys with musical elements. The music therapists would endeavour to incorporate these at-home musical elements in the individual sessions as a child-led portion. In some cases, PLG and siblings were able to join in for a more family-based music therapy session.

Social and emotional practice online

Through telehealth, it seems that the music therapists were able to find ways to incorporate musical aspects to address social competence and emotional regulation through various Therapeutic Music Experiences (TMEs). They used TMEs to embed social stories (Schwartzberg & Silverman, 2013) and songwriting through children’s suggestions and leadership (Baker & Wigram 2005), primarily through receptive and compositional music therapy methods (Bruscia, 2014). The focus areas for social competence included joint attention, common theme interactions, and music-making together. Emotion regulation and social competence are areas of focus at this early childhood learning facility.

Sena Moore and Hanson-Abromeit (2018) created the Musical Contour Regulation Facilitation (MCRF) protocol to address emotional regulation, as it plays a role in “social competence and school adjustment” (p. 409). Therefore, it was important to create sessions that included TMEs directed at both goals, emotional and social in all sessions. Even online, the music therapists were able to provide children opportunities for both emotion identification and regulation using a mixture of receptive music therapy methods and mindfulness exercises (Zeman et al., 2006). Furthermore, using the RTI model, children who might have struggled to practice these concepts in a group setting were able to process the information in their individual sessions. Subsequently, PLG at home could reinforce the information throughout the week by singing an approximation of the melody as a kind of mnemonic device or reminder of the emotion regulation goal area.

Props and tangibles

Through this online setting, we found that it was possible to use fewer props and tangibles. This meant that less transition time was needed for distributing and collecting instruments in sessions. For in-person group sessions, children would be tempted to play with the props. Instead, the online format meant that therapists needed to use few behaviour management strategies. Additionally, they could transition musically between TMEs, keeping the flow of the session at an optimal level.

Technology and environment

Implementing in-home telehealth music therapy sessions included certain difficulties. Some PLG were able to provide a larger screen with better speakers, external or attached to the computer interface, while others either did not have those means or chose to hand their mobile phone to the child for the individual sessions. In some cases, this limited the music therapists' ability to appropriately use music applications and online platform features such as screen and audio share. It is possible that, at times, PLG were not able to create an appropriate space for telehealth music therapy services with reduced distractions. The music therapists recorded some clinical notes to this effect, stating that in some cases, children had to be awakened from naps to have their music therapy session, for example. In addition, scheduling sessions around family emergencies, family dynamics and support, lack of instruments at home, and knowledge of how to use the online video conferencing platform likely impacted the music therapy sessions. Poole et al. (2020) recently created a 'Tele-intervention Virtual Visit Checklist' that is an outstanding recommendation for all early childhood professionals to consider for any future telehealth work to better navigate these problematic issues.

Group sessions had different technology and environmental challenges to navigate. The music therapists conducted a technology primer to familiarise ECP with the technology to be used in sessions and confirmed start times and durations of weekly music therapy sessions still needed to include time for setting up the projector, two tablets, online video sign-in information from the music therapists, and audio/video troubleshooting from the study observer (music therapy intern). While this time decreased over the first few weeks, the overall time given in direct service was shorter in the earlier sessions. The facility did not own the technology, so the music therapy company had to take on the cost of purchasing audio/visual equipment and troubleshooting technological issues from a distance. It also proved sometimes problematic for ECP as they were not able to use the technology successfully. These issues, directly before sessions, also meant that the children had unstructured time just prior to the expectation of the ritual hello song and structure provided by the music therapists for the session.

Therapeutic rapport

Therapeutic rapport and the therapeutic relationship are commonly understood terms for clinicians in the helping professions (Lambert & Barley, 2001) and in early childhood learning centres (Harden et al., 2010; Wolfgang, 2018). Therapists recognise that therapeutic rapport may often be the singular factor that determines whether progress is possible within any individualised clinical relationship. So, the focus of the assessment and initial sessions is on cultivating this therapeutic relationship. As stated earlier, the music therapy company had conducted sessions at this facility before 2020. However, the two interventionists had never met these children or ECP prior to the telehealth study.

Moreover, the music therapists had to work to create therapeutic rapport with two classrooms of children. In weekly team meetings, they expressed a lack of confidence that they were growing their working alliance with each child. Oldfield and Flower (2008) described the importance of music therapists establishing therapeutic rapport not only with children, but also with the adults as part of a child's microsystem (Bronfenbrenner, 1979). This seems to be one of the biggest challenges to

telehealth, at least preliminarily. Music therapists who are able to have an in-person relationship with the ECP and PLG might better establish therapeutic rapport with them.

Future research

Future research with ECP and PLG should include both quantitative and qualitative data, and outreach and connection to these two groups of individuals are paramount. Quantitative data that are usable by directors of childcare facilities is essential, particularly, in the United States where metrics are desirable to policy-makers. Some of the ECP in the study might have been less sceptical about the music therapy programme if we had evidence that showed them how their work might improve due to fewer incidences of unwanted physical touch between children or that more children are able to express a wider variety of emotions after going through a music therapy unit at a facility.

In terms of outreach and connection, music therapists in early childhood must work to gain cultural competence when working in such diverse settings. Rather than simply creating inventories and forms in other languages, we need to establish two-way communication with families in the language that they are most comfortable with. This helps us connect with parents to feel more included by virtue of availability of Spanish-language information about music therapy and what their child experiences. When a music therapist sends a session outline home with a parent tip, is there/should there also be a check-in every 20-25% of the music therapy programme to each PLG? Is there a way to work with the early childhood learning facility director to guarantee responses to pre- and post-data? Is there a way to assess 'buy-in' from ECP and PLG on a programme to ensure that it does not feel forced upon by families? Music therapists have to recognise ways to communicate the value of their work to ECP and then work with ECP to continue that line of communication to PLG. Instead of this post hoc interview analysis of ECP, is there a check-in structure that music therapists can implement to gain a continuous assessment of ECP regarding their awareness and thoughts about music therapy sessions? If that were established, music therapists would more easily address some of the issues in the main assertions in our findings.

We encourage ECP to partner with music therapy professionals and organisations to create more innovative methods including and independent of online formats. Research in music therapy and early childhood should continue to investigate the important topics around developmental stages of musical and non-musical development, as well as domains such as emotion regulation and social competence that are at the fore of the early childhood profession. At this point in the history of the profession, technology should not be a barrier that stops a potential service user from engaging in music therapy services. ECP and early interventionists, such as music therapists, can continue collaborating on research to identify best practices in using music to develop the social and emotional domains of young children.

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REFERENCES

- Administration for Children and Families (2023). *Office of Head Start: Head Start Services*. <https://www.acf.hhs.gov/ohs/about/head-start>
- Ary, D., Jacobs, L. C., Irvine, C. K. S., & Walker, D. (2018). *Introduction to research in education*. Cengage Learning.
- Baker, F., & Wigram, T. (Eds.). (2005). *Songwriting: Methods, techniques and clinical applications for music therapy clinicians, educators and students*. Jessica Kingsley Publishers.
- Boster, J. B., Spitzley, A. M., Castle, T. W., Jewell, A. R., Corso, C. L., & McCarthy, J. W. (2021). Music improves social and participation outcomes for individuals with communication disorders: A systematic review. *Journal of Music Therapy*, 58(1), 12-42. doi: 10.1093/jmt/thaa015
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, 21(1), 37-47. <https://doi.org/https://doi.org/10.1002/capr.12360>
- Briggs, C. (1991). A model for understanding musical development. *Music Therapy*, 10(1), 1-21. <https://doi.org/10.1093/mt/10.1.1>
- Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.
- Brown-Chidsey, R., & Steege, M. W. (2011). *Response to intervention: Principles and strategies for effective practice*. Guilford Press.
- Bruscia, K.E. (2014). *Defining music therapy* (3rd ed.). Barcelona Publishers.
- Devlin, K., & Meadows, A. (2021). Integrating Alternative and augmentative communication into music therapy clinical practice: A clinician's perspective. *Music Therapy Perspectives*, 39(1), 24-33. <https://doi.org/10.1093/mtp/miaa010>
- Eid, M. M., Abdelbasset, W. K., Abdelaty, F. M., & Ali, Z. A. (2021). Effect of physical therapy rehabilitation program combined with music on children with lower limb burns: A twelve-week randomized controlled study. *Burns*, 47(5), 1146-1152. doi: 10.1016/j.burns.2020.11.006
- Furman, A., & Humpal, M. (2006). Goals and treatment objectives, settings, and service delivery models in early childhood and early intervention settings. In M. Humpal & C. Colwell (Eds.), *Effective clinical practice in music therapy: Early childhood and school age educational settings* (pp. 82-96). American Music Therapy Association.
- Glesne, C. (2014). *Becoming qualitative researchers: An introduction* (5th ed.). Allyn and Bacon.
- Gray, D.E. (2009). *Doing research in the real world* (2nd ed.). Sage.
- Harden, B. J., Denmark, N., & Saul, D. (2010). Understanding the needs of staff in Head Start programs: The characteristics, perceptions, and experiences of home visitors. *Children and Youth Services Review*, 32(3), 371-379. <https://doi.org/10.1016/j.chldyouth.2009.10.008>
- Head Start (2024). *Staff-parent relationships that honor and support parenting*. Early Childhood Learning & Knowledge Center. <https://eclkc.ohs.acf.hhs.gov/family-engagement/staff-parent-relationships-honor-support-parenting/staff-parent-relationships-honor-support-parenting>
- Hodijah, S., & Kurniawati, L. (2021). Teachers' understanding on music for early childhood. In *5th International Conference on Early Childhood Education (ICECE 2020)* (pp. 159-162). Atlantis Press.
- Huisman Koops, L., & Webber, S. C. (2020). "Something is better than nothing": Early childhood caregiver-child music classes taught remotely in the time of COVID-19. *International Journal of Music in Early Childhood*, 15(2), 135-156. DOI: 10.1386/ijmec_00018_1
- Humpal, M.E. (2018). Early childhood music therapy. In A.J. Knight, A.B. LaGasse, & A.A. Clair (Eds.), *Music therapy: An introduction to the profession* (pp. 161-184). American Music Therapy Association.
- Jang, S. (2020). Intergenerational choir: A qualitative exploration of lived experiences of older adults and student music therapists. *Journal of Music Therapy*, 57(4), 406-431.
- Jimerson, S. R., Burns, M. K., & VanDerHeyden, A. M. (Eds.). (2016). Handbook of response to intervention: *The science and practice of multi-tiered systems of support* (2nd ed.). Springer Science + Business Media. <https://doi.org/10.1007/978-1-4899-7568-3>
- Kim, H. K., & Kemple, K. M. (2011). Is music an active developmental tool or simply a supplement? Early childhood preservice teachers' beliefs about music. *Journal of Early Childhood Teacher Education*, 32(2), 135-147.
- Kirby, A. L., Dahbi, M., Surraín, S., Rowe, M. L., & Luk, G. (2022). Music uses in preschool classrooms in the US: A multiple-methods study. *Early Childhood Education Journal*, 1-15. <https://doi.org/10.1007/s10643-022-01309-2>
- Knott, D., & Block, S. (2020). Virtual music therapy: Developing new approaches to service delivery, *Music Therapy Perspectives*, 38(2), 151-156, <https://doi.org/10.1093/mtp/miaa017>
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 357-361. <https://doi.org/10.1037/0033-3204.38.4.357>
- Makridis, C., Guan, K., Ludington, E., Hopkins, M., & Parassidis, S. (2021). The role of music and other arts in early childhood education. <http://dx.doi.org/10.2139/ssrn.3989366>
- National Center for Education Statistics (NCES). (2024). *School enrolment rates of young children*. <https://nces.ed.gov/programs/coe/indicator/cfa/enrollment-of-young-children>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 1609406917733847. <https://doi.org/10.1177/1609406917733847>
- Oldfield, A., & Flower, C. (Eds.). (2008). *Music therapy with children and their families*. Jessica Kingsley Publishers.

- Pasiali, V. (2012). Supporting parent-child interactions: Music therapy as an intervention for promoting mutually responsive orientation. *Journal of Music Therapy*, 49(3), 303–334. DOI: 10.1093/jmt/49.3.303
- Pierangelo, R., & Giuliani, G. (2008). *Frequently asked questions about response to intervention*. CORWIN Press.
- Poole, M. E., Fetting, A., McKee, R. A., & Gauvreau, A. N. (2020). Inside the virtual visit: Using tele-intervention to support families in early intervention. *Young Exceptional Children*, 25(1). <https://doi.org/10.1177/1096250620948061>
- Rajan, R.S. (2017). Preschool teachers' use of music in the classroom: A survey of park district preschool programs. *Journal of Music Teacher Education*, 27(1), 89-102. <https://doi.org/10.1177/1057083717716687>
- Schwartz, E. (2008). *Music, therapy, and early childhood: A developmental approach*. Barcelona Publishers.
- Schwartzberg, E. T., & Silverman, M. J. (2013). Effects of music-based social stories on comprehension and generalization of social skills in children with autism spectrum disorders: a randomized effectiveness study. *The Arts in Psychotherapy*, 40(3), 331-337. <https://doi.org/10.1016/j.aip.2013.06.001>
- Sena Moore, K., & Hanson-Abromeit, D. (2018). Feasibility of the musical contour regulation facilitation intervention for preschooler emotion regulation development: A mixed methods study. *Journal of Music Therapy*, 55(4), 408-438. DOI: 10.1093/jmt/thy014
- Stige, B., Malterud, K., & Midtgarden, T. (2009). Toward an agenda for evaluation of qualitative research. *Qualitative Health Research*, 19(10), 1504-1516. <https://doi.org/10.1177/1049732309348501>
- Vaudreuil, R., Langston, D.G., Magee, W.L., Betts, D., Kass, S., & Levy, C. (2020). Implementing music therapy through telehealth: Considerations for military populations. *Disability and Rehabilitation: Assistive Technology*, 17(2), 201-210. DOI: 10.1080/17483107.2020.1775312
- Wang, S. G., Cevasco-Trotter, A. M., Silverman, M. J., & Yuan, S. H. (2023). A narrative review of music therapy for neuropsychiatric symptoms in Alzheimer's disease and rationale for protocolized music teletherapy. *Frontiers in Medicine*, 10, 1248245.
- Wilhelm, K., & Knight, A. (2020). Music therapy private practice in the United States: Updated financial and marketing recommendations. *Journal of Music Therapy*, Advance online publication. <https://doi.org/10.1093/jmt/thaa011>
- Wolfgang, A. (2018). *The enduring impact of the childhood therapeutic relationship: A qualitative analysis*. [Doctoral dissertation, Carlow University].
- World Health Organization (2010). *Telemedicine: opportunities and developments in member states. Report on the second global survey of ehealth*. <https://iris.who.int/handle/10665/44497>
- Yang, Y. (2016). Parents and young children with disabilities: The effects of a home-based music therapy program on parent-child interactions. *Journal of Music Therapy*, 53(1), 27–54. DOI: 10.1093/jmt/thv018
- Zeman, J., Cassano, M., Perry-Parrish, C., & Stegall, S. (2006). Emotion regulation in children and adolescents. *Journal of Developmental and Behavioral Pediatrics: JDBP*, 27(2), 155–168. DOI: 10.1097/00004703-200604000-00014

Ελληνική περίληψη | Greek abstract

Μια ανάλυση των αντιλήψεων των φροντιστών για ομάδες τηλεϋγείας μουσικοθεραπείας στην πρώιμη παιδική ηλικία

Andrew Knight | Carol Ann Blank

ΠΕΡΙΛΗΨΗ

Οι μελέτες στο πεδίο της μουσικοθεραπείας κατά την πρώιμη παιδική ηλικία συνήθως εξετάζουν τις επιδράσεις των συνεδριών μουσικοθεραπείας στα παιδιά, αλλά λίγες μελέτες έχουν εξετάσει τις αντιλήψεις των φροντιστών: των γονέων και των παιδαγωγών/του σχολικού προσωπικού. Ο σκοπός της παρούσας εργασίας είναι η παρουσίαση της ανάλυσης των συνεντεύξεων με τους φροντιστές σε ένα πλαίσιο πρώιμης παιδικής ηλικίας μετά από ένα πρόγραμμα τηλεϋγείας μουσικοθεραπείας διάρκειας 12 εβδομάδων. Στη μελέτη συμμετείχαν έξι γονείς/νόμιμοι κηδεμόνες και πέντε επαγγελματίες πρώιμης παιδικής ηλικίας που έλαβαν μέρος εθελοντικά σε ατομικές συνεντεύξεις μετά την ολοκλήρωση των συνεδριών των 12 εβδομάδων. Οι ερευνητές διεξήγαγαν θεματική ανάλυση των συνεντεύξεων και δημιούργησαν κωδικούς, κατηγορίες και θεματικές ενότητες. Έξι θεματικές ενότητες προέκυψαν από την ανάλυση, δύο στις κατηγορίες Γονείς και Νόμιμοι Κηδεμόνες (PLG), και Επαγγελματίες Πρώιμης Παιδικής Ηλικίας (ECP), και δύο θεματικές που ήταν παρόμοιες και για τις δύο ομάδες. Τα αποτελέσματα έδειξαν ότι και οι δύο ομάδες φάνηκε να χρειάζονται περισσότερη πληροφόρηση σχετικά με το σκοπό των συνεδριών μουσικοθεραπείας. Δευτερευόντως, το γονεϊκό άγχος που προέκυψε από την πανδημία μπορεί να εμπόδιζε την ικανότητα και των δύο ομάδων να ενσωματώνουν τις πληροφορίες που παρέχονταν από τη μουσικοθεραπευτική ερευνητική ομάδα κατά τη διάρκεια της μελέτης. Στο άρθρο συμπεριλαμβάνονται μελλοντικοί στόχοι για

μουσικοθεραπευτές ερευνητές της πρώιμης παιδικής ηλικίας αναφορικά με τις σχέσεις τους με τους Γονείς και Νόμιμους Κηδεμόνες (PLG) και τους Επαγγελματίες Πρώιμης Παιδικής Ηλικίας (ECP).

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

γονείς, φροντιστές, πρώιμη παιδική ηλικία, τηλεϋγεία, μέθοδοι έρευνας, μουσικοθεραπεία

ARTICLE

Music Meet Up online edition: The pivot to an online music therapy group for adolescents and young adults with cancer

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ABSTRACT

The COVID-19 pandemic has heightened the unique emotional and social needs expressed by adolescents and young adults (AYAs) with cancer. To help address this, we adapted an in-person developmentally tailored group music therapy intervention to an online format. The purpose of this study was to gain preliminary data to explore the acceptability of the online version of the group. A qualitative descriptive approach was chosen to understand the experiences of program participants, who were patients at a tertiary cancer centre in Toronto, Canada. One-to-one semi-structured interviews were conducted with participants, and data was analysed using thematic analysis. A total of six interviews were completed, with five participants identifying as women. Ages ranged from 24-35, and various cancer types were represented. Overall, participants felt the online version of the program was beneficial. However, interviews pinpoint advantages and disadvantages with the online format. Delivering the program online enhanced accessibility but also created issues of disrupted/impaired “connectivity” between participants and the music. Online group psychosocial interventions, including music therapy, may continue to be offered long after the pandemic. These lessons could inform how other online music therapy interventions are delivered to AYAs between 18-39 years of age and beyond.

KEYWORDS

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BACKGROUND

Adolescence and young adulthood is a dynamic period that begins with the onset of puberty and ends with the achievement of developmental milestones including establishing independence, assigning increased importance to peers and relationships, and identity formation (Arnett et al., 2014; Geiger & Castellino, 2011). This process is fundamentally disrupted for adolescents and young adults (AYAs) with cancer due to the impact of a potentially life-threatening diagnosis and its required treatments (Warner et al., 2016; Zebrack & Isaacson, 2012). It has been shown that adolescents (between 15-18 years of age), and young adults (spanning 19-39 years of age), routinely experience social isolation, body image concerns, and dependence on caregivers, with associated emotional distress that can persist long after treatment is complete (Quinn et al., 2015). These unique challenges are often inadequately addressed by paediatric or adult-focused psychosocial supports (Warner et al., 2016).

The potential of music to provide developmentally informed care is immense, and although there is more literature to indicate the benefit in the paediatric population (see Kaka et al.), there is a growing body of literature in both adolescents (Miranda, 2012; Stegemann et al., 2019) and young adults (McFerran, 2020) that demonstrates the benefits of developmentally appropriate music-based interventions. Music-making can provide AYAs with a temporary diversion from life challenges and can play a pivotal role in coping (Bennett, 2001; Laiho, 2004; McFerran, 2010, 2020). Music therapy as a clinical practice has been shown to have enormous benefits for adolescents encountering developmental changes and challenges related to illness (Docherty et al., 2013; McFerran, 2010; Mondanaro & Loewy, 2015). Youth who listen to music report reduced stress, enhanced identity development, and increased control over mood (McFerran, 2010; 2020). Music-making can also reduce perceived stress during cancer treatment (Knoerl et al., 2021), and enhance coping, resilience, and social integration (Facchini & Ruini, 2021; Haase et al., 2020; Robb et al., 2014). With this evidence in mind, in 2018, a certified music therapist and a physician specialising in young adult medicine created and evaluated the feasibility and effectiveness of a novel in-person developmentally informed group music therapy intervention for AYAs undergoing cancer treatment at an adult tertiary cancer care centre in Ontario, Canada called “Music Meet Up.” (Samadi et al., 2021). Given that adolescent patients above the age of 18 are more likely to receive care at adult cancer centres, we decided to develop our “Music Meet Up” program to support AYAs between the ages of 18-39. The closed six-week in-person group integrated specific music therapy interventions (improvisation, receptive listening, songwriting, lyric analysis, verbal processing related to musical experiences) with psychoeducation and peer support through a supportive-expressive lens (Samadi et al., 2021).

Based on qualitative feedback from a feasibility and acceptability study exploring participants' experiences of the program, the program allowed participants to use music (through music therapy interventions described in Table 1) as a conduit to share their illness experience with others like themselves, thereby acquiring a ‘musical toolbox’ to enhance ways to cope with cancer (Samadi et al., 2021). Due to physical distancing, shelter-in-place, and stay-at-home orders of the 2019 novel coronavirus (COVID-19) respiratory illness pandemic, we decided to create and offer an online version of this program. This study presents results from data collected from the first online adaptation (over six sessions) to explore its acceptability among participants. The following research questions drove

this work: 1) How did the participants benefit from the online version of the program? 2) What were some drawbacks or challenges experienced when participating?

Component	Description
1. Initial psychosocial check-in	Facilitators guided a semi-structured check-in; each group member was invited to share thoughts on general, overall well-being and current status.
2. Therapeutic Interventions (co-occurring each week)	One or more of the following each week: Music Therapy: • Toning: group humming/ singing with guided breathing • Song-sharing: individual sharing of a meaningful song with opportunity for group discussion • Lyric analysis: conversation/discussion about meaningful lyrics • Group music-making: referential and non-referential improvisation with instruments provided (drums, auxiliary percussion, guitars and ukuleles) • Group songwriting: creating lyrics and melodies based on specific themes • Playlist creation: creation of personalised playlists that reflect a specific theme Psychosocial processing: • Group discussions about the experience of the music therapy interventions • Group discussions about shared experiences within the music itself • Facilitators offered support, insight, and ideas for the use music as a tool between sessions
3. Closing psychosocial check-in	Facilitators led a semi-structured closing check-in, allowing for connection and conversation between group members

Table 1: Components – group music therapy intervention

METHODS

We chose a qualitative descriptive approach to understand the experiences of program participants, who were patients at the Princess Margaret Cancer Centre in Toronto, Canada. One-to-one semi-structured interviews were conducted with participants, and data was analysed using thematic analysis (Braun & Clarke, 2006).

Qualitative descriptive research is a type of qualitative inquiry that seeks to describe an experience or to provide an accurate accounting of events (Sandelowski, 2000, p. 336). Researchers using this type of inquiry stay close to the words their participants use to describe experiences or events when compared to other types of qualitative inquiry that is considered more interpretive (e.g., grounded theory, phenomenological, ethnographic, or narrative studies). Qualitative description is lighter on interpretation and does not require going beyond the literal meaning of the words used by participants to describe an experience or an event (Sandelowski, 2010). This method was chosen to explore the feasibility and acceptability of the program, which does not require an in-depth interpretive analysis to achieve a conceptual, philosophical, or other highly abstract explanation of an experience. In this way, we were able to minimise any bias inherent in our analysis.

Setting – Music therapy group

The Princess Margaret Cancer Centre is a large regional hospital where over 1,000 AYAs are diagnosed annually. It has a robust department of Supportive Care, including psychosocial oncology and a dedicated AYA program. Supports at the hospital include a robust music therapy program overseen by a clinician/researcher who is a certified music therapist and registered psychotherapist. The program is targeted at inpatients and outpatients aged between 18-39 years old and offers individual music therapy and group music therapy by referral. The group music therapy program, entitled “Music Meet Up,” has been held four times since 2018 with three iterations completed in-person at an allocated space within the hospital and one conducted online using Microsoft Teams. Referral to the group was made by primary oncology or psychosocial providers to seek in-patient and out-patient participants, or via self-referral through advertisements on social media for out-patient participants.

The content of the in-person version was adapted for online and followed the same structure. Group participants took part in a series of three weekly interactional activities: 1) an initial psychosocial check-in; 2) guided music therapy interventions; 3) a closing psychosocial check-in. Components of each activity are described in Table 1. Instead of meeting in person, we gathered online using the Microsoft Teams platform. This platform provides an online group meeting space accessible via a specific URL, where users can connect via webcam and instant messaging (Siegel et al., 2021). Since we were unable to provide participants with a variety of instruments to try during the in-person program, participants were asked to be creative and make their own sounds especially for the improvisation activity. Instead, we instructed participants to improvise by humming, tapping their feet, clapping their hands, and making other sounds without the need for an instrument. The group was held once a week for six weeks; in-person sessions lasted two hours, and online sessions lasted for an hour. The content of the group, based on principles of music-centered psychotherapy (Bruscia, 2014; Aigen, 2005) and developmentally appropriate methods and techniques specific to the AYA population (McFerran, 2010), covered five areas of human experience (biological, emotional, cognitive, social, and spiritual; Foster & Pearson, 2018) and addressed how cancer may affect each domain. Specific music therapy techniques were coupled with psychosocial discussions tailored to AYA needs, to provide an opportunity for creative self-expression, emotional processing, and peer support, as well as facilitator-guided psychoeducation.

Sample

Enrolled group music therapy patients were invited to participate in the study prior to its commencement. They were informed that participation was voluntary and that they could still be a part of the group even if they did not want to participate in the research study. Preference not to participate or early withdrawal from the study did not impact clinical care. Participants were excluded if they were unable to attend most of the sessions or if they were non-English speaking. Our final sample included all registered participants in the online group (n=6). This study was approved by the University Health Network Research Ethics Board.

Data collection

To explore the patient experience, individual semi-structured interviews were conducted using the Microsoft Teams platform by a study team member within three months of the completion of the group (see Table 2 for interview guide). These interviews were audio recorded on Microsoft Teams and then transcribed by a research assistant. All recordings were deleted after the transcription process.

Question	Probes
Can you tell me why did you join the program?	• What expectations did you have before you started the program? • Who referred you to the program and how was it introduced to you? • How did you hope to benefit from this program? • Did you have any hesitations or concerns about the program before it began? • Was the program what you expected? In what way?
Did the program have any impact on your life or your illness?	• Can you tell me about the program's importance to you? • Did the use of music affect you outside of group time (e.g., in between sessions?) If so, how? • Did the use of music affect your relationship to the other group participants? If so, how? • Did the group impact your sense of connectedness with others outside the group? If so, how? • In what ways, if any, did participating in the group affect your mood or overall level of stress? • All told, how helpful do you think the program was for you on a scale from 1-10? Please explain.
How helpful/enjoyable or unhelpful/unenjoyable were the program's sessions/activities?	• Which parts of the program did you find most helpful/enjoyable or unhelpful/unenjoyable and what made them so? • Is there a session/musical experience that you remember as particularly helpful/enjoyable or unhelpful/unenjoyable? What made them so?
I will ask you now about some of the specific domains and musical experiences. With this I am again trying to understand if there is a specific domain or activity that can be improved or removed.	• What did you think of the domains (biological, emotional, social, cognitive, spiritual)? Were there any domains that were particularly helpful? Or unhelpful? • How did you find the experience of improvising as a group? How did you find the experience of drumming? How did you find the experience of using music to match or shift your mood? How did you find the experience of song writing as a group?
I will ask you now about the timing, length and location of the program.	• Could you help me understand when the program offered to you (i.e., what point in your illness trajectory – e.g., after diagnosis, during treatment, etc.)? • What do you think about having done the program at this point of your illness trajectory compared to other points? • What if the program were offered to you earlier/later? • The program is six sessions long; how did that feel for you?

	• When you were told about the number of sessions before you started the program, what did you think? What about the length of the sessions? • Would you like to receive refreshers or repeat the program? If yes: what would that give to you? If no: what would stop you? • What did you think about the location of the sessions? Was there anything about the location that was particularly helpful? Or uncomfortable?
I am going to ask you now about the group facilitators.	• Was there anything in particular the facilitators did that made you feel comfortable? Or uncomfortable?
I am going to ask you now if and how you are using the tools learned during the program.	• Have you thought about what you have learned? Have you used any of the tools? If so, which ones do you continue to use? How often? What are the challenges in doing so? What makes it possible? What triggers you to use the tools? Can you give me some examples? • Were you interested in keeping in touch with fellow group members or participating in other group opportunities? Did you manage to do so? • What would have you liked to be offered after the program ended? What would you like to be offered in the future?

Table 2: Interview guide

Data analysis

Qualitative interviews were analysed using Braun and Clarke's (2006) thematic analysis as a flexible guide. All coding was done by two independent coders (JA and SH). Each transcript was read, and notes were made describing initial thoughts and overall impressions of each interview. Then, each transcript was reviewed line-by-line and/or in segments to identify and highlight codes and preliminary categories. Constant comparative analysis (Boeije, 2002) was used to identify codes and categories, and to group these into relevant themes, which were then compared. Constant comparative analysis is an iterative process that allows researchers to use inductive and deductive reasoning to compare codes, categories, and themes across each individual transcript to develop themes that represent each participant experience. This movement between inductive and deductive reasoning allowed JA and SH to question insights as each interview was coded and as themes and categories were created. JA and SH met weekly to discuss the coding to collaboratively develop and refine a coding framework. This framework was then discussed and reviewed by the other co-authors to provide further insight and to minimise bias. This process continued until nothing new was being learned about the most relevant themes. Since this study was an extension of the in-person version of the program from Samadi et al. (2021), we began with the coding framework developed from that analysis and compared it with the data gathered from the online version to compare and contrast to illuminate the advantages participants gained from the online program and identify any drawbacks or challenges in comparison to the in-person version. Qualitative data analysis software NVivo 10 (QSR International, Australia) was used to help organise codes, themes, and categories.

FINDINGS AND DISCUSSION

A total of six participants registered for the online group. Each participant completed an interview with five out of six participants identifying as women. Ages ranged from 24-35, and various cancer types. All participants were not in active treatment (see Table 3).

Characteristic	Value
Age	Range 24-35; mean 30.5 years; SD 4.549
Gender	83% women (n=5); 17% men (n=1)
Cancer types	Breast cancer, Hodgkin lymphoma, Non-Hodgkin lymphoma, Melanoma, Ovarian, Lung
On active treatment	0%
Not on active treatment	100% (6/6)

Table 3: Demographic characteristics of the qualitative sample (n=6)

Overall, participants felt the online version of the program offered benefits comparable to those reported by individuals who took part in the in-person version (see Samadi et al., 2021). The online program taught participants to utilise music as a tool for connecting with and coping with emotions associated with a disease commonly linked to older age. For example, P006 shared: “I think the biggest impact that [the program] had is being connected to music and connecting it to my emotions.” This benefit was facilitated by the specific style of the program facilitators, a point highlighted by P001, who expressed that “not being forced to do or say anything you didn’t want to...” helped them connect to their emotions associated with their illness. This sentiment aligns with what participants expressed as the “challenge by choice” facilitation style experienced in the in-person version (see Samadi et al., 2021, p. 359). However, interviews conducted through the present study pinpoint advantages and disadvantages with the online format that were not experienced by those participating in the in-person version. Delivering the program online: 1) enhanced accessibility but also 2) created issues of disrupted/impaired “connectivity” between participants and the music.

1) Enhanced accessibility

Participants remarked that providing this program online enhanced its accessibility. Time spent travelling to the cancer centre (to attend the groups prior to the online format) was described as a barrier to access. The stress induced from the traffic and the time required to commute prompted P003 to question whether “it is worth it to travel over an hour to the [cancer centre] ... to meet for an hour and then travel back home?” when the program was offered in person. Offering the program online removed this barrier thereby enhancing access. P002 remarked “obviously, if you are commuting then you spend a little bit more time doing that. But I think online is good because you don’t have to rely on people to come in. They just join [online].” The online version allowed P005 to participate during their professional working hours: “[Access] mostly has to do with work life balance, luckily...I was working from home every Wednesday morning.” Participants also noted that that the online format allowed individuals from regions farther away, who were also experiencing mental health challenges and

mobility restrictions, to participate in this group without having to commute long distances to the cancer centre. "Seeing the different participants from different areas [regions] and seeing [name] and what he was going through... I appreciate how he's still trying to participate wherever he was and I really admired that" (P004). P001 felt "there is something [emotionally] triggering about going to the hospital." Providing an online version of the program allowed P001 to participate without this hospital-associated anxiety. Offering the program online provided increased access regardless of the participants' life circumstance and where they lived.

2) Created issues of disrupted/impaired "connectivity" between participants and the music

Our results provide important insights that can inform the facilitation and delivery of an online music therapy program. Our participants highlighted how the program was beneficial. The facilitation style and the content of the program taught participants to use music as a conduit to connect and cope with emotions from having a disease more commonly associated with older adults. We found a similar effect with the in-person version of the program (see Samadi et al., 2021). While the online version presented benefits such as enhanced accessibility through reducing the need to travel to the cancer centre, it also presented some drawbacks and issues such as disrupted/impaired connectivity. Other studies have pinpointed the benefits and drawbacks of transitioning from in-person support groups to online iterations during the COVID-19 pandemic (Kaka et al., 2021). For example, Kaka et al. (2021) described the benefit of removing the need to commute to the cancer centre. The need to take time off work and school as well as the incurred costs associated with transportation was largely eliminated, thereby enhancing the accessibility of these groups. However, these authors also pinpoint that the rapid shift to online supports" to "For example, Kaka et al. (2021) described the benefit of removing the need to commute to the cancer centre. The need to take time off work and school as well as the incurred costs associated with transportation was largely eliminated, thereby enhancing the accessibility of these groups. However, these authors also pinpoint that the rapid shift to online formats prevented opportunities for more organic formation of social connections found with in-person interactions like walking into the room early, sharing refreshments, and exiting the building together. Our interviews highlight similar and additional benefits and drawbacks. Providing the music meet-up online removed the need to commute to the cancer centre and provided participants with more flexibility to participate amid other personal obligations such as work and school. In addition, our results also highlighted how removing the need to commute also reduced any emotional distress triggered by returning to the cancer centre to receive additional supportive care. Emotional distress induced by returning to the cancer centre for follow-up appointments or additional supportive care has been widely reported (see Chan et al., 2018; Kwak et al., 2013). For example, in a longitudinal study of 151 AYAs with cancer, Kwak et al. (2013) showed that returning to a cancer centre for follow-up appointments was a trigger for post-traumatic stress. Removing the need to commute could ease this burden and was an additional benefit noted by our participants.

Our participants also noted similar drawbacks to Kaka et al. (2021). Sharing and interacting with others in music through the Microsoft Teams platform was not as conducive as creating an organic environment to form social connections when compared to the in-person iteration. Participants were unable to pick up the visual or auditory cues necessary to form this organic connection with others in the online group, thereby making it more challenging to gain the intended benefits of the Music Meet Up. Qualitative interviews conducted with AYAs who participated in the in-person iteration noted that the use of music helped them develop social and emotional connections with others in the group (Samadi et al., 2021). The online version was not as successful at achieving the same level of emotional and social connectedness with others.

Similar benefits and drawbacks were noted in the literature outside of the cancer field relating to online music therapy groups (Brault & Vaillancourt, 2022; Cephas et al., 2022; Goicoechea & Lahue, 2021; Tamplin & Thompson, 2023;). For example, Tamplin and Thompson (2023) found that there were technological challenges associated with connecting with others socially, including poor audio quality and lack of synchronous music-making in an online therapeutic choir group through the Zoom platform. Zoom and the Microsoft Teams platforms provide a similar user interface and have shown to have similar connective concerns when adapting to an online music therapy program. Cephas et al. (2022) found similar benefits when delivering a music therapy program using a specific telehealth platform different from Zoom and Microsoft Teams. They found that their pivot to an online program provided increased client agency by allowing participants to choose a physical space they felt most comfortable with when connecting virtually. Our participants vocalised a similar benefit by appreciating the ability to connect in an online space according to their comfort and schedules – for instance, being able to connect while at work rather than not being able to join due to work commitments.

Thus, our results highlight the potential benefits and drawbacks of an online group music therapy program for AYAs that contributes to an emerging field of online music therapy programs prompted by the COVID-19 pandemic. We will explore the online version of the program further for the next iteration by drawing on our results and the emerging literature to understand how to improve our online delivery. For example, we will explore how we can improve the facilitation of the online version. We will explore the availability of other online platforms that could be more appropriate for our Music Meet Up program. We will also consider notifying participants of the potential drawbacks that we found in our first version of the online program and seek their input as to how to improve the social elements of the program. In a scoping review that explored music therapists' transfer to remote forms of therapy in the context of the coronavirus outbreak, Kantorová et al. (2021) found that group facilitators who informed their participants of the possible challenges of remote versions of music therapy group interventions had more success creating an organic group environment. Participants seemed to collectively come together by overemphasising moving to the music over their web-cameras so that other participants could visually share in the experience. We will try a similar tactic in our next iteration. We will also be expanding our group offerings to explore the feasibility and acceptability of a hybrid approach of an in-person and online iteration of the program see if we can minimise the drawbacks while maximising the benefits of the online experience. We will also include pre- and post-test measures to explore quality of life changes to maximise these benefits.

CONCLUSION

Online group psychosocial interventions will continue to be offered long after the pandemic. Best practices are essential when developing online music therapy interventions, with careful attention to the nuances required in specific settings. Our results provide important insights that can inform the facilitation and delivery of an online music therapy program. In the next iteration of the program, we will inform participants of potential drawbacks in advance and more actively seek input from them to help improve the social elements of the program.

REFERENCES

- Aigen, K. (2005). *Music-centered music therapy*. Barcelona Publishers.
- Arnett, J., Zukauskienė, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18-29 years: Implications for mental health. *Lancet Psychiatry*, 1, 569-576. [https://doi.org/10.1016/S2215-0366\(14\)00080-7](https://doi.org/10.1016/S2215-0366(14)00080-7)
- Bennett, A. (2001). *Cultures of popular music*. Open University Press.
- Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity*, 36, 391-409. <https://doi.org/10.1023/A:1020909529486>
- Bruscia, K. (2014). *Defining music therapy*. Barcelona Publishers.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp0630a>
- Braut, A., & Vaillancourt, G. (2022). Group telehealth music therapy with caregivers: A qualitative inquiry. *Journal of Patient Experience*, 9. <https://doi.org/10.1177/2374373522110724>
- Cephas, A. S., Sofield, S., & Millstein, A. (2022). Embracing technological possibilities in the telehealth delivery of interactive music therapy. *Nordic Journal of Music Therapy*, 31(3), 214-227. <https://doi.org/10.1080/08098131.2022.2040579>
- Chan, C. M. H., Ng, C. G., Taib, N. A., Wee, L. H., Krupat, E., & Meyer, F. (2018). Course and predictors of post-traumatic stress disorder in a cohort of psychologically distressed patients with cancer: A 4-year follow-up study. *Cancer*, 124(2), 406-416. <https://doi.org/10.1002/cncr.30980>
- Docherty, S., Robb, S., Philips-Salimi, C., Cherven, B., Stegenga, K., Hendricks-Ferguson, V., Roll, L., Donovan stickler, M., & Haase, J. (2013). Parental perspectives on a behavioral health music intervention for adolescent/young adult resilience during cancer treatment: Report from the children's oncology group. *Journal of Adolescent Health*, 52(2), 170-178. <https://doi.org/10.1016/j.jadohealth.2012.05.010>
- Facchini, M., & Ruini, C. (2021). The role of music therapy in the treatment of children with cancer: A systematic review of literature. *Complementary Therapies in Clinical Practice*, 42, 101289. <https://doi.org/10.1016/j.ctcp.2020.101289>
- Foster, B., & Pearson, S. (2018). *The fundamentals of music care: Theory and context*. Room 217 Foundation.
- Geiger, A.M., & Castellino, S.M. (2011). Delineating the age ranges used to define adolescents and young adults. *Journal of Clinical Oncology*, 29(16), 492-493. <https://doi.org/10.1200/JCO.2011.35.5602>
- Goicoechea, T., & Lahue, K. (2021). Case studies in pediatric music therapy during COVID-19. *Music Therapy Perspectives*, 39(2), 126-132. <https://doi.org/10.1093/mtp/miab009>
- Gupta, A. A., Papadakos, J. K., Jones, J. M., Amin, L., Chang, E. K., Korenblum, C., Santa Mina, D., McCabe, L., Mitchell, L., & Giuliani, M. E. (2016). Reimagining care for adolescent and young adult cancer programs: Moving with the times. *Cancer*, 122(7), 1038-1046. <https://doi.org/10.1002/cncr.29834>
- Haase, J. E., Robb, S. L., Burns, D. S., Stegenga, K., Cherven, B., Hendricks-Ferguson, V., Roll, L., Docherty, S. L., & Phillips, C. (2020). Adolescent/young adult perspectives of a therapeutic music video intervention to improve resilience during hematopoietic stem cell transplant for cancer. *Journal of Music Therapy*, 57(1), 3-33. <https://doi.org/10.1093/jmt/thz014>
- Janssen, S. H., van der Graaf, W. T., van der Meer, D. J., Manten-Horst, E., & Husson, O. (2021). Adolescent and young adult (AYA) cancer survivorship practices: An overview. *Cancers*, 13(19), 4847. <https://doi.org/10.3390/cancers13194847>
- Kaka, A., Shama, W., Lucchetta, S., Nishimura, C., Cottingham, D., Positano, K., Markowitz, S., Fung, K., Yohan, A., Horan, R., Chin, M., Jensen, P., Chisholm, L., Alexander, S., & Korenblum, C. (2021). Virtual support groups in pediatric hematology/oncology during COVID-19: Lessons learned from the SickKids experience. *Pediatric Blood Cancer*, 68(12), 29378. <https://doi.org/10.1002/pbc.29378>
- Kantorová, L., Kantor, J., Horejsí, B., Gilboa, A., Svobodová, Z., Lipský, M., Marečková, J., & Klugar, M. (2021). Adaptation of music therapists' practice to the outset of the COVID-19 pandemic-going virtual: A scoping review. *International Journal of Research in Public Health*, 18(10), 5138. <https://doi.org/10.3390/ijerph18105138>
- Knoerl, R., Mazzola, E., Woods, H., Thornton, K., Berry, D., & Ligibel, J. (2021). Exploring the feasibility of a mindfulness-music therapy interventions to improve anxiety and stress in adolescents and young adults with cancer. *Journal of Pain and Symptom Management*, 63(4), 357-363. <https://doi.org/10.1016/j.jpainsymman.2021.11.013>
- Kwak, M., Zebrack, B., Meeske, K., Embry, L., Aguilar, C., Block, R., Hayes-Lattin, B., Li, Y., Butler, M., & Cole, S. (2013). Prevalence and predictors of post-traumatic stress symptoms in adolescent and young adult cancer survivors: A 1-year follow-up study. *Psycho-Oncology*, 22(8), 1798-806. <https://doi.org/10.1002/pon.3217>
- Laiho, S. (2004). The psychological functions of music in adolescence. *Nordic Journal of Music Therapy*, 13(1), 47-63. <https://doi.org/10.1080/08098130409478097>

- McFerran K. (2010). *Adolescents, music, and music therapy: Methods and techniques for clinicians, educators and students*. Jessica Kingsley Publishers.
- McFerran, K. (2020). Adolescents and music therapy: Contextualized recommendations for research and practice. *Music Therapy Perspectives*, 38(1), 80–88. <https://doi.org/10.1093/mtp/miz014>
- Miranda, D. (2012). The role of music in adolescent development: Much more than the same old song. *International Journal of Adolescence and Youth*, 18(1), 5-22. <https://doi.org/10.1080/02673843.2011.650182>
- Mondanaro, J., & Loewy, J. (2016). Music therapy with adolescents in medical settings. In J. Edwards (Ed.), *The Oxford handbook of music therapy* (pp. 89-111). Oxford University Press.
- National Comprehensive Cancer Network: NCCN clinical practice guidelines in oncology: Adolescent and young adult (AYA) and oncology v1. www.nccn.org/professionals/physician_gls/default.aspx
- Quinn, G., Goncalves, V., Sehoovic, I., et al. (2015). Quality of life in adolescent and young adult cancer patients: A systematic review of the literature. *Patient Related Outcome Measures*, 6, 19-51. doi: 10.2147/PROM.S51658
- Robb, S., Burns, D., Stegenga, K., Haut, P., Monahan, P., Meza, J., Stump, T., Cherven, B., Docherty, S., Hendricks-Ferguson, V., Kintner, E., Haight, A., Wall, D., & Haase, J. (2014). Randomized clinical trial of therapeutic music video intervention for resilience outcomes in adolescents/young adults undergoing hematopoietic stem cell transplant: A report from the Children's Oncology Group. *Cancer*, 120(6), 909-917. doi: 10.1002/cncr.28355
- Samadi, M., Avery, J., Black, SR., et al. (2021). Letter to the Editor: Music Meet Up – Preliminary results of a novel music therapy group intervention for adolescents and young adults with cancer. *Journal of Adolescent and Young Adult Oncology*, 10(3), 359-360. <https://doi.org/10.1002/cncr.28355>
- Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, 33(1), 77–84. <https://doi.org/10.1002/nur.20362>
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334–340. [https://doi.org/10.1002/1098-240X\(200008\)23:4<334::AID-NUR9>3.0.CO;2-G](https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G)
- Siegel, A., Zuo, Y., Moghaddamcharkari, N., McIntyre, R. S., & Rosenblatt, J. D. (2021). Barriers, benefits and interventions for improving the delivery of telemental health services during the coronavirus disease 2019 pandemic: A systematic review. *Current Opinion in Psychiatry*, 34(4), 434–443. doi: 10.1097/YCO.0000000000000714
- Stegemann, T., Geretsegger, M., Quoc, E., Reidl, H., & Smetana, M. (2019). Music therapy and other music-based interventions in pediatric health care: An overview. *Medicines*, 6(1), 25. doi: 10.3390/medicines6010025
- Tamplin, J., & Thompson, Z. (2023). How health-focused choirs adapted to the virtual world during the COVID-19 pandemic – An international survey. *The Arts in Psychotherapy*, 82, 101997. <https://doi.org/10.1016/j.aip.2023.101997>
- Warner, E., Kent, E., Trevino, K., Parsons, H., Zebrack, B., & Kirchhoff, A. (2016). Social well-being among adolescents and young adults with cancer: A systematic review. *Cancer*, 122, 1029-1037. doi: 10.1002/cncr.29866
- Zebrack, B., & Isaacson, S. (2012). Psychosocial care of adolescent and young adult patients with cancer and survivors. *Journal of Clinical Oncology*, 30, 1221-1226. doi: 10.1200/JCO.2011.39.5467

Ελληνική περίληψη | Greek abstract

Διαδικτυακή εκδοχή του Music Meet Up: Η στροφή προς μια διαδικτυακή ομάδα μουσικοθεραπείας για εφήβους και νέους με καρκίνο

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ΠΕΡΙΛΗΨΗ

Η πανδημία COVID-19 ενίσχυσε τις ιδιαίτερες συναισθηματικές και κοινωνικές ανάγκες που εκδηλώνουν οι έφηβοι και νέοι ενήλικες με καρκίνο. Για την αντιμετώπιση αυτού του ζητήματος, προσαρμόσαμε σε διαδικτυακή μορφή μια δια ζώσης ομαδική παρέμβαση μουσικοθεραπείας η οποία είναι αναπτυξιακά διαμορφωμένη. Σκοπός αυτής της μελέτης ήταν η συλλογή προκαταρκτικών δεδομένων για να διερευνηθεί η αποδοχή της διαδικτυακής μορφής της ομάδας. Επιλέχθηκε μια ποιοτική περιγραφική προσέγγιση για την κατανόηση της εμπειρίας των συμμετεχόντων στο πρόγραμμα, οι οποίοι ήταν ασθενείς σε ένα τριτοβάθμιο αντικαρκινικό κέντρο στο Τορόντο του Καναδά. Διεξήχθησαν ατομικές ημιδομημένες συνεντεύξεις με τους συμμετέχοντες και πραγματοποιήθηκε θεματική ανάλυση των δεδομένων. Ολοκληρώθηκαν συνολικά έξι συνεντεύξεις, με πέντε από τους συμμετέχοντες να προσδιορίζονται ως γυναίκες. Οι ηλικίες κυμαίνονταν από 24 έως 35, με διάφορους τύπους καρκίνου να εκπροσωπούνται. Συνολικά, οι συμμετέχοντες θεώρησαν ότι η διαδικτυακή εκδοχή του προγράμματος ήταν επωφελής. Ωστόσο, οι συνεντεύξεις επισημαίνουν τα

πλεονεκτήματα και τα μειονεκτήματα της διαδικτυακής μορφής. Η παροχή του προγράμματος διαδικτυακά ενίσχυσε την προσβασιμότητα, ενώ παράλληλα δημιούργησε ζητήματα διακοπτόμενης/μειωμένης «συνδεσιμότητας» μεταξύ των συμμετεχόντων και της μουσικής. Οι διαδικτυακές ομαδικές ψυχοκοινωνικές παρεμβάσεις, συμπεριλαμβανομένης της μουσικοθεραπείας, μπορούν να συνεχίσουν να προσφέρονται για μεγάλο χρονικό διάστημα μετά την πανδημία. Αυτά τα συμπεράσματα θα μπορούσαν να φανούν χρήσιμα ως προς τον τρόπο με τον οποίο άλλες διαδικτυακές μουσικοθεραπευτικές παρεμβάσεις προσφέρονται σε εφήβους και νέους ενήλικες ηλικίας μεταξύ 18 και 39 ετών και πέραν.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

έφηβοι και νέοι ενήλικες, ψυχοκοινωνικός, μουσικοθεραπεία, ομαδική θεραπεία

REPORT

Using Video Enhanced Reflective Practice (VERP) for the continuing professional development of a team of music therapists: Evaluation and reflections

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ABSTRACT

In 2018, six music therapists undertook a short course on Video Enhanced Reflective Practice (VERP). A group goal was co-constructed for team development as part of the project, with application for individual casework. The training course was held over two 1.5-hour sessions where the principles for developing attunement were explained, individual goals for each practitioner's development were decided upon, and casework discussion took place. The process for recording and analysing short film clips ahead of group supervision was also discussed. Target Monitoring and Evaluation (TME) was used to quantify the impact of the goals pre- and post-project. Other measures used included a self-rating scale of the Communication Principles before and after, and open ended questions on evaluation forms. TME data revealed a positive shift of 3 points for the group goal pre- and post-project, and an average shift of 3.6 points in a positive direction for individual goals. Furthermore, the self-rating scales of individual practitioners also showed increased frequency in their use of the Communication Principles in their interactions with children. This project builds on research that VERP is a professional development tool that enhances practitioner's self-belief and agency through self-awareness and knowledge of skills used in everyday clinical practice. Additionally, it provided a mechanism for a team to think and work creatively and therapeutically together.

KEYWORDS

agency,
attunement,
interaction,
empowerment,
target monitoring and
evaluation,
Video Enhanced
Reflective Practice
(VERP),
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BACKGROUND

Rationale for the Cambridgeshire Video Enhanced Reflective Practice (VERP) project

Video Enhanced Reflective Practice (VERP) – as highlighted by Kennedy et al. (2011) – is a methodology that is well suited for professional development and was considered to be complementary in supporting the ongoing reflective practice for music therapists post qualification. This view was taken particularly in light of Daniel Stern's (1985) model of affect attunement being common within music therapy training in the UK, which involves the use of video reflection for supervision and parent feedback. Parent feedback refers to the capacity and skill of the therapist to be able to give feedback that is supportive of a child's development to parents within the therapeutic process. As outlined by Trevarthen (1980, 1998), musicality and vitality are two essential components in the theoretical understanding of early attuned relationship between a caregiver and infant. For example, the basis of a trusted attuned relationship includes not only personal feelings within the therapist's relationship with their client, but also the dynamics of movement in the interaction (Ammaniti & Ferrari, 2013). These components are well understood and align well with the discipline of music therapy, and the VERP methodology was therefore considered to be well suited for use with this professional group, as well as the literature on the use of video feedback for adult learning. This project was commissioned to support the continuing professional development of a team of music therapists, as well as provide a mechanism for them to spend time together developing their practice and relationships with one another.

Introduction to VERP

VERP is derived from Video Interaction Guidance (VIG) and is a methodology that has a wide range of applications for professional development and practice. It uses recorded videos that participants bring in from their work – short film clips to help people understand and improve their communication with others. It has been used in a wide variety of contexts to support professional development, including perinatal and infant mental health in neonatal and health settings, nurturing relationships within schools, training teaching assistants to support children in mainstream and specialist settings, and advancing systemic change in schools. It has also been used to support staff to have better interactions with people with complex communication needs and as a leadership development tool in the banking industry, higher education, medical education, and educational psychologist trainee programmes. As far as I am aware, VERP has not been used to support the professional development of music therapists before.

The methodology specifically works to support and increase effectiveness of inter-professional or professional-pupil interaction by selecting short film clips that are used by the practitioner to illustrate their strengths and share with others in a trusted peer learning group to build confidence. It is an effective way of applying VIG to various training, team-building and professional development projects, leading to sustainable growth in communication skills in an organisation. VERP participants share videos of themselves in a work context with an Association of Video Interaction Guidance UK

(AVIG UK) accredited guider/s and are supported to reflect on what works well in terms of their attuned interactions.

VERP has been adapted from VIG in order to support professional development. VERP uses short film clips that are chosen by the group members themselves to reflect on their communication skills and consider how things can be even better (Kennedy et al., 2011). In VIG, it is the accredited guider who selects the short film clips to link to the client's helping question. VERP therefore, as a methodology, allows for more autonomy and self-directed learning, which aligns to other models of adult learning. Each member of the VERP group set their own personal goal of what they would like to achieve by the end of the VERP project.

The group sessions are led by a VERP guider who supports each member of the group to take turns in sharing their micro-analysis of video, and encourages the participants to identify further moments of attuned interactions. These group sessions typically take place every fortnight and were led by myself, in collaboration with one of the music therapist who had previously trained in VIG and had good relationships with the team. The participants of the group are encouraged to buddy up in pairs before coming to the group session to look at their selected film clips together.

The term attuned interaction comes directly from Trevarthen's view of intersubjectivity, which describes a communication episode where two or more people influence one other by being mutually receptive and sensitively responsive (Trevarthen & Aitkin, 2001). The mode of interaction

has been demonstrated by contemporary infant researchers such as Trevarthen (1979a) and is analogous to VIG's 'principles of attuned interaction and guidance.' Stern (2004) also described this mode of interaction when he used a phenomenological approach to explore what he calls 'present moments.' These 'present moments' are described as short episodes of untold emotional narratives that take place during an interaction, which is mentally grasped as it is still unfolding through non-symbolic and non-verbal processes. (Chalse, 2011, p. 245)

In other words, in any conversation, there are two equally important people where emotional dialogue is of central importance.

VERP thereby supports the professional development of colleagues through developing an understanding of what intersubjectivity looks like in action and how communication between two or more people can have an effect on each other by being mutually receptive and sensitively responsive. As highlighted above, it has been used in many professional fields as it empowers individual practitioners to find clips that are most helpful to them towards their personal goal.

Etelapelot et al. (2013) suggest that the term 'agency' tends to be associated with "active striving, taking initiative, or having an influence on one's own life situation" (p.46). Barrow and Todd (2015) have taken this idea further to suggest that

in order to address complex challenges faced by communities in the domains (and beyond) of health, education and social care we need agentic practitioners. Uncertainty in the contemporary workplace has led to a growing interest at both

an academic and policy level in agency at work. (Etelapelot et al., 2013, as cited in Barrow & Todd, 2015, pp.282-283)

Further in Chapter 23, Barrow and Todd (2011) outline the purpose of VERP as:

An alternative to instrumentalist expert-led training in the workplace, and may be used by agentic professionals to facilitate positive change in the relationships and ethos of the workplaces. VERP uses short video clips in which practitioners view positive moments of their own interactions with service users or other practitioners (for example, in a team meeting or supervision context). Through the VERP process they are guided to identify strengths in their own communication that have contributed to the positive interaction demonstrated in the video. VERP emphasizes the dyadic nature of communication. Its focus, therefore, is mutuality and attuned relationships rather than building an individual's skills base. (p. 291)

Typically, every VERP session occurs once every 2 to 4 weeks, in order to allow participants to record videos of their professional interactions. During the session, each participant shares their video clip with the rest of the group who takes on the role of a 'reflective team.' A reflective team approach is a way of deepening the discussion by structuring the reflective process such that they make a 'back row and observe in silence' whilst the trainee and VERP guider review and discuss the video clips (by making a triangle between the video, trainee and guider). As the sessions develop, the VERP guider moves from a supportive teaching role to a facilitator, to enable participants to take more ownership of their development. The building blocks of attuned interactions are illustrated below in Figure 1. The VERP guider uses these principles for developing attunement with the trainee during the VERP sessions to support them to feel attended to, received and to develop discussion with them around the clips.



Figure 1: The principles for developing attunement¹

¹ The figure is courtesy of the Association of Video Interaction Guidance UK (AVIG UK).

CONTEXT FOR CAMBRIDGESHIRE MUSIC VERP PROJECT

This VERP project was commissioned through conversations with the team lead of Cambridgeshire Music (www.cambridgeshiremusic.org). The team lead was keen in exploring VERP training to enhance reflective practice of the music therapy team through group supervision (called shared reviews) of video clips from clinical practice. VERP was suggested as a methodology to meet the following aims: 1) to empower and increase confidence of the music therapy team in using video in their work with families; and 2) to increase the reflective capacity of the team by looking at short clips of their interactions with the children and young people they work with.

METHODOLOGY

Participants

Six female music therapists aged between 30-60 years old took part in the project. All of them had more than ten years of clinical experience and two had undergone additional training in systemic practice. Working for Cambridgeshire Music™, their work was typically delivered in clinics, homes, and schools throughout the counties of Cambridgeshire and Peterborough in response to the commissioners to their services.

Procedure

An introductory meeting was held with the music therapy team at one of their team meetings. Subsequently, two training sessions were held in March 2018 and April 2018. The purpose of these training sessions was to share the aims of VIG and VERP approaches, introduce the VIG attunement principles, outline expectations for VERP training including the content of the course, and discuss practicalities around filming.

A two-day training programme was held over two sessions: Day 1 included the co-construction of a group goal – *To balance the child-led initiatives with the objectives/goals of music therapy to inform our actions as therapists* – and a group name for the project. Everitt, a member of the team who was training in VIG, facilitated the process of co-constructing the group goal by listening, receiving, and reflecting back the words, thoughts, and feelings of the group. Day 1 also included didactic teaching on how to film sessions, how to select and edit films to illustrate the principles for developing attunement, the concept of following the client's initiatives, and exercises of identifying attuned interactions on film.

Day 2 comprised of completing baseline measures; setting, scaling, and recording personal goals; identifying a parent to work with; preparing consent forms for filming; clarifying expectations for recording and micro-analysis of video clips for group supervision; and outlining next steps for supervision.

Measures used

Target Monitoring and Evaluation (T.M.E.; Dunsmuir et al., 2009) was used as an evidence-based outcome measure. This was adapted from Goal Based Outcomes that was used in medical settings as a Likert Scale (between 1-10; e.g. 1 = not present; to 10 = always present) to help participants formulate a helping question or goal and define what this goal looks like at baseline and at the end of the project (achieved) to evaluate change. The researcher supported each participant to set an individual goal by asking them what they wanted to work and what this would look like in their current practice. This form of goal setting was used pre- (April 2018) and post-project (September 2018) to evaluate outcomes.

Three group supervisions (of 1.5 hours each) were held every month between May and July 2018. This was facilitated by myself (an accredited VIG supervisor) alongside a VIG guider in training (Stage 3). The music therapists brought films to supervision that showed them using attunement principles in their interactions with children and young people. This was linked to their individual goals as illustrated in Table 1. I enabled and led the group to explore films together in group supervision (shared reviews), supporting each to identify positive moments of attuned interaction and next steps to take forward. A final celebration session was held during the final meeting (July) to acknowledge the strengths and the next steps of practice for each music therapist.

"What am I doing to deepen discussion with X (child) to explore/express verbally issues around his emotions and anxieties?" "How am I receiving with words to develop shared meaning of language in a purposeful way?" "What is it that I'm doing to guide and extend a child into developing effective verbal communication?" "What is it that I'm doing to support the balance of communication, holding in mind both the child's and my own agenda?" "What am I doing to guide the child into deeper discussion to facilitate insight for the child?"

Table 1: Individual participants' helping questions (or individual goals)

During this final celebration, rating of the VIG attunement principles as well as the individual and group goals using T.M.E. took place again, alongside a short questionnaire. Certificates of attendance were given to each participant for completing the VERP project (led by the VIG Supervisor (myself) and VIG practitioner (Everitt) and for the purposes of continuing professional development record for the music therapy team.

FINDINGS

As part of our evaluation of VERP for music therapists in this setting, we used pre- and post- T.M.E. scores. Overall, this showed an effect size of 1.71 (mean post T.M.E. scores – mean pre T.M.E. scores / SD). This would be considered to be a large effect size (Coe, 2002). The T.M.E. data revealed positive shifts of 3 points for the group goal pre- and post-project. The T.M.E. data also revealed average shifts of 3.6 points in relation to progress with individual practitioner's goals (Table 2).

Post-T.M.E. scores showed that by the end of the project, participants used VIG communication principles more frequently in their interactions with children. Participants also completed a self-rating scale on their use of the VIG Attunement Principles pre- and post-project. The self-rating scales showed increased frequency in the participant's use of the VIG Attunement Principles in their interactions with parents.

Qualitative feedback from participants revealed positive responses. There was an overall sense that the team was more cohesive and connected on completion of the project.

Group goal and individuals' helping questions	Pre-	Post-	Shift in T.M.E. score
Group goal			
To balance the child led initiatives with the objectives/goals of the therapy to inform our actions as therapists.	4	7	+3
Individuals' goals			
What am I doing to deepen discussion with X (child) to explore/express verbally issues around his emotions and anxieties?	6	7	+1
How am I receiving with words to develop shared meaning of language in a purposeful way?	3	8	+5
What is it that I'm doing to guide and extend a child into developing effective verbal communication?	3	9	+6
What is it that I'm doing to support the balance of communication, holding in mind both the child's and my own agenda?	6	9	+3
What am I doing to guide the child into deeper discussion to facilitate insight for the child?	5	8	+3

Table 2: Likert scores (1-10) using pre- and post-T.M.E.

DISCUSSION: REFLECTIONS AND IMPLICATIONS FOR PRACTICE

This project was valued by the service lead. Also, participants indicated that this opportunity gave them time to 'press the pause' in the business of professional practice, allowing them to connect and reflect together through a shared group learning experience. All colleagues reported enjoying time together, feeling empowered and experiencing a shared sense of purpose and belonging. Although empowerment, agency, and belonging were not the primary focus of the project (so not measured formally), these would be useful to consider in future work. A follow-up study could be done to analyse the qualitative comments more by looking at emerging themes using content or discourse analysis, for example.

Upon completing the project, I found that participants needed additional modelling on how to identify moments of positive attunement initially. Additionally, they needed more time to think about physical positioning of the filming device within their own shared reviews with clients to enable empowerment. They also needed more time to complete the micro-analysis of films between group supervisions in their pairs, given that participants were working in a time demanding role of a busy music therapy practice.

Overall feedback indicated that the course was perceived as a supportive and enabling opportunity to develop professional practice and professional confidence. Additionally, practitioners reflected that they learnt how to put forward a client-centred goal and valued the safe space to reflect and learn from each other's practice.

The theme of increased agency – the feeling of control over their actions and their consequences and increased confidence in putting forward a goal for the client was noticeable. Also participants shared that the group supervision reinforced an awareness of their attuned interactions with clients and one another from a shared collaborative learning experience with peers. A full summary of the comments is included in the Appendix.

Reflections and implications for music therapy practice

How do you think your communication with your clients has changed?

Practitioners indicated that they felt their communication with clients had changed as a result of attending the course. They indicated that they were more reflective in sessions: they made links with previous sessions in their current conversations with clients. They also felt that they were following the children's initiative more during therapy to guide children into using more language by reflecting back their words. Other practitioners felt that they had more confidence in identifying when an interaction was working well. For instance, some noted that by waiting and giving more space, they were better able to look for positive moments of communication.

How will you use what you have learned on the course in your work?

Participants reported increased motivation to consider other forms of video feedback training (such as VIG) as well as a willingness to continue to develop verbal reflection skills – using and reflecting back a client's words – when appropriate. There was also increased motivation to think about how staff within the school context could use video recording as a tool for reflection. Participants felt more confident to wait, listen, and follow the client as they learnt how these behaviours positively impacted their music therapy practice.

What are you doing differently now as a result of participating in the VERP course?

Individual practitioners reflected on the impact of the VERP course on their practice. Some examples include:

We are all now following the children's initiatives more.

I feel I am more confident in thinking about what the child's initiatives are and what my 'Therapist intentions' are, and how I might share these in a session.

It's good to keep in mind how much structure I am putting in, and the balance of leading and following. It has made me think about following the child more to get the balance in communication.

I'm thinking more about how to allow the child to lead more, rather than following the Therapy objectives. I certainly feel like there is more balance now, otherwise you can get into a pattern.

It is easy to lead all the time, I think I have shifted to following the child's initiatives more.

During the final celebration session, the team lead shared the impact that the project had for staff confidence. She also indicated feeling empowered to report a large effect size in terms of T.M.E. outcome data pre- and post-project and positive comments as illustrated in the qualitative feedback to the Cambridgeshire's Local Authority Ofsted inspection. These findings replicate previous research that found increased staff confidence as a result of using video feedback to support training (Gooding & Standley, 2010). The team leader also indicated that the project was a 'good spend' in being able to evidence the impact of the project, and to support the continuing professional development of the team. An additional unexpected benefit that came about through this project is that it embedded the Attunement model and the use of video reflection for supervision and parent feedback, much more firmly. The team leader reflected that "the questioning used in VERP was really helpful and helped to sharpen our reflective practice skills, for example notice some things that we may have been doing already but were not articulating or understanding" and "the questioning model and script really helped to then improve confidence for work with parents and gave a structure and language for discussion and reflection."

The team lead reflected that another gap for music therapists is often the use of language with clients:

Non-verbal communication and attunement is 'quite easy' for music therapist but practitioners do not always have training in the use of words or verbal reflection without taking some short counselling type course.

Spending time thinking about similarities and differences between musical and verbal attunement was key and joined up some gaps. Rehearsing scripts and language were also key.

One limitation of this project included the duration of the project. Ideally, another group supervision (called a shared review) would have enabled further learning, but this proved to be difficult because we needed to balance this against the time for continuing professional development within

the context of a busy service, childcare needs, and colleagues having access to recording equipment. Other limitations included not controlling for confidence level and prior experience of engaging with video feedback as a tool for professional development. Two colleagues (out of six) anecdotally reported extensive use of video feedback due to prior training opportunities.

In summary, this project was considered a successful joint endeavour between agencies within one Local Authority (Cambridgeshire Music and the Educational Psychology Service in Cambridgeshire). The use of an embedded learning reflective video model for continuing professional development provided learning opportunities for both practitioners and the supervisor, alongside one music therapist who had trained in VIG who took a supervisory role alongside myself.

REFERENCES

- Ammaniti, M., & Ferrari, F. (2013). Vitality affects in Daniel Stern's thinking – A psychological and neurobiological perspective. *Infant Mental Health Journal*, 34(5), 367-375.
- Barrow, W., & Todd, L. (2015). Reflections on the potential of Video Enhanced Reflective Practice (VERP) to support agency in the contemporary workplace. In H. Kennedy, M. Landor & L. Todd (Eds.), *Enhanced Reflective Practice: Professional development through attuned interactions* (pp.282-291). Jessica Kingsley Publishers.
- Chasle, C. (2011). Reflecting on VIG practice from a relational systemic perspective. In H. Kennedy, M. Landor & L. Todd (Eds.), *Video interaction guidance: A relationship-based intervention to promote attunement, empathy and wellbeing* (pp.243-254). Jessica Kingsley Publishers.
- Coe, R. (2002). *It's the effect size, stupid – What effect size is and why it is important*. Paper presented at the British Educational Research Association annual conference, Exeter, 12-14 Sept 2002.
- Dunsmuir, S., Brown, E., Iyadurai, S., & Monsen, J. (2009). Evidence-based practice and evaluation: From insight to impact. *Educational Psychology in Practice*, 25(1), 53-70.
- Etelapelot, A. Vahasantanen, K., Hokka, P., & Paloniemi, S. (2013). 'What is agency? Conceptualising professional agency at work.' *Educational Research Review*, 10, 45-65.
- Gooding, L. F., & Standley, J. M. (2010) The effect of music therapy exposure and observation condition on analytical clinical skills and self-confidence levels in pre-intern music therapy students. *Music Therapy Perspectives*, 28(2), 140-146.
- Kennedy, H., Landor, M. & Todd, L. (Eds.). (2011) *Video Interaction Guidance: A relationship-based intervention to promote attunement, empathy and wellbeing*. Jessica Kingsley Publishers.
- Kennedy, H., Landor, M., & Todd, L. (Eds.). (2015). *Video Enhanced Reflective Practice: Professional development through attuned interactions*. Jessica Kingsley Publishers.
- Stern, D. (1985). *The interpersonal world of the infant. A view from psychoanalysis and developmental psychology: the sense of a subjective self*. Routledge.
- Trevarthen, C. (1980). The foundations of intersubjectivity: Development of interpersonal and cooperative understanding of infants. In D. Olsen (Ed.), *The social foundations of language and thought: Essays in honor of J.S. Bruner* (pp.316-342). Norton.
- Trevarthen, C. (1998). The concept and foundations of infant intersubjectivity. In S. Braten (Ed.), *Intersubjective communication and emotion in early ontogeny*. Cambridge University Press.
- Trevarthen, C., & Aitken, K. J. (2001). Infant intersubjectivity: Research, theory, and clinical applications. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, 42(1), 3-48.

APPENDIX

Comments received from participants on the VERP course:

"Discussions deepened and moved toward transition to post school education, rather than anxieties. There was good linking between conversations/ topics past and present."

"A supportive opportunity to reflect on my own practice."

"I found sharing my work with colleagues really useful, and keeping focused on the positives."

"Really useful to share and review clinical skills together."

"Reinforced awareness in sessions including shared learning practice/experience."

"It was useful to share and follow up reflections with the team as part of sessions, but also in ongoing discussions after with team."

"Enjoyable course and good to have the chance to share video material with the team. Maybe next time I would choose a different goal."

"Sharing video material/discussion, and good hearing and seeing others' Music Therapy work."

"Thank you very much! A very interesting and enjoyable course!"

"I do feel more confident (agency) putting the goal (my agenda) forward than I would have in the past."

"I would recommend this course to other colleagues because of the emphasis on positive attributes and reduction in problem saturated conversations."

"Identifying the positive interactions and sharing work in an affirming manner."

"I found the course extremely useful, particularly when thinking of positive communication skills."

"I would recommend this course to analyse your communication and that of the client, and find a 'weak' point to strengthen."

"Identifying the positive interactions and sharing work in an affirming way."

Ελληνική περίληψη | Greek abstract

Χρησιμοποιώντας την Ενισχυμένη Πρακτική Αναστοχασμού μέσω Βίντεο (VERP) για τη συνεχή επαγγελματική ανάπτυξη μιας ομάδας μουσικοθεραπευτών: Αξιολόγηση και στοχασμοί

Miriam Craddock

ΠΕΡΙΛΗΨΗ

Το 2018, έξι μουσικοθεραπευτές παρακολούθησαν μια σύντομη εκπαίδευση για την Ενισχυμένη Πρακτική Αναστοχασμού μέσω Βίντεο (Video Enhanced Reflective Practice - VERP). Συν-σχεδιάστηκε ένας ομαδικός στόχος για την ανάπτυξη της ομάδας ως μέρος του προγράμματος, με εφαρμογή στην ατομική εργασία περιστατικών. Η εκπαίδευση πραγματοποιήθηκε κατά τη διάρκεια δύο συναντήσεων διάρκειας 1,5 ωρών, κατά τις οποίες εξηγήθηκαν οι αρχές για την ανάπτυξη συντονισμού, αποφασίστηκαν ατομικοί στόχοι για την ανάπτυξη κάθε ασκούμενου, και διεξήχθη συζήτηση για την ατομική εργασία περιστατικών. Συζητήθηκε επίσης η διαδικασία καταγραφής και ανάλυσης σύντομων βιντεοκλίπ πριν από την ομαδική εποπτεία. Η παρακολούθηση και αξιολόγηση στόχων χρησιμοποιήθηκε για να καταμετρηθεί η επίδραση των στόχων πριν και μετά το πρόγραμμα. Άλλες μετρήσεις που χρησιμοποιήθηκαν περιλάμβαναν μία κλίμακα αυτοαξιολόγησης των Αρχών Επικοινωνίας πριν και μετά το πρόγραμμα, καθώς και ερωτήσεις ανοιχτού τύπου σε φόρμες αξιολόγησης. Τα δεδομένα της παρακολούθησης και αξιολόγησης στόχων αποκάλυψαν θετική μεταβολή 3 βαθμών για τον ομαδικό στόχο πριν και μετά το πρόγραμμα, και μέση μεταβολή 3,6 βαθμών προς τη θετική κατεύθυνση για τους ατομικούς στόχους. Επιπλέον, οι κλίμακες αυτοαξιολόγησης των ασκούμενων έδειξαν αυξημένη συχνότητα στη χρήση των Αρχών Επικοινωνίας στις αλληλεπιδράσεις τους με τα παιδιά. Το πρόγραμμα αυτό βασίζεται σε έρευνα που δείχνει ότι η VERP είναι ένα εργαλείο επαγγελματικής ανάπτυξης που βελτιώνει την αυτοπεποίθηση και αυτενέργεια των ακούμενων μέσω της αυτογνωσίας και της γνώσης των δεξιοτήτων που χρησιμοποιούν στην καθημερινή κλινική πράξη. Επιπρόσθετα, παρείχε έναν μηχανισμό για μια ομάδα να σκέφτεται και να εργάζεται δημιουργικά και θεραπευτικά μαζί.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

αυτενέργεια, συντονισμός, αλληλεπίδραση, ενδυνάμωση, παρακολούθηση και αξιολόγηση στόχων, εκτίμηση, Ενισχυμένη Πρακτική Αναστοχασμού μέσω Βίντεο, μουσικοθεραπεία, αυτο-αναστοχασμός

INTERVIEW

“GIM grabs you, it takes you into the experience that you’re ready to have”: An interview with Jim Borling

Jim Borling

Radford University, Radford, VA, USA

Anna Giménez Castells

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ABSTRACT

Jim Borling is a renowned practitioner and primary trainer of the Bonny method of Guided Imagery and Music (BMGIM). His career spans more than thirty years. From the Atlantis Institute for Consciousness and Music, he offers training in several countries such as Spain, where the interviewer currently attends his seminars. In this interview, he explains that GIM is something that changed his own life as well as the lives of many others. This is due to the fact that GIM approaches not only the psycho-social, psycho-emotional, and biographic aspects of clients’ therapeutic work, but also the spiritual dimension of people. He goes over the past, the present, and the future of BMGIM. This semi-structured interview is based on the transcription of a recorded online meeting. We tried to keep the tone informal, offering the vitality of our spoken conversation. Our aim here is to capture a way of understanding and experiencing this method which is increasingly recognised worldwide.

KEYWORDS

Bonny method of Guided Imagery and Music (BMGIM), music therapy, psychotherapy, spirituality, healing

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Anna G. Castells: First of all, what has Guided Imagery and Music (GIM) meant to you?

Jim Borling: I could talk a long time about this, but GIM has been a life changer for me, and I say that GIM has deeply impacted me in many, many ways. I never intended to do what I’m doing today. I never could have imagined that I would be doing what I’m doing today. But when I think of the changes in my life and the way certain things in my life needed to change, I don’t believe it’s too strong to say that in some ways, GIM saved my life.

In that, what I really mean, even though it's not a physical life I speak of, it was a kind of a spiritual, emotional life. So, it's one of the most important things in the history of all that I've done, particularly in the field of music therapy.

In the trainings, and particularly with this deep psychotherapeutic work, I talk about facing the dragon, a metaphor for people meeting those obstacles in life that require dramatic change.

It can be transformative for those who answer the call (Bush, 1995). It can also be the seed and the root of an existential crisis or something worse for those that don't answer the call. My specialisation clinically is with addictions and trauma and not everybody is able to face those dragons that are required when dealing with addictions. GIM is uniquely qualified to do that if the client is on board.

Anna: You have practiced GIM for over 30 years. How has the method developed over this time?

Jim: This is a good question and historically, of course, Helen Bonny never set out or intended to develop GIM. It came out of some of her clinical, musical, personal, spiritual and transcendent experiences (Grocke & Moe, 2015; Grocke & Wigram, 2002).

So, when she developed the Bonny Method several decades ago, it was taught, presented, and developed in the way that she presented it to us. However, as clinicians, we began to work in a deeper psychotherapeutic manner and, particularly with the Atlantis Institute for Consciousness and Music, really took a focus on clinical work, which is not necessarily separating out from what Helen did. But in addition to that spiritual, transformative work that Helen was so well known for, we began to see a real clinical foundation for the GIM method. Now in that, there are many things that have occurred: the development of new music programmes, the allegiance to certain theoretical underpinnings that Helen may not have necessarily talked about but were certainly birthed with her early work. So, how the GIM method developed over time is that it is now very applicable to clinical issues, as well as socio-cultural issues, and psycho-spiritual issues. It's hard to stop describing the applications for GIM.

I think one of the most exciting things that I'll end my answer with is this: is the development of new music programmes. Helen was a master, of course, at developing and putting together the music programmes that she did but as we gained these decades of experience, we now see the development of other programmes, new programmes or certain ways of looking at the music programmes that may be an off-shoot and quite different than the way that Helen initially envisioned this process unfolding.

Anna: You have taught courses in the United States, Spain, Korea, Germany and so forth. How is it possible that GIM fits with people of such different cultures?

Jim: This is a question that I often get as an international trainer. GIM can be different, in different cultures initially. And what I mean by that is we need to be culturally sensitive. For example, South Korea and Japan are culturally quite different from Spain and Mexico, and even the United States. So as a trainer, particularly from the United States, I have to be sensitive to what the cultural norms are for the group of people that I'm working with. And be sensitive to these cultural norms in the way that we teach, in the way that we guide, in the expectations that we hold for these trainees to experientially engage in the GIM experience.

However, what we notice over time is that we begin to deepen into the human experience, which is not limited just to particular cultural norms or boundaries. In other words, when we think of the growth and healing, spirituality and transcendence all residing deep within, we are tapping into a universal principle that many scholars talk about. It's not limited just to the Asian cultures or the European cultures or the Latin cultures or the American cultures at all. We begin to tap into that essence of the human experience which I have come to believe is universal. It has been a total gift to be in these different cultures to work with people like you in Spain and to see how this universal nature of humanity expresses itself. There's that natural innate human potential that begins to rise to the surface. So, in that sense, yes, very different cultures on the surface, even deep into ritual tradition, but fundamentally, we're dealing with the core human aspect of growth, transcendence, healing, and spirituality. It's the essence of being a human, and that's not limited by cultural norms or boundaries.

Anna: Helen Bonny had a mystical experience while playing the violin. This was perhaps an important developmental step for the method. Helen was principally a Christian, but it seems that she was opening to universal principles of spirituality, particularly as a result of this mystical experience. What do you think?

Jim: Yes, Helen had a mystical experience playing the violin. She was performing in a religious context and this was very familiar to her as it is for many musicians. But as she described, the music began to take her over and the music began to express in a way that she knew was not coming from her, a trained professional violinist. She felt at that moment that the music was something much greater than herself coming through. That was the door that opened her up to this sense of transcendent spirituality. Some of the considerations that Abraham Maslow offered in his "Toward a Psychology of Being" writings (1962) or Alan Watts (1951) when he speaks of going beyond the 'skin encapsulates ego' were then becoming a reality for Helen. In other words, she had experiences that were not natural to her, that were not part of her tradition, which was Christian. But she also was very open-minded and that was the beginning of her search for answers. It was the beginning of her effort to understand what this was, what happened, and what part music played in this experience. Is it just music in general? Is it this particular music or does music in a universal sense begin to express aspects of the human experience that are core, essential, and fundamentally healing? I think that was what was so meaningful to her. These universal principles of spirituality, healing, and transcendence that are so contrary to our limited sense of self, our limited sense of the human experience, and our limited sense of what it means to be fully realised as a human being have now become a primary focus for Helen. So, it was a beautiful beginning, this experience that she had with the violin, a beautiful beginning to what we know now in the 21st century as the Bonny Method of Guided Imagery and Music.

Anna: You have added new music programmes to the GIM library. Can you explain the process?

Jim: That's difficult. I'll share with you that just recently, I completed a new music programme. I was in the process of developing a new music programme and decided to use it for the first time with a client. And it was a very meaningful experience for the client. It was a process of letting go for her. It was a sense of surrender for her to something much greater than herself.

It takes me quite some time to develop a programme. It generally starts with me hearing a piece of music that touches me deeply. I will set it aside, waiting for another piece to touch me in a similar manner. So, I begin to sequence these pieces of music that initially invite a traveller or client into the experience. Then deepen the client into the experience to do the fundamental work that is relevant to their current growth process, whether it is uniquely clinical, emotional, spiritual, or biographical. As long as we, I'm not saying this well, but as long as we match the music with the needs of a client, and the client is open to the experience, this client will begin to respond in a particular way. Well, when I listen to music, the music begins to suggest to me that it will help the client in a particular way. So, again, that invitation aspect of any programme, followed by the working portion of the music, and then ultimately leading to an anchoring or an integration of the experience. So, developing music programmes generally follows that formula.

But one programme can be very different from the other, because one might be addressing a psychoemotional need of a client; another might be addressing a transcendent spiritual need; or another might be addressing a deep, strong emotional need, like anger or anxiety or frustration, or maybe something like grief or sadness. So, the formula for programme development can be similar across the board but the intent of the programme can vary quite a bit within the music library.

As I said, Helen developed several programmes early in her career and we all worked with those and they were, and still are, exceptional programmes. But as we began to evolve and see how GIM can meet certain clinical needs, psychoemotional needs, biological needs, we began to develop programmes around those core issues. And I will say this: it takes a long time, in my humble opinion, to be qualified to develop a GIM programme. I've seen new trainees immediately want to develop a new programme and I'm thinking, yeah, but you don't know the current and old programs yet. You need to learn the programmes that already exist and then, being patient, beautiful things begin to occur.

The most recent programme that I just started using yesterday took quite some time to develop. I was really unsure if it was right but using it yesterday, I found that it worked with a client whose clinical issue was appropriate and I realised right away that it was ready for use in a GIM setting. It's a good programme, but there was a lot of questioning in my mind and I've been doing this a long time.

I hope that makes some sense. Developing music programmes is not as easy as it looks.

Anna: Although you are a music therapist/music psychotherapist and professor emeritus, how do you view GIM in the context of a bona fide psychotherapy process?

Jim: This is a really good question. We refer to the Bonny Method of GIM as music-centred psychotherapy. Sometimes you'll hear someone say it's a music-centred transformational process, or that it's a music-centred holistic process, but it's really psychotherapy in the truest sense of the word. We're working with the deeper aspects of the human psyche, recognising that to define the human psyche is very difficult to do. But I know that, particularly with Atlantis Institute, we lean towards some of the Jungian ideas of consciousness, the conscious mind, the unconscious mind, the collective unconscious, archetypal process, and so on, self and shadow, all of that.

When we begin to work at that level of depth, we're really working at the psychotherapeutic level. We're not working at a level that is more coping-mechanism oriented or cognitive-behavioural oriented, all of which have value. But sometimes a client needs something deeper.

Anna: Can you describe the challenges you have being a music therapist who is trained in GIM where this type of experiential practice is not fully recognised or supported?

Jim: The music therapist doesn't always have the opportunity to use GIM in a way that can support a professional practice. The GIM community has licensed professional counsellors, licensed clinical psychologists. We have licensed social workers who all make use of GIM as a psychotherapeutic tool and can build a business based on their professional credentials. It is important here to note that these professionals cannot and should not refer to themselves as music therapists. Their GIM practice is offered in the context of their professionally credentialed work. It can be difficult for some music therapists who are not necessarily licensed, and I'm talking more specifically in the United States. But I think this is relatively true in other countries as well.

I hope what you're hearing in my answer is that GIM is a deep psychotherapeutic process that is life-changing and works with the structures of the psyche in a way that will impact all aspects of a client's life. The core structure of the psyche is impacted when facilitated by a qualified and experienced GIM guide.

Anna: How do you see the future of GIM?

Jim: Well, one of my mentors says with some regularity that GIM is exploding around the world. I think there's some truth to that. It's really international now. Europe is very strong. The Asian countries are very strong. Mexico is very strong. It's building in strength in South America now and Canada, of course.

So, in that sense, the future is good in that this is a method that's impactful and very effective for the work that people do. I caution against growth that happens too fast and anything that grows too quickly, however. We run the risk of losing some of the integrity of the method. You know, it's been interesting to have moved through the COVID era where we have gone, in part, to working online. We've developed hybrid models to implement GIM sessions and trainings online. But we need to be careful. Yes, there is value in the hybrid model, but caution should be our guide. Upholding the integrity of the model is essential. We don't want to sacrifice method for the sake of convenience.

And one of the things that I mean by that, that's really important to me, is the music. Are we sacrificing the quality of the music by working online? Are we sacrificing the presence of the therapist, the energetic presence of the therapist by working online? I'm not saying don't work online at all, but I'm saying that as we evolve, as we develop, particularly post-COVID, we need to keep a focus on the integrity of the method, on the quality. Those quality points of the music and the way that we present the music, also the fundamental principle of the therapeutic relationship between the guide and the traveller, so much of which is unspoken and experienced in an energetic exchange could be lost if we are not diligent in our commitment to the method.

So, as we grow as a modality, there will be new programmes developing as well. There will be GIM growing in different parts of the world. My hope is that we continue to explore the integrity and

how this growth is enhancing the Bonny Method and not in some subtle way taking away from the impact of the Bonny Method that we know to be accurate and true.

Anna: What are your thoughts about current research of psychedelics in the GIM process?

Jim: It's a good question. Well, we know that Helen's early work as a result of her transcendent experience with violin brought her into the research with psychedelics, with LSD-25. This was government-sanctioned research that was happening, looking at the impact of spirituality, or peak experience, and the high-dose LSD experiences on healing in a grand sense. OK, that's fantastic. And that was wonderful, wonderful work. It was consistent with some of the work that was happening around the globe at that time.

Of course, that research got shut down, and now there is a resurgence. There is a reemergence of psychedelic research; it looks a little different than what was happening in those early days. What I mean by that is it's not necessarily high-dose experiences that people are having but more of a measured use of things like psilocybin, MDMA, even LSD, and I may be missing a few here, but this research is very calculated.

What this question is asking is what about that union of music or GIM with this psychedelic research. I think there's a lot of potential there. My hope is that it goes forward, but in a very managed and ethical manner. For me, it is not until we arrive at, and are comfortable with, the managed and ethical practice of blending psychedelics with GIM that we should endorse the exploration of this practice. We need to, in a quantified and scientific manner, begin to collect data. We need to see what's going on, what's happening, what's the impact here, and be sure that when we do bring in the music, like in the early days, that it supports the contour of the psychedelic experience.

I want to be cautious, however, that we're not saying there is a potential for GIM and psychedelics to be a preferred method. What we're actually beginning to reinforce once again is that GIM and the way that we use music very intentionally can begin to speak to those deep layers of the human experience that were exposed through that early psychedelic research. Now we're beginning to replicate some of that, and the exposure of those deep transcendent experiences and the impact on healing is beginning to manifest. That's good. Let's see the data. Let's see how replicable those experiences are in a very measured way.

I think Lisa Summer is doing a wonderful job of stepping into the role of representing GIM in a measured way; how GIM and psychedelics can take the client where they need to go, be that enhanced spiritual development, transcendence, recovery from trauma, even addictions recovery as we understand addictions today. So, I think there's something there. I do want to take baby steps, but I'm actually very excited about it.

Anna: Is there anything else you would like to add?

Jim: Again, one of my mentors... let me mention that as a faculty member for the Atlantis Institute for Consciousness and Music I have been blessed to be mentored by Sierra Stearns and Carol Bush. These individuals are central to the changes in my life that I've experienced, and I feel deeply grateful to have had them as my teachers, as my mentors.

Is there anymore that I would like to add? In a way, and I think that Carol and Sierra would say this as well, GIM grabs you. It takes you into the experience that you're ready to have.

I never intended to do this GIM work at this level, and now GIM has taken me all around the world several times. I can't imagine that Carol and Sierra ever intended this journey to manifest the way it has, the way it beautifully has. So, GIM grabs us and takes us into the journey that we are ready to experience. It is not without our sense of readiness and full participation, but it grabs us!

There was a time early in my life and I'm talking about 40 years ago now, where I had some experience with GIM in Miami, Florida but it was not my time. There was a seed that was planted, however. But it wasn't until many years later that I went to a workshop offered by my mentors, Sierra and Carol, and that was the birth of my experience as I know it today.

So, for those of you who are sincerely interested in GIM, if you're really ready for the ride, it will take you. There must be a readiness but if you are, in fact, ready, it will change your life.

REFERENCES

- Bush, C. A. (1995). *Healing imagery and music: Paths to the inner self*. Rudra Press.
- Grocke, D. E., & Moe, T. (Eds.). (2015). *Guided Imagery & Music (GIM) and Music Imagery methods for individual and group therapy*. Jessica Kingsley Publishers.
- Grocke, D. E., & Wigram, T. (Eds.). (2002). *Guided Imagery and Music: The Bonny method and beyond*. Barcelona Publishers.
- Maslow, A. (1962). *Toward a psychology of being*. D Van Nostrand.
- Watts, A. W. (1951). *The wisdom of insecurity: A message of an age of anxiety*. Pantheon Books.

Ελληνική περίληψη | Greek abstract

«Η KNAM σε αρπάζει, σε μεταφέρει στην εμπειρία που είσαι έτοιμος να έχεις»: Μια συνέντευξη με τον Jim Borling

Jim Borling | Anna Giménez Castells

ΠΕΡΙΛΗΨΗ

Ο Jim Borling είναι ένας φημισμένος επαγγελματίας και κύριος εκπαιδευτής της μεθόδου Bonny της Καθοδηγούμενης Νοερής Απεικόνισης και Μουσικής (KNAM). Η καριέρα του εκτείνεται σε περισσότερα από 30 χρόνια. Από το Atlantis Institute for Consciousness and Music, προσφέρει εκπαίδευση σε διάφορες χώρες όπως η Ισπανία, όπου η συνεντεύκτρια παρακολουθεί επί του παρόντος τα σεμινάρια του. Σε αυτή την συνέντευξη, εξηγεί ότι η KNAM είναι κάτι που άλλαξε τη δική του ζωή καθώς επίσης και τις ζωές πολλών άλλων. Αυτό οφείλεται στο γεγονός ότι η KNAM προσεγγίζει όχι μόνο τις ψυχοκοινωνικές, τις ψυχοσυναισθηματικές και τις βιογραφικές πτυχές του θεραπευτικού έργου των πελατών, αλλά την πνευματική διάσταση των ανθρώπων. Ο Borling μιλάει για το παρελθόν, το παρόν και το μέλλον της μεθόδου Bonny της KNAM. Αυτή η ημι-δομημένη συνέντευξη βασίζεται στην απομαγνητοφώνηση μιας ηχογραφημένης διαδικτυακής συνάντησης. Προσπαθήσαμε να κρατήσουμε τον τόνο ανεπίσημο προσφέροντας τη ζωντάνια της προφορικής μας συζήτησης. Ο στόχος μας είναι να αποτυπωθεί εδώ ένας τρόπος κατανόησης και βίωσης αυτής της μεθόδου η οποία αναγνωρίζεται ολοένα και περισσότερο παγκοσμίως.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μέθοδος Bonny της Καθοδηγούμενης Νοερής Απεικόνισης και Μουσικής (KNAM), μουσικοθεραπεία, ψυχοθεραπεία, πνευματικότητα, θεραπεία

BOOK REVIEW

Intersectionality in the arts therapies (Collier & Eastwood, Eds.)

Reviewed by Sangeeta Swamy

California Institute of Integral Studies, USA

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Title: Intersectionality in the Arts Therapies **Editors:** Jessica Collier & Corrina Eastwood **Publication Year:** 2022 **Publisher:** Jessica Kingsley Publishers **Pages:** 272 **ISBN:** 9781787754348

REVIEWER BIOGRAPHIES

Sangeeta Swamy, (she/they) Ph.D., LCMHC, MT-BC is Associate Professor and Co-Chair of the Integral Counseling Program at CIIS. As a queer, Indian American educator, Dr. Swamy specialises in culturally responsive and liberatory pedagogy, scholarship, and supervision and has taught undergraduates and graduate counselling, music therapy, and expressive arts therapy students for 15 years. As a therapist, Dr. Swamy has worked with children, adolescents, and adults in group homes, outpatient settings, and is currently in private practice. [sswamy1@ciis.edu] **AJ Phipps** (they/them) is a licensed marriage and family therapist serving a diverse group of clients in the San Francisco Bay. They currently serve as Assistant Professor in the Integral Counseling Psychology program, working with psychotherapy clients in a relational psychodynamic framework, and a spiritually centred practice for therapists and healers, called Witchy Sh!t for Therapists. Many paths converged to bring AJ to the field of psychotherapy including time spent volunteering in hospice, their own journey of healing, and their decades of studying esoteric and mystical traditions, including a focus on astrology, which led them to Jungian psychology. [aphipps@ciis.edu]

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INTRODUCTION

Intersectionality in the Arts Psychotherapies, edited by Jessica Collier and Corrina Eastwood (2022), dives into the timely and emergent topic of intersectionality, outlining applications to the creative arts therapies through in-depth theoretical discussions, self-reflections, and case examples. Coined in 1989 by Kimberle Crenshaw, *intersectionality* articulates a process of how multiple oppressed identities, most specifically the multifarious and compounding challenges around race, class, and gender, legally impact women of colour. While a relatively newer discourse in music therapy and the arts therapies, the unpacking of intersectionality across and within other disciplines outside of the field of law (where Crenshaw conceived the term) has been exponentially growing in the last several decades. This is a critical conversation for the music therapy field, which is still in the early stages of understanding the role of the sociocultural identity within the therapeutic, as well as the musical, process. Contemporarily, intersectionality is almost infinite in its complexity and constantly evolving, along with changing conceptions and expressions of race, gender, ethnicity, disability, sexual

orientation, socioeconomic status, religion, age, neurodivergence and other identity categories. Collier and Eastwood's book is a major contribution to not just the creative arts therapies but to this wider discourse, highlighting how intersectionality must be given nuanced consideration in each of the arts psychotherapies, as each discipline contains its own legacy, often tied to Eurocentric patriarchal values and assumptions. This is certainly true in music therapy.

Self-reflexivity is the primary tool used in this volume for exploring the various facets of intersectionality. This inner-seeking lens facilitates the examination of the authors' and editors' biases and internalised oppression, which they effectively convey with humility and vulnerability, acknowledgment and modelling of countertransference and sociocultural positionality. Interrogating one's clinical relationships publicly, with the level of self-reflective rigor demonstrated in this book, is brave work. Each chapter and case study also exposes the power dynamics, misses, and "normative unconscious processes" (Layton, 2020) that undergird therapeutic treatments. This manner of explication, accountability, and self-reflexive discipline is rare and refreshing. It is an invitation to all therapists, a form of praxis that we hope readers will take up for themselves and carry into their own work.

While this book mostly focuses on art therapy, with two chapters on music therapy and one on dramatherapy, it contains valuable discussions and modelling for the music therapy community. Refreshing nuances in thinking, comprehensive theoretical discussions, interdisciplinary citations, and important critical discussions run counter to many "how to" manuals or steps within the music therapy literature. Clinical vignettes are thoughtful and reflective, reflexive in approaches, attitudes, and analyses and discuss how intersectionality shifts basic assumptions about therapeutic processes. The clinical scope of this book is quite broad, covering topics such as sexual abuse, misogyny, intimate partner violence, chronic pain, and others in a variety of settings such as in prisons, universities, community and other contexts.

HIGHLIGHTS AND AREAS FOR GROWTH

Authors in this volume seem united in their intention of not only creating generous space for their clients' whole personhood, but also their own. This work requires openness to non-judgmentally meeting the other both externally and internally, as one encounters their own biases, prejudices, and internalised self-persecutors in relation to "others" that most would prefer not to recognise. This purity of intention and unflinching self-examination are the book's strengths, which we feel are qualities that cannot be modelled enough in the counselling and creative arts therapies field. The assembled chapters represent the sincere efforts of therapists from a variety of arts psychotherapies to heal with integrity their clients, themselves and even, ambitiously, the wounds in our troubled society. While these are lofty pursuits, the tone of the book is rooted in embodied practice, humility, and non-defensive accountability for mistakes.

Eastwood both sets and bookends a moving and vulnerable tone for the book in the opening and final chapters, deeply sharing the intergenerational wounds within her family and culture, the Gypsy, Romani Traveler (GRT) community and highlighting the need for therapists to examine their own internalised oppression, internalised shame, white gaze and white fragility. One of the book's main themes is excavated in four chapters explicitly discussing a feminist perspective. This begins

with Collier's chapters (7 and 12) on art therapy with those experiencing sexual violence, assault and rape and another addressing sexism and misogyny in work with women offenders in the criminal justice system in the UK. Chapters 8, 11 and 14 take this further with Sejal Chad providing an in-depth analysis of the MeToo movement, discussing themes of shame, victim blaming, stigmatisation, denial, and implications of therapist disclosures; Kairo Maynard unpacking the risk of stereotypes such as those of the angry Black woman; and Baum, Datlen, Eastwood and Elliston discussing the intersection of race, class and gender in clients with abuse and trauma histories. Three chapters also highlight another critical theme, the intersection of therapist and activist. Baum, Datlen, Eastwood and Elliston highlight how political action is clinical work, Chad expands the role of the art therapist or creative art therapist to the role of activist or social worker, and S.J. Langer (chapter 3) discusses street activism for therapists in trans communities.

Along with its strengths, looking ahead and thinking critically, there are a few significant areas to highlight for growth in this work. Thirty-five years since the inception of Crenshaw's (1989) terminology, contemporary society's ability to think intersectionally still seems nascent. This volume makes an excellent effort at considering social identities at play in the arts psychotherapies. However, a chapter-per-case approach seems to restrict consideration to one or two identities per chapter, thereby shaving off large pieces of the whole of one's social location and missing opportunities for more complex discussions.

Additionally, chapters on music therapy and dramatherapy were missing significant material on the arts-based nature of the work of creative arts therapists. For instance, chapter 9, a timely and insightful narrative about a music therapy project in Palestine, and chapter 13, outlining the intersection of disabled and LGBTQ+ identities, would have benefitted from the addition of Community Music Therapy and other music therapy references, and more extensive discussion of the music therapy process itself. Similarly, in chapter 11, Maynard discusses a vulnerable, humble, and authentic case study from her own positionality as a Black woman but includes very little about the dramatherapy process.

Furthermore, we wondered about the intended audience of the book and felt sensitive to how readers from marginalised identities and various locations might receive it, especially since most of the authors are cisgender women practising in the UK. For example, while two chapters are written by trans/non-binary authors, other chapters in which gender is named are deeply entrenched in the gender binary, almost as though it exists in a separate, gender-binary world. Inclusive discussions of non-normative gender identities are neglected in many chapters. This could be dissonant for readers of diverse genders expecting full representation. In addition, a few clinical examples mention self-reflexive regrets from white clinicians who neglected to consider and name racial differences and biases at the time of treatment. Giving full credit to the authors for their bravery and humility in naming these, we wondered about the impact on readers of colour of continuing to share stories of failure in this area.

In summary, the architects of the work assembled here, Jessica Collier and Corrina Eastwood, have assembled a thought-provoking set of readings which thoroughly explore identity, and encourage humility and self-examination. This work is so deeply needed in all branches of psychotherapy, and certainly the authors describe the need for this in the creative arts psychotherapies, in particular. Contributors to *Intersectionality in the Arts Psychotherapies* should

feel proud of their rigorous, vulnerable self-interrogation. By sharing their stories, their clinical work, and their calls to action for the field, they have added to its richness, modelled immense integrity, and set a fine example for practitioners, supervisors, students, and teachers.

REFERENCES

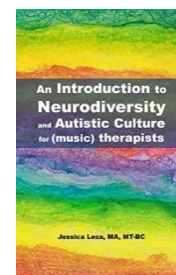
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 140, 139-167.
- Layton, L. (2020). Enacting identity: Normative unconscious processes in clinic and culture. In L. Layton (Ed.) *The Unconscious* (pp. 101-122). Routledge.

BOOK REVIEW

An introduction to neurodiversity and autistic culture for (music) therapists (Leza)

Reviewed by Bronte Arns

Giant Steps, Australia



Title: An introduction to neurodiversity and autistic culture for (music) therapists **Author:** Jessica Leza **Publication Year:** 2023 **Publisher:** La Migdalia Press **Pages:** 239 (pdf) 359 (paperback) **ISBN:** 979-8-218-22073-0 **E-ISBN Kindle edition:** B0C56DQ3N8

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Bronte Arns is the National Director of Music Therapy for Giant Steps Australia. In her leadership role, she works across teams to develop a range of music therapy programs for autistic school students and adult participants. Her research has focused on how music therapists collaborate with other disciplines in transdisciplinary teams, supporting students with complex needs to increase engagement. She is interested in the organic development of professional language over time, and learning how changes may positively influence the ways in which we write about our work.

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Jessica Leza's book, *An Introduction to Neurodiversity for (Music) Therapists*, is a welcome contribution to the literature for anyone curious to know more about autistic culture and creating inclusive, welcoming spaces for people on the autism spectrum. It is also a timely addition, responding to the needs of therapists looking for ways to shape their practice that are informed by the voices of the people they aim to support. It is essential that autistic voices lead the way in these conversations, and this text is powerfully constructed from neurodiverse public figures, scholars, and advocates.

My first impression of this book was that the scope is enormous. Leza has done an incredible job of gathering a wide range of information for (music) therapists, drawn from both her own lived experience and the collective perspectives of autistic people from various walks of life. The text is very dense and peppered with references. However, it is worth taking the time to work through the large volume of material. If time-poor, the reader can also be selective and focus solely on the sections relevant to their needs. The book as a whole is formatted in the style of an online learning course. In this, it lends itself well to being a resource that can be dipped into as needed, or absorbed in stages alongside the reflective questions provided. Several sections conclude with a practical list of ways music therapists can make shared spaces more accessible and inclusive. This will no doubt appeal to readers looking for immediate changes they can implement to improve their practice.

Leza begins by inviting the reader to acknowledge and understand their own biases. By doing so, she encourages the reader to consider the ways in which they may improve relationships in their practice and set relevant and respectful goals for therapy work. Anyone associated with the

neurodiversity movement will know that perspectives, language, and research in autism are continually evolving. Leza acknowledges that autistic culture, like all cultures, is not stagnant, and that this book only represents a snapshot of knowledge and views from this point in time. The chapters move through a long list of topics, with the final two chapters involving deep explorations of the many ways therapists may create more welcoming autistic spaces and the importance of including autistic people in all aspects of research. At the beginning, middle and end, Leza offers a list of reflective questions to guide the reader through the material, to highlight conscious and unconscious biases, and to reflect on ways to minimise the risk of harm in our work. These could be relevant for personal or group reflection, or supervision discussions. A useful glossary of terms and an extensive list of over 400 references concludes this publication. A thoughtful touch is the list of potentially triggering subjects and their page numbers, listed at the end of the book.

One of the interesting aspects of this text is how Leza has woven historical context throughout, giving the reader a sense of how current discourse has been formed over time. To me, this is one of the strengths of this book, giving the reader the chance to reflect on the many possible factors that bring about these changes. Examples of this can be found in Chapters 1, 2 and 4, with focuses on terminology, labelling, and specifically the history of neurodivergence as viewed through an Applied Behaviour Analysis (ABA) model.

It is important for therapists to learn about the history of ABA and the major concerns about it raised by autistic people. Leza highlights the long-term impacts ABA may have on individuals, including the devaluing of internal feelings and the insistence on compliance, often leading to increased vulnerability through the inability to refuse adult requests. I have found this language around compliance and 'consistent' performance can still linger in therapy literature, so I welcomed the chance to hear about direct experiences resulting from this language and types of practices. It invites music therapists to look at how goals are set, the language used to craft them, how progress is assessed, and how music therapy work is communicated to others.

The deep exploration of language and use of symbols is a healthy challenge for therapists. Leza's comments around not saying anything for fear of saying the 'wrong' thing were all too familiar to me. This issue is regularly raised when mentoring both new graduates and therapists who have been in the field for some years who now question if they are keeping up with changes in language and practice. In Chapter 2, she reminds the reader of how language can even come full circle over time; for example, how initially professionals used identify-first language to describe autistic clients or participants, then shifted to person-first language, with the current preference now returning to identity-first language. In Chapter 3, she even calls therapists to consider the use of common symbols – perhaps when promoting therapy work – and to learn more about their history before aligning with them. However, it is not just about identifying the issues, as she also suggests alternatives and guides the reader to other resources for further learning. This keeps the tone forward-looking and positive.

Of special note was the chapter on intersections, a rarely explored offering to the music therapy community. Whilst the neurodiversity paradigm is complex in and of itself, considering the range of possible intersections adds another layer to providing truly holistic care. Music therapists who see their participants only during music therapy session time may not always be privy to the presence of these intersections, such as gender, sexuality, race, religion, or parenting. By bringing these potential intersections to the attention of therapists, Leza provides a good reminder that there may be other

ways in which practice can naturally be adjusted to include neurodiverse people from a range of backgrounds and lived experiences.

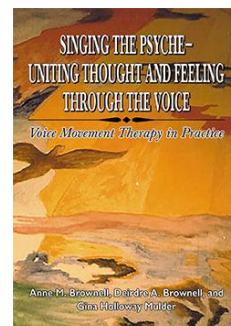
Whilst Leza states that the book may be helpful for therapists other than music therapists, it was refreshing to read something so in-depth on neurodiversity and therapy that *did* speak in the language of music therapists, as we are so often reading about it through the lens of other disciplines. I enjoyed discovering descriptive terms, including 'samefooding,' 'stimdancing' and 'neurocosmopolitan,' and the length of the reference list highlights the range and quantity of autistic scholarship available. I would suggest approaching this book as a series of learning modules and taking time to read, absorb and reflect on the material over several sessions. I would recommend this book to anyone wondering "am I saying or doing the right thing?" or wishing to know more about how to make and nurture relationships with autistic people, both in therapy practice and in wider social circles. I do hope that, as a first-person lived experience text, this helps pave the way for similar writing to be included wherever therapists access their professional development.

BOOK REVIEW

Singing the psyche: Uniting thought and feeling through the voice (Brownell et al., eds.)

Reviewed by Tina Warnock

Belltree Music Therapy, UK



Title: Singing the psyche: Uniting thought and feeling through the voice **Editors:** Anne Brownell, Deirdre Brownell & Gina Holloway Mulder
Publication Year: 2023 **Publisher:** Charles C. Thomas Publisher **Pages:** 320 **ISBN:** 978-0-398-09424-9

REVIEWER BIOGRAPHY

Tina Warnock founded Belltree Music Therapy CIC in Brighton in 2009, having worked on NHS music therapy teams in London since 2001. In 2018, she began working closely with Diane Austin, initiating and undertaking the first UK-based distance training programme in Austin Vocal Psychotherapy (AVPT). She continues to be involved in the growth of AVPT in the UK and Europe as a teacher in training, alongside her postgraduate research and clinical and supervision practice. Her vocal psychotherapy clients include people with cancer, respiratory disease, trauma, mental health issues and learning disabilities. Her publications have focused on the music therapist's voice, sense of self and therapeutic approach. [tinaw@belltree.org.uk]

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My interest in the interrelationship between the voice and the self was ignited in the late-nineties, and in part propelled by the prequel to this book, *'Therapeutic Voicework'* by Paul Newham (1997). Hence, when I realised this new publication was written by graduates from Newham's training programs, I was immediately intrigued. The title *'Voice and the Psyche: Uniting Thought and Feeling Through the Voice'* prepares us effectively for what is to come.

The focus of this book is Voice Movement Therapy (VMT), its foundations, history and form, and the ways that practitioners have gone on to use it in their rich and varied work settings. It became apparent early in the reading that this international group of practitioners align themselves firmly with the Expressive Arts and Arts in Health communities, as opposed to the Creative Arts Therapies or Allied Health Professions as is the case for music therapy in the UK. VMT has clearly gathered momentum in recent years, with several contributors having completed PhDs and other research projects on their VMT work. For example, Irene Kessler's PhD dissertation *'Sounding Our Way to Wholeness'* and Deirdre Brownell's *'Re-embodying the Voice'* (see references: Kessler 1997 & Brownell, 2020), and in chapter two Sophie Martin describes her pilot project researching the efficacy of VMT with young women who self-harm (Martin, 2013). A core group of practitioners have also formed an international members association for VMTs, further evidencing their passion, vocational calling and sense of ambition for the method.

In the context of the music therapy profession, the ethos and foundations of VMT align most closely with Austin Vocal Psychotherapy (AVPT), developed by Diane Austin since the 1990's (Austin, 2008). There are some striking crossovers between these two approaches which I will be comparing and contrasting later in this review.

Chapter 1, 'The Voice Unchained' sets the scene by detailing the origins and history of VMT and outlining the core principles. As the personal histories of key influential figures Alfred Wolfsohn, Roy Hart and founder Paul Newham's are described, it becomes clear that each experienced childhood trauma and issues of identity which led to a search for a sense of wholeness through vocal exploration. Newham combined his vocal discoveries with his knowledge of psychoanalytic theory, dance movement and physical theatre to create VMT, which aims to help people discover how facilitating a more embodied voice can support a "greater expression and expansion of one's sense of self" (p.24).

Clear descriptions by Brownell give the reader a good understanding of how muscular patterns concerned with the voice are intricately connected with our emotions and how these can be manipulated to "unearth and work with unconscious material" (p.17), integrating mind and body. The Core Principles of VMT (pp.17-28) describes in detail the ten vocal components and five non-vocal principles upon which all the work is based; together they provide the tools for VMTs which aim to facilitate the full spectrum of human expression, and many examples are given throughout the book to demonstrate how these can be applied.

The second chapter 'Psychology and Soul Work' is comprised of contributions from eight different practitioners and introduced by Anne Brownell. It is the most substantial section of the book and contains descriptions of a vast array of different projects. With a strong focus on trauma, VMTs describe their projects with people who have been displaced, sexually abused or struggling with self-harm, addiction and psychiatric disorders. Their approaches are highly varied, including choirs run "using the lens of VMT" (p.41), singing pre-composed songs, and individual body-based work using breath, movement and vocal interventions. The depth of the work is striking, and with safety in mind, I wondered how the practitioners manage the strong feelings arising in the sessions. It was reassuring to learn that they have supervision structures in place in their various roles and many of the practitioners have additional credentials as psychological therapists (detailed information can be found in the Contributors section). These credentials, however, do not seem to be a prerequisite to undertake the training.

In Chapter 3, 'Channels of the Voice – Affect and the Brain', author Deidre Brownell shares her personal background and describes the two main channels of communication worked with in VMT "the cognitive (words used to convey meaning) and the affective (the tones of voice used to reflect the bodily sensations which underlie them and convey how we are really feeling)" (p.112). In-depth case studies with clients with selective mutism, stroke, Parkinson's disease are moving and intuitive, and at times it felt like I was reading a book about music therapy. Brownell describes how she is "meeting a person where he is and giving him some control over what he does" (p.123), matching her client's keyboard playing with her voice and introducing other instruments such as the harmonica.

Common therapeutic terms are used throughout the book, but particularly in this third chapter – mirroring, reciprocal engagement, attunement, containment, transitional objects, transference and countertransference, secure attachment, emotional regulation – all give the

impression of a held, therapeutic relationship. It was surprising to discover how many crossovers VMT has with music therapy and vocal psychotherapy practice without any mention of relevant literature. In general, academic references are few and far between, even where links to theories and practices from other disciplines are obvious. For example, Bruscia, Austin, Wigram, Pavlicevic, Winnicott – all come to mind whilst reading. I wondered how much of this knowledge is accessed by VMT practitioners during and after training.

Chapters four and five are both introduced by Gina Holloway Mulder who trained with Paul Newham in the late 1990s and is based in Durban, South Africa where she runs her own VMT training programme. She addresses the link between unexpressed emotion and illness, disease and addiction and describes projects which encourage participants to “enter into a process to contact and develop a voice” so they become “more alive, better and more able to look after themselves” (p.154). The case examples that follow engage with deep unconscious material through the use of the VMT tools, incorporating Jungian concepts such as the Shadow, archetypes, active imagination and parts of the self or ‘sub-personalities’.

Whilst reading this book I noted similarities and differences between VMT and AVPT. There are some obvious similarities, particularly in the central use of the Jungian concepts mentioned above and the individuation process. Both methods utilise the thinking from developmental psychology; in VMT this is mainly through guided physical movement and vocal exercises, whereas in AVPT, developmental processes such as merging, and the separation of self and other, are considered in the context of two voices within vocal improvisation. Key differences are in how they approach the process; VMT draws specifically on the vocal components and non-vocal principles outlined in the first chapter and engages in detail with the anatomy of the voice, within a framework of guided activities to address the therapeutic aims. AVPT more closely resembles a sung psychotherapy session where the content and pace of the session is guided by the client, with the vocal psychotherapist using vocal and verbal interventions in a responsive manner. While the vocal therapist may encourage certain breathing exercises to connect with the body, the sessions mainly involve the key interventions vocal holding and free associative singing in combination with two holding chords on the piano, intermixed with talking. Psychodrama methods are also commonly used in AVPT to, for example, sing about, to, or as a significant person in one’s life. One important difference is that almost all AVPTs have a master’s in music therapy prior to training, whereas VMTs have a wide variety of academic and vocal backgrounds; this creates a significant difference in how musical improvisation is used to support the process.

The fourth and fifth chapters include several accounts of how periods of vocal development came alongside times of personal growth and change. For example, Phillips describes how the use of myth in story and song can “open paths to show us who we really are” (p.191) and Harrold writes: “Our voices are the doorway between our concept of ourselves (cognitive) and the felt sense of our own presence (affective)” (p.219). Since I have experienced this connection between my own voice and sense of self (Warnock 2011, 2019), I found this very affirming.

Holloway-Mulder describes the impact of the VMT training on her experience as both a therapist and a performer, and how it enables practitioners to better meet their clients’ needs. This theme is explored further in chapter five when Mali Sastir describes her own personal transformation that took place during her VMT training:

I was encouraged not just to face but trust the dark in myself – not to fear it but to discover its treasures [...] it is through the experience of sharing the work – of performing, being witnessed and received – that the personal has a chance to expand into something larger than the individual self. (pp.205-206)

Having undertaken some shadow work in AVPT training, and seen others experience significant transformations in their personal lives over the training period, I resonated strongly with this. I also understand how these personal shifts translate into our therapy practice; by 'going there' ourselves, we become better able to accompany our clients' process. The fact that both VMT and AVPT offer a two-year, process-based learning experience involving deep engagement with the voice and the psyche makes them uniquely connected, and I believe there is potential for each to learn from the other.

The final chapter 'Towards a living harmony' written by Gina Holloway, focuses on the importance of community and how VMT projects have brought positive change within communities and workplaces in South Africa following the impact of apartheid, the pandemic and world conflict. It describes how working with body-based methods in groups supports healthy dynamics on a micro and macro level.

This book presents VMT as an embodied practice which has many strengths and great potential in a world where there is a growing understanding of how the body, mind and spirit are connected (Van der Kolk, 2016). The lack of references to current psychological theory such as attachment or object relations theories, or evidence of learning from music therapy or vocal psychotherapy disciplines was surprising. I feel that if VMTs really are unaware of these significant bodies of knowledge, they are limiting opportunities to integrate their practice with other health professionals, for the benefit of their clients. The application of a VMT's skills seems dependent on the individual practitioner's background and other credentials which vary widely, so my impression is that the quality and type of support offered by practitioners is equally varied. I very much enjoyed reading this book, particularly the rich case studies which brought the method to life, and I believe it could be a great resource for any therapist with a desire to deepen their knowledge of the interconnection between the voice and the psyche. Music therapy training courses vary greatly within and between countries in how much time they give to this subject, so any additional inspiration such as this is very welcome!

REFERENCES

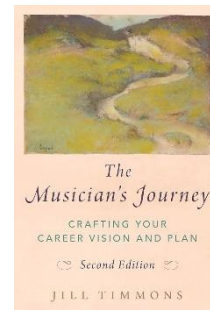
- Austin, D. (2008) *Vocal psychotherapy theory and practice: Songs of the self*. Jessica Kingsley Publishers.
- Brownell, D. (2020) *Re-embodying the Voice: Uniting body and mind through the voice to strengthen the self*. [PhD dissertation, Meridian University].
- Kessler, I. (1997) *Sounding our way to wholeness: Linking the metaphorical and physical voice in a pilot study with women using breath, voice and movement*. [Unpublished dissertation, Union Institute].
- Martin, S., Martin, G., Lequertier, B., Swannell, S., Follent, A., & Choe, F. (2013). Voice movement therapy: Evaluation of a group-based expressive arts therapy for nonsuicidal self-injury in young adults. *Music and Medicine*, 5(1), 31-38.
- Newham, P. (1997). *Therapeutic voicework: Principles and practice for the use of singing as a therapy*. Jessica Kingsley Publishers.
- Van der Kolk, B. (2016). *The body keeps the score*. Penguin Books.
- Warnock, T. (2011). Voice and the self in improvised music therapy. *British Journal of Music Therapy*, 25(2), 32-47.
- Warnock, T. (2019). Voice and the autistic self. In H. Dunn, E. Coombes, E. Maclean, H. Mottram & J. Nugent (Eds.), *Music therapy and autism across the lifespan: A spectrum of approaches*. Jessica Kingsley Publishers.

BOOK REVIEW

The musician's journey: Crafting your career vision and plan (2nd ed.) (Timmons)

Reviewed by Natalie Jack

Independent scholar, Australia



Title: The musician's journey: Crafting your career vision and plan (2nd ed.) **Author:** Jill Timmons **Publication Year:** 2023 **Publisher:** Oxford University Press **Pages:** 232 **ISBN:** 9780197578520

REVIEWER BIOGRAPHY

Natalie Jack is an Australian Registered Music Therapist based in Melbourne. In her over 25 years as a music therapist, she has worked clinically across a variety of adult and paediatric populations in both Australia and Canada, developing an interest in working in forensic mental health. Currently, Natalie runs a private practice providing supervision, professional development and Mental Health First Aid courses to allied health and other professionals. In addition to her music therapy qualification Natalie holds a Diploma of Business, a Diploma of Counselling and a Master of Mental Health. [natalie@nataliejack.com]

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Can a book about using entrepreneurship to create and sustain a career as a music performer and teacher be relevant and useful for music therapists? This is the question I set out to answer when reading *The Musician's Journey: Crafting Your Career Vision and Plan* (2023, 2nd Ed.) by Jill Timmons. Timmons is a renowned performing artist, teacher, author, entrepreneur, and mentor. Born and raised in the USA, she now holds dual citizenship in both America and France (Arts Mentor, 2023).

The Musician's Journey begins with an explanation of who and what musicians are, acknowledging that musicians of all types are fearless and courageous. Timmons emphasises the multifaceted roles musicians often play, including advocacy, finance, marketing, and technology. For music therapists too, this multifaceted approach is particularly relevant. Music therapists often need to wear multiple hats – clinician, business owner, performer, and advocate – requiring a diverse skill set similar to that of entrepreneurial musicians.

The concept of career dissatisfaction is thoroughly explored: a concept Timmons calls “soul loss” (p.11). She describes her own journey to entrepreneurship, transforming her career to support musicians and other artists. This notion of “soul loss” and subsequent reinvention will unfortunately resonate deeply with music therapists, especially those who experience burnout or disenchantment with the profession and might seek to diversify or completely change their careers. Timmons encourages readers to reconsider preconceived notions of a music career, which is crucial for music therapists looking to innovate within their field. Perhaps as a direct counter to the experience of career dissatisfaction, Timmons argues that musicians should embrace entrepreneurship, defining

it as “the ability to create and sustain a viable career in the music industry” (p.19). This entrepreneurial mindset is essential for music therapists striving to build sustainable business and practices. By adopting entrepreneurial strategies as described in this book, music therapists can enhance their professional autonomy and financial stability and ultimately provide superior outcomes for their clients and communities.

A strong focus in *The Musician’s Journey* is on inspiring creativity and confidence in creating a career vision. Timmons draws on science, mental health, and ancient wisdom to guide readers toward their “inner Muse” (p.39). For music therapists, this holistic approach underscores the importance of self-awareness and personal growth, crucial for effective therapeutic practice. Techniques like retreats, therapy, journaling, and mentorship are valuable tools for music therapists to maintain their own well-being and professional development, and these tools can also be incredibly useful when focused on business development and entrepreneurial skills. One specific section, entitled *From Vision to Plan*, is pivotal, bridging a gap between the somewhat intangible ‘vision’ and the more concrete business strategies. Interestingly, Timmons differentiates between a ‘job’ and a ‘career’, noting that sometimes deciding to take a ‘day job’, potentially outside of your chosen profession, is a fantastic strategy for being able to devote time to your actual career – the activities that you are passionate about and that keep you inspired. This advice in effect advocates for a multifaceted and creative approach to entrepreneurship. This is particularly relevant for music therapists who often juggle multiple roles and income streams. Timmons’ advice to embrace various creative and professional pursuits aligns with the diverse career paths many music therapists navigate.

The Musician’s Journey provides robust and detailed business knowledge, including how to build a strong business plan, including mission statements, legal identity, financial plans, marketing, management, and timelines. This practical guidance is invaluable for music therapists establishing private practices or expanding their services. The included business plan checklist can serve as a roadmap for creating a sustainable and impactful business practice. Timmons also dedicates significant space to grant writing, offering insights that, while USA-centric, are adaptable to other contexts and cultures. Music therapists often rely on grants for at least partially funding their business models, making this section particularly beneficial. Similarly, the information on academic roles, though centred on the USA, provides a framework for those in academia globally, offering strategies to secure positions and navigate academic systems.

The topic that particularly speaks to Timmons’ experience discusses integrating entrepreneurial skills into undergraduate music education, a concept that can be adapted to training programs for music therapists. By incorporating these skills early, future therapists can be better prepared for the diverse demands of their careers. Timmons also shares twelve stories of musician-entrepreneurs, illustrating how creativity and entrepreneurship can lead to fulfilling careers. These generous real-life examples can inspire music therapists to explore new directions and innovative practices in their own careers. In future editions of this book, it would be wonderful to see stories of music therapist entrepreneurs included, to complement the stories of other music-based professionals.

The Musician’s Journey offers a wealth of insights and practical advice that music therapists can apply to their careers. From embracing entrepreneurship to building a sustainable practice, Timmons’ guidance is both relevant and inspiring. Music therapists will find the discussions on soul, passion, creativity, self-awareness, business planning, marketing, and finance particularly useful. I highly

recommend this book to any music therapist seeking to enhance their business, career and professional and personal fulfilment.

REFERENCES

Arts Mentor. (2023). Info. <https://artsmentor.com/info>

CONFERENCE REPORT

The 3rd Music Therapy Charity Conference: 'The value of research for music therapy'

Lee Cheng

Anglia Ruskin University, United Kingdom

CONFERENCE DETAILS

The 3rd Music Therapy Charity Conference

'The value of research for music therapy'

17-18 January 2025, Cambridge, UK

AUTHOR BIOGRAPHY

Lee Cheng is currently an Associate Professor at Anglia Ruskin University. His research interests include music, technology, gamification, immersive media, education, therapy and wellbeing. [lee.cheng@aru.ac.uk]

Publication history:

Submitted 19 Jan 2025

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"The value of research for music therapy" was the third Music Therapy Charity (MTC) Conference, held as a hybrid event co-organised by MTC and the Cambridge Institute for Music Therapy Research (CIMTR) at Anglia Ruskin University, Cambridge, United Kingdom. The conference gathered around 100 music therapists, researchers, students, and representatives from charities and non-governmental organisations, who shared insights about evidence-based and best practices in music-based interventions. It fostered new ideas and collaborations among researchers, practitioners, and organisations.



Photograph 1: Keynote speech by Mark Ettenberger



Photograph 2: Keynote speech by Orla McDermott and Bryony Waters-Harvey

The two-day conference featured two keynote speeches, seven paper presentations, and four workshops. The first keynote speech was delivered by Mark Ettenberger, Director of SONO – Centro de Musicoterapia, Colombia. He shared his experiences implementing music therapy in 12 hospitals across Columbia with neonatal, child and adult patients, exploring the intersections, opportunities, and challenges of service development, clinical practice, and research. He emphasised the importance of culture and surrounding environment in hospitals, which play an importance role in the service development of music therapy in clinical contexts. The second keynote speech, presented towards the end of the conference by Orie McDermott and Bryony Waters-Harvey from the University of Nottingham and the University of Sheffield, focused on their experiences in developing and evaluating a manualised music therapy skill-sharing training programme in care homes during the COVID-19 pandemic. They discussed the importance and challenges of skill-sharing in clinical settings, emphasising the need to articulate and enhance staff self-awareness of “attuned” interactions with their residents with dementia. Both keynotes highlighted the importance of critically engaging with evidence-based practice and struck a balance between standardised and personalised approaches, which are important for improving service quality and therapeutic outcomes. These efforts have the potential to better address the needs of the targeted populations, hence enhancing the long-term impact of research.

Seven paper presentation were delivered by recipients of MTC grants, who reported on the progress and outcomes of their funded projects. These presentations emphasised co-production, person-centred approaches, and the value of diverse perspectives in music therapy research. Topics included the role of music therapy in fostering emotional connection, supporting mental health, and addressing the unique needs of underrepresented populations, including children in palliative care, displaced families, and individuals with rare neurological disorders. The presentations collectively highlighted the transformative potential of music therapy as a tool for healing, communication, and social connection. Several studies highlighted the importance of involving service users, caregivers, and practitioners in the research process to ensure meaningful outcomes. Methodological innovations, such as arts-based and mixed-methods approaches, were used to amplify voices often overlooked, such as children and displaced caregivers, and to address gaps in knowledge about music therapy’s impact in varied settings. These approaches enable a more inclusive and holistic understanding of the needs and outcomes of diverse populations in context, particularly those who have been excluded from previous studies. Drawing insights and practices from other disciplines such as arts, philosophy, and cultural heritage, these interdisciplinary approaches help improve the accuracy of music-based interventions and create a more comprehensive picture of their therapeutic benefits.

In addition to the keynotes and presentations, four workshops were led by CMITR staff members, offering practical insights and takeaways for attendees. I attended the workshop by Rebecca Atkinson and Claire Molyneux, who shared their experiences evaluating clinical services, including the skills required to plan, gather, analyse, and report data. The music technology workshop led by Jörg Fachner showcased emerging, existing, and adaptive technologies capable of capturing non-linguistic and physiological data that are not commonly used in conventional approaches. These included tools for measuring audio and musical artefacts, body and eye movements, visual reception, and brain activities. While recent years have seen better acceptance and adoption of technology among music therapists, such technologies have the potential to better support the development of more personalised approaches and upscaling of standardised practices in music-based interventions in an interdisciplinary manner (Agres, Foubert et al., 2021, Agres, Schaefer et al., 2021), a goal that corresponds to the directions mentioned in the keynotes.

A recurring theme throughout the conference was the interconnectedness of service development, clinical practice, and research, as highlighted by Mark Ettenberger in his keynote. This interrelation underscores the importance of collaboration and knowledge exchange to enhance the effectiveness and further the development of music therapy interventions. The conference also emphasised the need for



Photograph 3: Jörg Fachner, Mark Ettenberger, and Clemens Maidhof demonstrating the use of a dry-EEG Headset to measure electrical activity in the brain when playing music

culturally informed and evidence-based practices, innovative methodologies, inclusive approaches, and practice-based research to address the diverse needs of service users effectively.

As an associate professor in the same faculty with some board membership experiences in local and international music organisations, I started to think about how small and local music therapy funding organisations, which rely heavily on donations and charitable activities, can remain sustainable. This reliance can be challenging, particularly during economic downturns, which often lead to reduced donor contributions and increasing competition of limited funds. At the same time, there are concerns over accessibility and diversity in funding opportunities in music therapy research and practice, as pointed out by Tang (2024) in his previous conference report. While challenges and uncertainties remain prevalent, I suggest that MTC could make efforts to enhance the inclusivity of its offerings, such as diversifying its officers and governors, and actively engaging with individuals and organisations that are underrepresented in the current regime of music therapy research. This could include initiatives such as establishing targeted funding schemes and bursaries for underrepresented participants, which help broaden access and promote social justice.

REFERENCES

- Agres, K. A., Foubert, K., & Sridhar, S. (2021). Music therapy during COVID-19: Changes to the practice, use of technology, and what to carry forward in the future. *Frontiers in Psychology*, 12, Article 647790. <https://doi.org/10.3389/fpsyg.2021.647790>
- Agres, K. A., Schaefer, R. S., Volk, A., van Hooren, S., Holzapfel, A., Bella, S. D., Müller, M., de Witte, M., Herremans, D., Melendez, R. R., Neerincx, M., Ruiz, S., Meredith, D., Dimitriadis, T., & Magee, W. L. (2021). Music, computing, and health: A roadmap for the current and future roles of music technology for health care and well-being. *Music & Science*, 4. <https://doi.org/10.1177/2059204321997709>
- Tang, J. (2024). The 2nd Music Therapy Charity conference: "Music therapy in the UK". *Approaches: An Interdisciplinary Journal of Music Therapy*, 16(1), 150–152. <https://doi.org/10.56883/aijmt.2024.49>

CONFERENCE REPORT

The 11th Nordic Music Therapy Conference 'Let's face the music'

Sunny Yat-Cheong Wong

The University of Melbourne, Australia

Napak Pakdeesatitwara

The University of Melbourne, Australia

CONFERENCE DETAILS

The 11th Nordic Music Therapy Conference

'Let's face the music'

26–29 June 2024, Aalborg, Denmark

AUTHOR BIOGRAPHIES

Sunny Yat-Cheong Wong has a dual role as a registered music therapist and an accredited speech therapist based in Hong Kong, who currently works with children and adults in the education, community, and private sectors. He received his master's in music therapy from the University of Melbourne and holds a bachelor's degree in Speech and Hearing Sciences from the University of Hong Kong. Sunny is passionate about supporting individuals with communication, emotional, and social needs through creative means. His PhD research at the University of Melbourne seeks to understand the perceptions and experiences of music therapists and music therapy participants in Hong Kong of therapeutic songwriting in Cantonese. [yatcheongw@student.unimelb.edu.au]

Napak Pakdeesatitwara (Na) is a registered music therapist working in Bangkok, Thailand. His areas of interest include older adults, rehabilitation, mental health, sustainable approach in music therapy, and health tech innovation. His PhD research at the University of Melbourne focuses on empowering sustainable therapeutic engagement with music in people with chronic health conditions. Napak also works as a vice president of the Thai Association of Music Therapy (TAMT). His responsibilities include research, academic, international relations, standards, and ethics. [npakdeesatit@student.unimelb.edu.au]

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The 11th Nordic Music Therapy Conference (NMTC) was held in a hybrid format. The presenters came from across the world to present in person in Aalborg, Denmark, while the audience could join in person or online for selected elements of the programme. The hybrid format allowed people from anywhere in the world to access the rich and diverse perspectives presented at the conference. We, two Asian graduate researchers currently studying at the University of Melbourne, were honoured to participate and present at the NMTC for the first time. Coming from different lands (Hong Kong and Thailand), we were excited to share what we learned from our research and connect with fellow international colleagues.

Attending a conference is a journey that connects us with people and places both while travelling and at the destination. Our journey started from Hong Kong to Bangkok. Then, we flew to Copenhagen and made a transit to Aalborg. Our first impression of Aalborg was "healthiness." The city was clean, the air was fresh, healthy food was easily accessible, and the city was planned in a way that enabled healthy living. Moreover, the city offered us a sense of healthiness and tranquillity (Photo 1). Thus, we found Aalborg a perfect fit to hold this conference and to live healthily throughout the conference period.



Photo 1: Healthiness and tranquillity in Aalborg
(photo by Amy Howden)

Walking across a long promenade of Limfjorden (Photo 2), we arrived at Musikkens Hus (The House of Music), the conference venue. The Viennese architectural studio Coop Himmelb(l)au designed the building. We were impressed by the contrast between the flowy curves in the building and its cubic outer shapes (Photo 3). This place seemed ideal for interactions and knowledge exchange among 291 participants from 28 countries. Soon enough, we were drawn to the lively discussions in the foyer. Some participants expressed excitement about meeting and hearing from each other after the COVID-19 pandemic.



Photo 2: A scene of Limfjorden from the 3rd floor of Musikkens Hus (The House of Music)



Photo 3: PhD graduate researchers from the University of Melbourne in front of Musikkens Hus
(From left to right: Sunny, Amy, Lesley, and Na)

The evening opening ceremony established a sense of invitation, respect, connectedness, and humour, which was maintained during the three-day conference. The theme "Let's Face the Music" provided a powerful platform for music therapists, researchers, and educators to explore the profound role of music as a therapeutic mediator. It all started with the catchy theme song of the conference, "Face the Music Tonight." True to the conference theme, participants were invited to face and engage with the multifaceted nature of music's influence across diverse contexts and populations. For instance, Hanne Mette Ochsner Ridder questioned whether music is an escape from reality or a resource to help us face reality.

The conference arrangement details were participant- and sustainability-oriented. Lunch was offered and consisted of multiple healthy options for people with different diets. Another notable example is the plantable seed name tags that allowed us to plant small flowers and vegetables after the conference. Upon reflection, we realised that the idea of planting and sharing seeds could be a thematic thread to link our experiences and perspectives captured in this conference report.

Throughout the three-day event, presenters and interactive workshops were thematically grouped into therapeutic contexts (e.g. disability, neurorehabilitation, families, mental health), music therapy practice (e.g. assessment, approaches), professional topics (e.g. supervision, training, research) and other broader topics (e.g. music, health and culture, gender diversity). This grouping allowed participants to hear different perspectives within the same topic area. Although we sometimes faced difficulties with the room and equipment, the committed crew members and the warm-hearted audience supported each other. We felt at ease in this warm atmosphere, although being a first-time presenter could be nerve-racking.

In many conferences, poster presentations are often overlooked by attendees, although they hold academic merit and involve efforts no less than oral presentations (Glass, 2020). Some posters are completed research studies and deserve equal respect to other presentation formats. Due to the venue's schedule, the posters' location was changed multiple times (e.g., hallway, basement, foyer). We acknowledged and respected the committee's efforts to overcome logistical challenges. We hope that, in the future, the posters would be held in the foyer for the duration of the conference, allowing extended time to absorb the information and for in-depth discussion between the authors and other attendees. Nonetheless, this conference succeeded in shining light on the poster presentation through a one-minute pitching session in the foyer of Musikkens Hus. The foyer was full of attendees who celebrated each pitch with applause and raised their champagne glasses.

During one of the lunchtime sessions, the committee led workshops that encouraged attendees to actively "face the music" through singing, drumming, instrumental playing, and dancing at different spots in the venue. Deliberately, the committee introduced us to the same folk song in each workshop. We were touched by the celebratory moment where all participants converged all the music-making modalities into a big farewell during the closing ceremony. We are all natural music makers; this integration of diverse musical expressions symbolised the unique, holistic, transformative potential of "facing the music" together.

We found that the idea of "harmony" was prominent and consistently conveyed through academic discussion, presentations, and comedic storytelling (i.e., "the cow story"). Our key takeaway is to set aside any potential arrogance and create dialogues on different music therapy perspectives with others and within our minds. Through conversations with others, we see similarities, differences and resonances, allowing us to grow collectively as a profession. These dialogues and open-mindedness for others' ideas and visions are our first step towards harmony and growth of the profession. Moreover, no single perspective works best for everyone at any time. Through internal dialogues, we might piece together, in our minds, a more holistic reality of the client and the music. In a roundtable (Hakvoort & Gattino, 2024), Davide Woods further reflected that we can also use different perspectives sequentially depending on what fits our client at each moment. Apart from upholding standards and ethics to deliver music therapy to our clients safely, music therapists should strive to understand different theoretical perspectives and understandings that may complement our work. More importantly, some more significant challenges and opportunities require our collective efforts to pursue.

Being a music therapy practitioner, educator, and researcher can be lonely because not many of us are in each workplace, especially in Asia. Coming to this conference, we experienced strong threads of connection that hold music therapists together in person, over great distances, and through time. These threads helped us feel that we are not alone and should be confident in what we do. After the conference, although we were exhausted from the long week, we felt recharged and motivated to finish up our ongoing research. We received the seeds of passion and knowledge from the conference attendees and will plant them in our work. We believe these seeds will flourish in our diverse soils and bear unique fruits for others in the future.

Finally, to reflect on our collective experiences in the conference, we want to respond using lyrics from the Cantonese song *Seed*, sung by Hong Kong singer Jacky Cheung:

May the warmth in our hearts make the seeds of love blossom. Let sincerity and blessings spread throughout this world.

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REFERENCES

- Glass, D. (2020, March 10). *Poster presentations at conferences - are they really worth it?* Sage Perspectives. <https://sagejournals-blog-mmef.squarespace.com/blog/sussex-hive/poster-presentations-at-conferences-are-they-really-worth-it>
- Hakvoort, L. & Gattino, G. (2024, June 26-29). *“What’s music got to do with it?” Facing the role of music among different music therapy approaches* [Conference session]. 11th Nordic Music Therapy Conference, Aalborg, Denmark. www.nmtc24.aau.dk

