

**You Light Up My Life:
A Phenomenological Study of Interpersonal Relationships
between Music Therapists and Adults with Profound
Intellectual and Multiple Disabilities**

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Abstract

This research is an investigation of the lived experiences of music therapists who have established meaningful interpersonal relationships with adult clients with Profound Intellectual and Multiple Disabilities (PIMD). Although music therapists in clinical practice observe the benefits of music therapy for this group of clients, there has only been four research studies conducted since 1990 (Agrotou, 1998; Lee & McFerran, 2012; Oldfield & Adams, 1995; Wigram, 1997). This presents a need to conduct an empirical research study that examines and understands the non-verbal interactions and meaningful interpersonal relationships between music therapists and their adult clients who have PIMD.

This qualitative study was informed by phenomenology whereby five pairs of music therapists-clients were invited to participate. Each music therapist was interviewed and asked to describe his/her experience of building the interpersonal relationship with the client. The study also included a video recording of a single music therapy session of each pair. In the last part of the interview, the music therapist watched the video footage with the researcher and identified a meaningful moment. To analyse the interviews, a descriptive phenomenological microanalysis method (McFerran & Grocke, 2007) was used. The results of the interview analysis then informed a subsequent analysis of video footage. Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) was used for video analysis, which further resulted in the development of a new video microanalysis method, Interpretative Phenomenological Video Analysis (IPVA).

The interview analysis resulted in five distilled essences of individual experiences and a final global essence. The process of establishing interpersonal relationships with an adult with PIMD was described as requiring mutual efforts over time with the context impacting on the quality of relationship. The music therapist's role in improving psychosocial wellbeing of the client was thought to be significant.

The video analysis resulted in five thick descriptions of meaningful moments. A further interpretive analysis was conducted to discover the implicit meanings of each moment to the music therapist, the client, and the pair as were seen and

perceived by their music therapists. The classification of meaningful moments suggested by Amir (1992) were utilised for this process. The results indicate that three clients experienced moments of *joy and ecstasy*, and two clients experienced moments of *completion and accomplishment*. Three music therapists experienced moments of *completion and accomplishment*, and two music therapists experienced moments of *surprise*. On the interpersonal levels, three pairs experienced moments of *physical closeness*, and two pairs experienced moments of *musical intimacy*.

The findings of the current study provide a fresh perspective about the processes of music therapy with adults with PIMD. The types of moments identified also provide insights into the meaningful moments that lead to psychosocial wellbeing in a long term. Moreover, the current study incorporates descriptions of contemporary practice, that challenge some of the assumptions associated with more conventional approaches to practice with adults with PIMD. Based on these findings, the future direction of music therapy with adults with PIMD is discussed. Improving work conditions of music therapists working in community settings is highlighted as important, and Community Music Therapy is proposed as one approach that might actualise the true meaning of social inclusion and meaningful participation in community for adults with PIMD.

Declaration

This is to certify that:

- i. the thesis comprises only my original work towards the degree of Doctor of Philosophy except where indicated in the Preface,
- ii. due acknowledgement has been made in the text to all other material used,
- iii. the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed:

Juyoung Lee

Preface

This thesis includes two published articles and one submitted article that is under review in two chapters:

Paper 1¹ in Chapter 5:

Lee, J. (2014). A phenomenological study of the interpersonal relationships between five music therapists and adults with profound intellectual and multiple disabilities. In D. Keith (Ed.), *Qualitative Inquires in Music Therapy: A Monograph Series* (Vol. 9, pp. 43-86). University Part IL: Barcelona Publishers.

Paper 2² in Chapter 6:

Lee, J., & McFerran, K. (2014). Applying interpretative phenomenological analysis to video data in music therapy. *Qualitative Research in Psychology*.

Paper 3³ in Chapter 6:

Lee, J., Kim, J., & McFerran, K. (Under Review). Meaningful moments with adults with profound intellectual and multiple disabilities in music therapy: An interpretative phenomenological video analysis.

¹ Paper 1 reports the methods and results of interview analysis and was published in July 2014.

² Paper 2 introduces the new video microanalysis method, Interpretive Phenomenological Video Analysis (IPVA). This paper was published in September 2014.

³ Paper 3 reports the methods and results of video analysis and was submitted to a peer-reviewed journal and is still under review.

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Finally, I thank *the participants of the current study*: the five music therapists, their clients, and their mothers. They welcomed me to their private and intimate worlds. This thesis is about them. I am greatly honoured to be the one presenting on their amazing lives. Thank you very much everyone.

Dedication

To the music therapists and adult clients with
Profound Intellectual and Multiple Disabilities
all around the world,
celebrating their meaningful moments.

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“I become through my relation to the Thou;

as I become I,

I say Thou.

All real living is meeting”

(Buber, 1965/2000, p. 2).

CHAPTER 1

INTRODUCTION

This thesis begins with contemplating lyrics of the inspirational song “You light up my life”⁴ (Brooks, 1977). This was the favourite song of one of my client’s, Henna, who has moderate intellectual disability and profound physical disability. Henna said that this song depicts her lonely life and also reminds of her carer Lucy who accompanied her at night by singing songs to her. Let’s appreciate the lyrics in this context:

You light up my life

*So many nights, I sit by my window,
waiting for someone to sing me his song
So many dreams, I kept deep inside of me,
alone in the dark
But now you’ve come along.*

*And you light up my life,
You give me hope to carry on
You light up my days and fill my nights with song.*

For me, this song seems to powerfully describe the phenomenon of this thesis, which is about the meaningful interpersonal relationships between music therapists and adult clients with Profound Intellectual and Multiple Disabilities (PIMD). This song describes how a person who seems hopeless and helpless finds a hope and strength to live on through meeting someone who sings for him/her. For the last three and a half years, I explored the miraculously beautiful moments co-created by five pairs of music therapists and adults with PIMD in music therapy. I now invite you to

⁴ “You Light Up My Life” (Brooks, 1977) is a pop ballade song from the 1970s.

a world full of stories and songs. First, I will share with you my personal experiences that motivated me to conduct this study.

Motivation for the Study

As I reflect my years as a PhD candidate, and then the early days as a music therapy student, I still vividly remember several significant and emotional experiences that impacted my head and heart.

The first experience.

In my first year as a music therapy student, I spent many hours reading case studies of music therapy. One day, I happened to read two articles that describe clinical case studies with adults with severe and profound multiple disabilities (Agrotou, 1994; Ritchie, 1993). Fiona Ritchie and Anthi Agrotou insightfully described individual music therapy over several years. Despite my limited English, I was fully immersed with their stories and was able to understand the depth and richness of the process of music therapy. When the clients first came to music therapy sessions, the client with severe disability displayed self-injurious and destructive behaviours, and the client with profound disability presented extreme passivity and fear of meeting other human being. The process of music therapy with these individuals appeared intensely emotional and physically demanding. Thus, I was just amazed by the music therapists' patience and courage in working with these clients. Toward the end of therapy, when the clients and the music therapists felt deep connection with each other through the non-verbal and musical interactions, and when the clients went out of music therapy sessions to reach out to other people in their communities, my eyes were filled with big tears. I recognised that this is music therapy.

The second experience.

In 2006, I finally became a registered music therapist in Australia and was employed by a not-for-profit disability organisation. The work involved me travelling all over Melbourne, visiting clients in various community based settings, such as clients' private homes, Community Residential Units (CRUs), Adult Day-care Services, neighbourhood houses, and aged care services. I worked with a diverse and broad range of clients including children and adults with developmental, intellectual, physical, multiple disabilities; Autistic Spectrum Disorders; mental illnesses, as well as aged people with dementia. As a passionate new graduate, I immensely enjoyed the dynamic experiences that I was gaining in the community music therapy settings.

In particular, the clinical work with adults with Profound Intellectual and Multiple Disabilities (PIMD) in an Adult Day-care Centre required unexpected patience and caused emotional distress in my early days despite my early readings of the case studies. Because the clients were not able to use any conventional communication tools including speech and sign language, and not familiar with interacting with others, I soon found it extremely challenging. Each and every client presented with a different set of complicated conditions and displayed idiosyncratic demeanours and way of being. Most of all, they did not seem to positively accept me straight away. Instant connection and exciting musicking that often occurring with more functioning clients were not guaranteed with this group of clients. At times, I did not even know whether they were paying attention to me. As a result, I struggled for approximately six months, and during that time I spent most of my time conducting individual or small group sessions to better understand each client.

One day, I experienced a breakthrough. One of my clients, who was easily distressed and often injured herself by hitting or scratching, was sitting on the ground in the front yard of the centre. She was enjoying the sun and being alone. As I approached her, she appeared relaxed, welcoming me, which was unusual. I showed her several song-cards that have different pictures and found one song that might be of interest to her. As I sang Rock around the clock (Freedman & Myers, 1954), an amazing thing happened. She was enjoying the song so much that she was looking at me with a big smile on her face and rocking her upper body vigorously with immense

excitement. As she usually could not tolerate a small room with others or big group sessions, I had not seen her enjoying a song in this way before. Similarly, other clients had not shown this reaction before. Therefore, it was the very first time that I found hope that I could engage and musically interact with the clients in the centre.

After that, I started observing each client's preference for a particular song and presented the song excitedly so that they were motivated to respond to me. Feeling connected with each other through sharing preferred songs was a great way to enjoy each other's company. With time, my relationships with the clients grew. Later, I even conducted a music therapy research project with them to demonstrate the positive improvement of non-verbal communication skills of the clients (Lee & McFerran, 2012). I worked there for six years, and during the last few years, I felt enormous joy and pleasure in working with the clients. For me, it was phenomenal.

The third experience.

One day, while discussing my Masters research study conducted with adults with PIMD, one of my friends recommended me a book, "Annie's Coming Out" (Crossley & McDonald, 1980). The book was about the life of Annie McDonald who was born with profound physical disability in 1961 in Australia. When she was three, she was taken to an institution because of the disability. Although she was intelligent, due to her profound physical disability, people did not notice her intellectual ability and failed to provide her rightful education and therapy. The institution even failed to provide sufficient food, and Annie witnessed many children being starved to death. In the book, Annie wrote⁵ about the experience of institutionalisation thus:

To be imprisoned inside one's own body is dreadful. To be confined in an institution for the profoundly retarded does not crush you in the same way; it

⁵ Although Annie could not speak, she was able to write her opinion by using method of Facilitated Communication, which is "a hands-on training technique which aims to give people the skills they need to use communication aids effectively with their hands" cited from <http://www.annemcdonaldcentre.org.au/facilitated-communication-training>.

just removes all hope. I went to St Nicholas Hospital when I was three. The hospital was the state garbage bin. Very young children were taken into permanent care, regardless of their intelligence. If they were disfigured, distorted, or disturbed then the world should not have to see or acknowledge them. You knew that you had failed to measure up to the standard expected of babies. You were expected to die (Crossley & McDonald, 1980, p. viii).

Until I read this book, I did not know anything about the lives in institutions. Annie's story was shocking and unbelievable.

Luckily, Annie was a survivor. When she was 16 years old, Rosemary Crossley came to the hospital for her student placement, and soon discovered Annie's intelligence. From Rosemary, Annie learnt to read and write, and then together they fought for Annie's right to live in a community. Because many people, including her parents, did not believe in Annie's intelligence, her case had to go to the Victorian Supreme Court. They won the long battle, and when Annie was 18 years old, she was finally discharged from the hospital.

Receiving unconditional care and support from Rosemary, Annie continued her education, finally went to a University and received a Bachelors degree in humanities. With Rosemary, she wrote the book and established Anne McDonald Centre⁶ to help people with disabilities. She also continued writing and presenting to advocate the basic human rights of people with disabilities. In particular, she was passionate for the Right to Communicate of people with severe and profound disabilities. She claimed people should be provided with meaningful means of communication regardless of one's ability to speak. In 2008, she received Australian National Disability Award for Personal Achievement. In her address, she wrote:

If you let other people without speech be helped as I was helped they will say more than I can say.

They will tell you that the humanity we share is not dependent on speech.

They will tell you that the power of literacy lies within us all.

⁶ More information about Annie and Anne McDonald Centre can be found at <http://www.annemcdonaldcentre.org.au/>.

Although Annie died of a heart attack in 2010, she still inspires us with her writings and I am one of them. Reading Annie's writings significantly impacted my view on my clients ever since. I started believing there might be many Annies out there waiting for our help. I started believing the value of non-verbal but meaningful communications with my clients. Most of all, I was motivated to share my music therapy experiences with others to inform and inspire them like Annie did for me.

Statement of the Problem

Although I personally experienced the indispensable value of music therapy on the lives of many people with profound levels of disabilities, music therapy is not yet recognised as an important therapeutic intervention in the field of intellectual disability. Public awareness of the profession of music therapy is low, and professional skills in providing the therapeutic intervention are poorly acknowledged. For example, in most community-based settings where I worked, I was often called "music teacher" or "music girl." The disability support workers were unfamiliar with the term music therapist, and the way I interact with the clients with PIMD. Our music therapy sessions were often called music lessons.

Furthermore, a survey study conducted by Vlaskamp and Nakken (2008) also demonstrates the lack of recognition of music therapy by the service providers in the Netherlands and Belgium, which are the two most advanced countries in providing quality services to people with PIMD. The researchers asked the service providers in disability service centres to identify therapeutic interventions that they frequently provide for adults with PIMD. A total of 16 interventions were identified such as snoezelen, sensory integrative therapy, aromatherapy, and basic stimulation. However, music therapy was not included on the list, which greatly disappointed me.

In order to understand this outcome, I reviewed the literature in the field of music therapy. I soon noticed that in fact, we have not provided enough evidence so far. More research studies were conducted with children with disabilities than adults with disabilities, and adults with mild and moderate disabilities received more attention than adults with severe and profound disabilities in the field of music therapy (McFerran, Lee, Steele, & Bialocerkowski, 2009). Since the 1990s, only two papers described music therapy work with adults with PIMD (Agrotou, 1994; Watson,

2007) and four papers reported research studies (Agrotou, 1998; Lee & McFerran, 2012; Oldfield & Adams, 1995; Wigram, McNaught, Cain, & Weekes, 1997). In relation to this issue, Vlaskamp and Nakken (2008) state:

The lack of ‘evidence-based’ therapeutic interventions for people with PIMD makes services vulnerable: if services are unable to demonstrate the effectiveness of their care, the willingness of those who are responsible for the actual costs (such as health insurers, or local systems providing financial assistance) will decrease or decline (p.339).

Consequently, I recognised a great responsibility to provide more empirical studies with this population.

Aim and Scope of the Study

As a constructivist, I consider “the data of experience as imperative in understanding human behavior and as evidence for scientific investigations” (Moustakas, 1994, p. 21). I also value studies that explore “meanings and essences of experience rather than measurements and explanations” (Moustakas, 1994, p. 21). Therefore, the aim of the current study was to understand meanings and essence of the lived experiences of the five music therapists who had been building interpersonal relationships with adults with Profound Intellectual and Multiple Disabilities (PIMD). Bruscia’s definition of Interpersonal Relationships is used for the current study:

those that exist between one person and another, or among persons in a family or therapy group. These relationships are not within the musical realm. Examples are between: one client’s behavior and another client’s feelings; the client’s behavior and the therapist’s behavior; one client’s tone of voice and another client’s verbal response; the client’s body language and the therapist’s body language (Bruscia, 1998, p. 128).

In this definition, Bruscia highlights the non-verbal and affective interactions that are exchanged through behaviours, tone of voice, and body language between people. As the adult clients with PIMD are non-verbal and affective communicators,

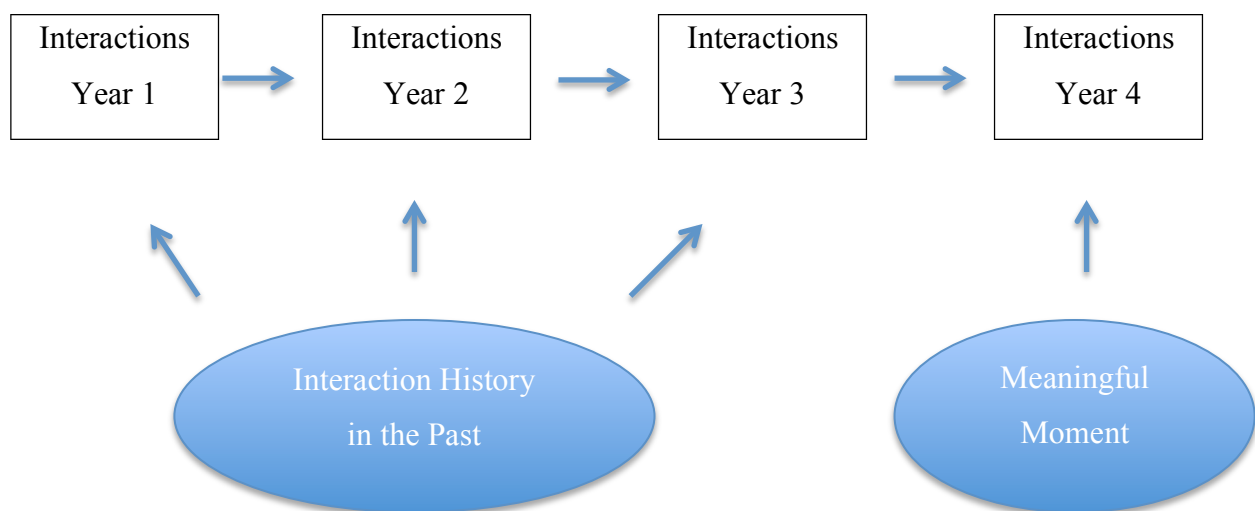
this definition seemed to provide a useful context and perspective for the study. Moreover, as the interpersonal relationships are formed by “a series of interactions leading to a client-therapist relationship rather than a single interpersonal encounter” (Bruscia, 1998, p. 33), the phenomenon of an interpersonal relationship in music therapy could be examined in a time context to understand it as a whole. Daniel Stern (1985), who examined interpersonal relationships of mothers and infants, also considers *the history of interactions* as an important element in understanding this phenomenon. Consequently, each music therapist’s experience of an interpersonal relationship with a client with PIMD over several years was explored in two time points in the current study such as:

- a) the history of interactions from the past to the present
- b) the interactions occurring at the present

Figure 1 shows the two perspectives in time.

Figure 1.

An Interpersonal Relationship in Two Perspectives in Time



In order to investigate interpersonal relationships, I invited authentic pairs of therapist-client who had been practising music therapy over several years. Each music therapist was interviewed and asked to describe the history of interactions with the client. To explore the present moment of their relationships, a single music therapy session was video-recorded at their natural setting prior to the interview. In the last part of the interview, the music therapist watched the session with me and was asked to identify a meaningful moment.

Philosophical and Methodological Approaches to the Study

As I was interested in the lived experiences of music therapists, conducting a qualitative naturalistic investigation that was guided by phenomenology was suitable for the study. In particular, I chose to take an intersubjective philosophical perspective. The notion of intersubjectivity, referring to the shared experience between two subjects, was identified from mother-infant interactions studies, and provided an important context as the interactions between the mother-infant as well as music therapists-clients with PIMD are characterised by non-verbal exchanges. Although phenomenology is about looking at the phenomenon with open, fresh, and wondering eyes, and therefore does not advocate using particular theoretical lens, at the later stage of this study, an interpretative approach was used for video analysis and taking an intersubjective theoretical perspective was useful in interpreting the non-verbal interactions to discover the implicit meanings. Furthermore, relevant theories such as communicative musicality (Malloch & Trevarthen, 2009b) and forms of vitality (Stern, 2010) were useful when the video data invited the theories for the in-depth and critical discovery of meanings.

Methodologically, the current study used both descriptive and interpretative phenomenological approaches. Although using two different approaches in one study generally is not suggested in the field of phenomenology (Finlay, 2014; Giorgi, 2006), the two different types of data required unique approaches. The interviews were analysed first. As music therapists provided in-depth and rich descriptions on their interaction histories, using a descriptive phenomenological analysis method was appropriate to keep the music therapists' voices intact. The video data was analysed next, and the results obtained from the interview analysis helped me in interpreting

the implicit meanings of the idiosyncratic non-verbal behaviours of the adults with PIMD. Consequently, taking an interpretative approach to the video data by using Interpretative Phenomenological Analysis (IPA) was useful, which resulted in development of a new video microanalysis method, Interpretative Phenomenological Video Analysis (IPVA).

Significance of the Study

As I took a qualitative and phenomenological approach to the phenomenon in the current study, it was expected that I would generate rich descriptions of *the interpersonal relationships* and the meaningful moments between the music therapists and adult clients with PIMD in music therapy. Through generating rich descriptions, I also planned to discover implicit meanings and essence of the lived experiences in music therapy.

Subsequently, results and findings of the current study were expected to be significant in providing knowledge and insight into music therapists' subjective experiences of working with adults with PIMD. As literature suggests that working with people with PIMD requires patience and sensitive therapeutic skills to support idiosyncratic needs of each individual (Oldfield & Adams, 1995; Watson, 2007), the findings of the current study were expected to provide in-depth information on music therapists' tacit knowledge and unique perspectives. This study was also expected to reflect on the current status of contemporary practice.

In a similar context, this is the first PhD research study that investigates music therapy practice with adults with PIMD in Australia. Although Australian music therapists have been actively working with this group of people, they had little chance to document their lived experiences. By providing the clinicians with opportunities to raise their voices and offer their perceptions on working with adults with PIMD in Australian context, this study was expected to provide meaningful information to the music therapists as well as parents, disability support workers, and allied health professionals in the fields of intellectual disability. It may also inspire them to improve or alter their views on music therapy and the role of music therapists, and consequently, it provides opportunities for them to recognise the value of music therapy as an important therapeutic intervention for adults with PIMD in the future.

Overview of the Thesis

This thesis is comprised of the seven chapters including the current *Chapter One Introduction*.

Chapter Two, Background and Context for the Study, provides an overview of the disability history and reviews intellectual disability literature concerning people with PIMD. This chapter also provides a theoretical context for the study by discussing the theory of intersubjectivity developed from mother-infant interaction studies. Relevant theories such as communicative musicality and forms of vitality are discussed as well.

Chapter Three, Literature Review, offers an extensive review of music therapy literature concerning people with disabilities, followed by a specific literature review on adults with PIMD. The aim of this chapter is to identify gaps and provide a rationale for the current study, developing research questions.

Chapter Four, Research Design and Methodology, presents the study design and methods used in the current study. The rationale for choosing a qualitative naturalistic study design and phenomenological methodology is discussed. In particular, two different approaches in phenomenology, which are descriptive and interpretative, are discussed in detail in relation to their philosophical origins to provide a rationale for using these two approaches in the data analysis.

The results of the current study are reported in Chapter Five and Six, which include two published articles and one article that is submitted and under review.

Chapter Five, Interview Analysis: Methods and Results, presents the first published paper that reports the methods and results of the interview analysis.

Chapter Six, Video Analysis: Methods and Results, presents the second article, which was accepted and will be published, that introduces the new video microanalysis method IPVA developed from the current study. The second part of the Chapter Six also contains an article that is under review at the time of thesis submission. This article reports the results of the video analysis.

Chapter Seven, Meta-Discussion and Conclusion, finally provides a meta-discussion of the results by comparing the findings of the current study with previous literature. The second part of this chapter provides a discussion of methodology and

methods in detail. Then, the implications of the findings to the fields of music therapy and intellectual disability are discussed. Finally, limitations of the study are identified, and recommendations for the future studies are provided, which is followed by a conclusion for the study.

CHAPTER 2

BACKGROUND AND CONTEXT FOR THE STUDY

The aim of this chapter is to provide a historical background and theoretical context for the study. It is divided into three parts. The first part overviews the history of people with disabilities. Major social changes that affected the way disability was viewed are discussed, and the medical and social models of disability are compared. In the second part, findings of the research studies conducted with people with Profound Intellectual and Multiple Disabilities (PIMD) are discussed to better understand the client participants of the current study. Lastly, the third part provides a theoretical context for viewing the interactions and relationships with adults with PIMD. Theories originating from mother-infant interaction studies such as innate intersubjectivity (Trevarthen, 1979), four senses of self (Stern, 1985), communicative musicality (Malloch & Trevarthen, 2009b), and forms of vitality (Stern, 2010) are discussed.

History of People with Disabilities

For many hundreds of years, people with disabilities have been marked as different, separated and often cast out from society. Those deemed mad, sick, uncontrolled, deaf, blind, mute, leprous, and disfigured have been subject to laws and mores branding them different and a people apart. Subject to apartheid, people with disabilities have been sequestered and controlled in special institutions (Goggin & Newell, 2005, p. 123).

As reflected on the statement above, people with disabilities have been oppressed and discriminated by people without disabilities in our societies for a long time (Barnes, Oliver, & Barton, 2002; Gibilisco, 2010; Goggin & Newell, 2005; Mertens, Sullivan, & Stace, 2011). Goggin and Newell (2005) argue that this is because people were afraid of other people who appear different from them

(apartheid). Gibilisco (2010) claims that the political, economical, and cultural concerns of people with disabilities have made them marginalized from the society. As a result, children born with disabilities were often taken from their parents and locked in paediatric hospitals and institutions. In these environments, they were “denied education, denied employment, and denied meaningful lives” rather than being “loved, cherished, and nurtured in their families and communities” (Mertens et al., 2011, p. 227). In many cases, they were even deprived from basic food and clothes, and their dignity and rights as human beings were ignored. Then, major social events and following changes influenced the way people saw disability.

Disability rights movement in the late 1960s.

The World War I (1914-1918) and World War II (1939-1945) made significant impacts on many people all around the world. Some people lost their loved ones in brutal battles, or other people became war veterans left wounded and impaired both physically and mentally. Families and friends of the war veterans then realised that having disabilities is not only an individual’s problem but also an issue of society. At the same time, the United Nations (UN) was established on 24 October 1945 to prevent another conflict and tragedy like the Second World War and promote international co-operation. After three years, on the 10th of December 1948, the UN proclaimed “The Universal Declaration of Human Rights”. A total of 30 articles were claimed, and the first two articles highlight the rights, freedoms, and equality of every human being regardless of conditions they are born in such as:

- Article 1: All human beings are born free and equal in dignity and rights.
- Article 2: Everyone is entitled to all the rights and freedoms set forth in this Declaration without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

This declaration ignited various types of rights movements, and the Disability Rights Movement began on “both sides of the Atlantic in the late 1960s” (Mertens et al., 2011, p. 227). Because of the efforts by many people who recognised the real

sufferings of people with disabilities, “the basic humanity of ‘the disabled’ began to be recognised and they became either ‘disabled people’ or ‘people with disability’” (Mertens et al., 2011, p. 227).

Later in 1976, a group of people called the Union of Physically Impaired Against Segregation (1976) published “Fundamental Principles of Disability” booklet in the United Kingdom (UK), which later facilitated the emergence of British social model of disability (Shakespeare & Watson, 2002; Thomas, 2002). Influenced by these movements, the UK government started publishing booklets that provide guidelines and information of the disability policy. The green paper *Care in the Community* (UK Department of Health, 1981) and the white paper *Valuing People* (UK Department of Health, 2001) and *Valuing People Now* (UK Department of Health, 2009) were published. In Australia, the Disability Rights Movement was started from 1970s and recently, in 2011, a group of researchers have published a booklet, “Disability Expectations: Investing in a Better Life, a Stronger Australia” (PwC, 2011), to provide guidance and direction for the future.

Deinstitutionalisation movement in the 1970s.

Originally suggested by Scandinavia in the 1960s, the notion of normalisation questioned the quality of life of people who were institutionalised. Goggin and Newell (2005) further explain the development of this movement:

The aim of this disparate movement was to give back to people with disabilities their control and freedom. In the early 1970s, ‘normalisation’ was reconceptualised by Wolfensberger, who argued for the adoption of a new term, ‘social role valorisation (SRV)’. SRV was taken up in an almost religious fashion in Australia and elsewhere. Governments engaged with these movements quickly learned not only that it was possible to provide an alternative to institutional walls smeared with excrement, but that in a variety of circumstances they might be actually cheaper. Deinstitutionalisation of people with disabilities was embraced not just for reasons of justice but also because it dovetailed with the rise of policy discourses framed by neoclassical economics (p.128).

Consequently, the movement facilitated a relocation of people, who were institutionalised because of their physical and mental illnesses, into small Community Residential Units to live normally in a community around the most Western countries such as the UK and US.

In Australia, although the movement of deinstitutionalisation started in the 1970s, the actual implementation of relocating people took some time. In the state of Victoria, the first purpose built institution by the Victorian Government, which was built as the Idiot Ward in 1887 and later known as Kew Cottage House, was finally closed in 2008. The history of over 121 years of Kew Cottage House has been published as a book, “Bye-bye Charlie: Stories from the Vanishing World of Kew Cottages” by Manning (2008). This book also describes the process of deinstitutionalisation in detail quoting the descriptions given by the staff, residents, and their families. If the Disability Right Movements in the 1960s changed the way people view disabilities, this movement of deinstitutionalisation has made practical changes in the lives of people with disabilities.

Emergence of the social model in the 1980s.

According to Shakespeare and Watson (2002), the social model of disability was “developed in the 1970s by activists in the Union of the Physically Impaired Against Segregation (UPIAS), it was given academic credibility via the work of Vic Finkelstein (1980, 1981), Colin Barnes (1991) and particularly Mike Oliver (1990, 1996)” (p.10). Oliver (1990, p. 3) also acknowledges that “the idea of the individual and the social model was taken quite simply and explicitly from the distinction originally made between impairment and disability by the Union of the Physically Impaired Against Segregation (1976).” Consequently, the British social model was formed and critically influenced on the disability policies and practices all over the world. The social model can be appreciated from differentiating it from the medical model in terms of the philosophical view on disability; focus and model of care; place for care and its impact on people with disabilities. Table 1 compares the contrasting notions and practices of the medical and social models.

Table 1

Comparison between the Medical and Social Model of Disability

	Medical Model	Social Model
View on disability	What people have is disability	What people have is Impairment
Responsibility of care	Individual's problems to seek medical treatments	Part of human condition that is the responsibility of the society
Model of care	Experts model	Partnership model
Focus of care	Pathology driven	Person driven
Place for care	Institutionalisation	Deinstitutionalisation
Impact on the people	Social exclusion from the community	Care in the community

First, the fundamental view on disability is different. Gibilisco (2010) explains it such as:

the medical model of disability sees a disability as a diagnosable set of symptoms which either have to be alleviated or might entail the isolation of the person from wider society. The social model of disability views the physical or mental impairment as being a social construction, and believes the attitudes and prejudices about it are compounded by a lack of accessible and socially rewarding information, and by a lack of appropriate institutional arrangements (p.67).

Accordingly, people who support the medical model believe that a pathology driven care should be provided by the experts in institutions. In contrast, the people who support the social model consider a person “with impairments in a context, a society” (Gibilisco, 2010, p. 69). Accordingly, they believe that a person driven care should be provided by a group of carers forming a partnership model in their context in society. These two contrasting philosophies of care produce different results, either social exclusion from or inclusion of the community. Consequently, in the

contemporary practice, along with the deinstitutionalisation movement, the social model of disability has become an ideal approach to follow.

The convention on the rights of persons with disabilities.

In 2006, UN reaffirmed the rights of people with disabilities as full and equal citizens of the world by declaring “the Convention of the Rights of Persons with Disabilities” (United Nations, 2006). Article 1 states the purpose of this declaration:

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity (United Nations, 2006, p. 4).

Ever since, this convention has affected many people including the world’s political leaders, service providers, and academics in the field of disability. For example, according to Gibilisco (2010), US President Barack Obama provided “a comprehensive agenda to empower people with disabilities in order to equalize opportunities (White House, 2009) aligned to the UN Convention on the Rights of Persons with Disabilities” (p. 70). Providing supports and resources on four areas are promoted in this agenda such as:

- (a) providing educational opportunities;
- (b) providing funding to pragmatically end discrimination and promote equal opportunity;
- (c) increasing the employment rate;
- (d) supporting independent, community-based living by enforcing the Community Choice Act (White House, 2009:1 as cited in Gibilisco, 2010).

This example shows the impact of this convention on the disability policy. Likewise, the convention has an academic importance as well. It played a significant role in the recent international conference, “the 4th IASSIDD Europe conference”, organised by International Association of Scientific Study of Intellectual and Developmental

Disability (IASSIDD), in the University of Vienna, in July 2014. Theme of this conference was “pathways to inclusion” and participants were encouraged to detect areas for future research with respect to an evidence-based promotion on those rights as expressed in the Convention on the Rights of People with Disabilities. Apparently, the impact of this convention on the lives of people with disabilities will continue in the future.

The world report on disability.

In a similar context, commissioned by UN, the World Health Organization (2011) jointly with the World Bank Group “documents the current situations for people with disability, highlights gaps in knowledge, and stresses the need for further research and policy development” (p. 23). Lead by the foreword written by Professor Stephen W Hawking, the report begins with reminding people of the importance of changing views on disability such as:

disability is part of the human condition – almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. Disability is complex, and the interventions to overcome the disadvantages associated with disability are multiple and systematic – varying with the context (p.3).

Accordingly, “running throughout the report is a central theme; that disability is fundamentally an issue of human rights” (Emerson, 2012, p. 495). The main part of the report discusses the disabling barriers for ensuring the human rights of people such as inadequate policies and standards; negative attitude; lack of provision of service; problems with service delivery; inadequate funding; lack of accessibility; lack of consultation and involvement; lack of data and evidence. After discussing the impact of these disabling barriers on the lives of people with disabilities, the report consequently provides nine recommendations “for action at national and international levels that will promote the well-being, dignity, social inclusion and human rights of people with disabilities around the globe” (Emerson, 2012, p. 495) such as:

- 1) Enable access to all mainstream systems and services
- 2) Invest in specific programmes and services for people with disabilities
- 3) Adopt a national disability strategy and plan of action
- 4) Involve people with disabilities
- 5) Improve human resource capacity
- 6) Provide adequate funding and improve affordability
- 7) Increase public awareness and understanding
- 8) Improve disability data collection
- 9) Strengthen and support research on disability.

In particular, the recommendation two and nine appear relevant to music therapy profession. To be recognised and invested as an effective therapeutic intervention, providing the evidence of effectiveness on the people with disabilities seems essential in the future. On the other hand, the initial cost for producing the evidence through research projects should be funded according to the recommendation six and nine. Most importantly, in relation to the recommendation seven, attitudinal changes toward the people with disabilities, particularly those with severe and profound disabilities, will bring the most fundamental change in the future as Officer and Shakespeare (2013) claim:

The slogan for the World Report on Disability was “Disabling barriers—break to include,” and this should promote an awareness that the key to ensuring the well-being of all people with disabilities is to remove the negative attitudes and lack of access and failures of provision that currently leave so many millions of people on the margins (p.88).

In summary, the historical background of disability was provided to provide a context for the current study. The following section now reviews the literature concerned with people with PIMD in the field of intellectual and developmental disability.

People with Profound Intellectual and Multiple Disabilities (PIMD) Now

As mentioned previously, people with PIMD have received little attention in many areas in society including academic fields. Evidently, more research studies have been conducted with people with mild and moderate disabilities than severe and profound disabilities; children with severe and profound disabilities than adults with severe and profound disabilities. Some expressions such as *an ignored minority* (Samuel & Pritchard, 2001), *invisible citizens* (Carnaby & Pawlyn, 2009), and *forgotten citizens* (Chen, 2008; Fornefeld, 2008) indicate the social position that people with PIMD hold in our society. In order to advocate their own rights, PMLD (Profound and Multiple Learning Disability) network consisted of advocates of people with PIMD was formed in 2003. Special Interest Research Group on Persons with Profound Intellectual and Multiple Disabilities (SIRG-PIMD)⁷ was also established in 1999 (Nakken & Vlaskamp, 2002). Since then, more research was conducted with people with PIMD on various topics for people with PIMD. Communication; interactions; preference and choice; quality of life are the most researched topic with this group of clients.

Furthermore, commissioned by UK government and Mencap, which is a UK charity organisation for people with learning disabilities, specific booklets that provide information and insights by reviewing relevant researches were published, such as:

- “Valuing People with Profound and Multiple Learning Disabilities (PMLD)” (PMLD Network, 2003);
- “People with Profound and Multiple Learning Disabilities: A Review of Research about Their Lives” (Carnaby, 2004);
- “Raising Our Sights: Services for Adults with Profound Intellectual and Multiple Disabilities” (Mansell, 2010).

⁷ This special interest group belongs to the International Association of Scientific Studies of Intellectual and Developmental Disabilities (IASSIDD).

In Australia, the booklet, “Disability Expectations: Investing in a Better Life, a Stronger Australia” (PwC, 2011), also reflects the recent development. Although this booklet is not specifically written about people with PIMD, it includes information on people with severe and profound intellectual disabilities in detail. The following section overviews the findings of the research studies on adults with PIMD for the current study. Various terminologies and definitions of PIMD as well as the numbers and support needs of people with PIMD are discussed, followed by the discussion of communication, interaction, quality of life, and interventions for people with PIMD.

Terminologies.

In 2007, Nakken and Vlaskamp investigated various terms used in the 12th World Congress of IASSID (International Association of Scientific Studies of Intellectual Disabilities) in 2004. 41 presentations and posters were examined, and a total of 10 different terms and abbreviations were identified such as:

- 1) Profound multiple disabilities: PMD
- 2) Profound and multiple disabilities: P(a)MD
- 3) Profound intellectual and multiple disabilities: PI(a)MD
- 4) Profound intellectual multiple disabilities: PIMD
- 5) Profound and complex disabilities: PCD
- 6) Severe intellectual and motor disabilities: SIMD
- 7) Severe and profound intellectual disabilities: SPID
- 8) Severe multiple disabilities: SMD
- 9) Complex intellectual and sensory disabilities: CISD
- 10) Children with complex needs: CCN
- 11) Intellectual disabilities: ID

According to Carnaby (2004), two words, which are “profound” and “multiple”, are important when referring to this group of people. This is because these two terms indicate the severity and complexity of the disabilities. In order to

provide better services, a unified term is crucial. Accordingly, in 2008, SIRG-PIMD⁸ in Intellectual Association of Scientific Studies of Intellectual and Developmental Disabilities (IASSIDD) chose the term “Profound Intellectual and Multiple Disabilities (PIMD)” as “the most appropriate way of describing a heterogeneous group of individuals” (Pawlyn & Carnaby, 2009, p. 8). Although many people continue to use other terms such as PMLD (Profound Multiple Learning Disabilities), in recent documents, the British government and some academics have changed the use of term from PMLD to PIMD in their important documents (Mansell, 2010; UK Department of Health, 2011). Like the term ‘mental retardation’ has been changed to ‘intellectual disability’ in the US (Schalock et al., 2007), the use of unified term PIMD seems to increase in the future.

Definitions.

As many as the various terms, definitions of PIMD have been diverse. In particular, in relation to the intellectual abilities of people with PIMD, key health organisations and academics suggest different views (Pawlyn & Carnaby, 2009, p. 6) such as:

- World Health Organization (1993): equates profound intellectual disability with an Intelligence Quotient (IQ) of below 30;
- American Psychiatric Association (2000): equates profound intellectual disability with an IQ ranging between 20 and 25;
- Ware (1996): people with PIMD are functioning at a developmental level of 2 years of less;
- World Health Organization (1996): people with PIMD are functioning at a level of below 3 years developmentally.

In order to suggest a unified definition of PIMD, in 2002, SIRG-PIMD of IASSIDD provided a working definition of PIMD: “individuals with profound cognitive disabilities (IQ<20), profound neuromotor dysfunctions (such as spastic

⁸ Abbreviation of Special Interest Research Group on Persons with Profound Intellectual and Multiple Disabilities

quadriplegia), and often sensory impairments and medical problems (such as seizures, respiratory problems and/or feeding problems)” (Nakken & Vlaskamp, 2002). This definition has been important in the literature.

However, this definition focuses on the description of the intellectual and physical, and medical impairments without “stressing the service needs of individuals” (Bellamy, Croot, Bush, Berry, & Smith, 2010, p. 223) which is useful for service providers. As a result, a group of researchers (Bellamy et al., 2010) in UK developed a new definition. At first, they interviewed 23 health care professionals, service managers, and carers of people with PIMD to choose the most appropriate definition among ten different definitions used by different organisations and academics. The definition suggested by Samuel and Pritchard (2001) was most selected:

Children and adults with profound learning disability have extremely delayed intellectual and social functioning with little or no apparent understanding of verbal language and little or no symbolic interaction with objects. They possess little or no ability to care for themselves. There is nearly always an associated medical factor such as neurological problems, physical dysfunction or pervasive developmental delay. In highly structured environments, with constant support and supervision and an individualized relationship with a carer, people with profound learning disabilities have the chance to engage in their world and to achieve their optimum potential (which might even mean progress out of this classification as development proceeds). However, without structure and appropriate one-to-one support such progress is unlikely (p.39).

Improving upon this definition, a new definition was suggested.

People with profound and multiple learning disability (PMLD):

- extremely delayed intellectual and social functioning
- limited ability to engage verbally, but respond to cues within their environment (e.g. familiar voice, touch, gestures)

- often require those who are familiar with them to interpret their communication intent
- frequently have an associated medical condition which may include neurological problems, and physical or sensory impairments.

They have the chance to engage and to achieve their optimum potential in a highly structured environment with constant support and an individualized relationship with a carer (Bellamy et al., 2010, p. 233).

Although this definition uses the term PLMD, it provides a comprehensive perspective on the limited abilities as well as the specific needs of people with PIMD. In particular, the emphasis on the needs of a *highly structure environment* and *individualized relationships* is highly relevant to what music therapy offers. Accordingly, this definition is the most appropriate for the current study.

Numbers.

Pawlyn and Carnaby (2009) identified two different figures for the number of people with PIMD. American Psychiatric Association (2000) reported that people with PIMD form 1-2% of the entire population with Intellectual Disabilities (ID). In contrast, Cooper et al. (2007) identified 18% of people with ID as having PIMD. The two different figures might be explained by the fact that they used different inclusion criterion for the people with PIMD. Perhaps also these two figures might have reflected the increased numbers of people with PIMD between 2000 and 2007. More recently, Mansell (2010) reported that:

the number of adults with PIMD is estimated to increase by on average 1.8% each year to 2026, when the total number would be just over 22,000 people. In an ‘average’ area in England with a population of 250,000 the researchers suggest this would mean that the number of adults with profound intellectual and multiple disabilities will rise from 78 in 2009 to 105 in 2026, and that the number of young people with profound intellectual and multiple disabilities becoming adults in any given year will rise from 3 in 2009 to 5 in 2026 (p.3).

Therefore, in fact, the number of people with PIMD is increasing every year.

Similarly, this increase is also reported in Australia (PwC, 2011):

In 2009, approximately 1.3 million Australians had a severe/profound core activity limitation. These 1.3 million people (and other people with a disability) were supported by approximately 772,000 (calculated on an FTE basis) informal carers. In 2099, it is estimated that approximately 4 million people will have a severe/profound core activity limitation in Australia – more than triple the current number. However, the Australian population is estimated only to double over this same time period; hence, it is likely that the same amount of informal care will not be available in the future to support people with disabilities. The formal workforce will need to grow significantly to meet this increasing demand (p. 9).

According to Nakken and Vlaskamp (2007), it is “a result of advanced medical care, efforts of parents, and availability of varied facilities for education and living” (p.83), that now more children with severe and profound disabilities survive into adulthoods. Beside, the world report on disability (World Health Organization, 2011) reports that even people without disabilities now live longer with severe and profound disabilities as a result of ageing. Consequently, as mentioned above, this increase in numbers requires significant needs for specific and comprehensive supports for people with PIMD in the future (Bellamy et al., 2010; Mansell, 2010; Parrott, Tilley, & Wolstenholme, 2008).

Support needs.

Several academics have reviewed literature and described the complex support needs of people with PIMD (Carnaby, 2004; Mansell, 2010; Petry & Maes, 2007).

Commissioned by Mencap⁹, Carnaby (2004) provided a review of research about the

⁹ Mencap is the abbreviation of **M**entally **H**andicapped and the leading learning disability charity in UK.

lives of people with PIMD. A total of 11 themes of support needs are discussed, and suggestions for each theme were provided for future research. The themes include: quality of life; choice and decision-making; communication; therapeutic interventions; sensory needs; staff training and staffing issues; parent and carer issues; mental health and well being; challenging behaviour; physical health; personal relationships and sexuality. With regard to provision of therapeutic interventions, Carnaby (2004) recommended to “establish reliable evidence-based data about meeting people’s needs” (p. 28). This need for evidence-based practice has been echoed by other academics particularly to demonstrate the effect of therapeutic interventions (Officer & Shakespeare, 2013; Vlaskamp & Nakken, 2008).

Similarly, Petry and Maes (2007) conducted an overview of literature to describe the support needs of people with PIMD. This review was conducted based on the manual, “Mental Retardation: Definition, Classification, and Systems of Supports,” provided by American Association on Mental Retardation (AAMR)¹⁰ in 2002. Five basic dimensions suggested by 2002 AAMR manual were re-examined to identify specific needs of people with PIMD. The five dimensions are intellectual disability; adaptive behaviours; participation, interaction, and social roles; health; and context. Before discussing each dimension further, table 2 provides the definitions as suggested by Petry and Maes (2007).

¹⁰ Now the association has changed its name to “American Association on Intellectual and Developmental Disabilities (AAIDD)”, and the manual also has revised the term, “mental retardation” into “intellectual disability” (Schalock et al., 2007).

Table 2.

The Five Dimensions of 2000 AAMR System and Definitions

Five dimensions	Definitions
Intellectual abilities	A general mental ability that includes reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, learning quickly, and learning from experience (Luckasson et al., 2002, p. 51).
Adaptive behaviour	The collection of conceptual, social and practical adaptive skills that have been learned by people in order to function in their everyday lives (Luckasson et al., 2002, p. 73).
Participation, interaction, and social roles	Participation and interaction: are determined by directly observing one's engagement in everyday activities and asking whether the individual is actively engaged with his or her environment. Social roles: a set of valued activities normal for a specific age group (Petry & Maes, 2007, p. 131).
Health	A state of complete physical, mental and social well-being and the way in which it influences functioning (Petry & Maes, 2007, p. 132).
Context	The interrelated conditions within which people live their everyday lives and includes the immediate social setting, including the person, family, and/or advocates; the neighbourhood, community, or organization providing education or habilitation services or supports; and the overarching patterns of culture, society, larger populations, country, or socio-political influences (Schalock & Luckasson, 2004).

Intellectual abilities.

As the IQ of people with PIMD is generally believed to be under 20 to 25 or their mental age is below 24 months, Piaget's theories on the knowledge development of infants through understanding *object permanence, imitation, operational causality, object relations in space, and cognitive schemes* are relevant to the intellectual abilities of people with PIMD. Another crucial element is that people with PIMD can learn through *habituation*:

the effect of repeatedly presenting a stimulus. By means of associative learning, people learn to see the association between two stimuli or situations on the basis of repeated experiences, routines, and rituals in daily living conditions. This insight enables them to predict events and to anticipate them (Petry & Maes, 2007, p. 132).

Adaptive behaviour.

Improving *social adaptation skills* is considered important for people with PIMD, which include:

- (a) *conceptual and communicative skills*;
- (b) *social and emotional skills*;
- (c) *practical skills*¹¹.

Conceptual and communicative skills refer to the skills of “demanding something, indicating yes or no, making eye-contact and listening to stories” (Petry & Maes, 2007, p. 133); *social and emotional skills* are “such as expressing and understanding emotions, taking turns, playing together, learning rules, making choices, taking initiative and task orientation” (Petry & Maes, 2007, p. 133). For people with PIMD

¹¹ “such as toilet-training, eating, drinking, and getting dressed” (Petry & Maes, 2007, p. 133).

to learn and develop these skills, maintaining adequate levels of alertness, attention, and motivation to participate are important. Moreover, adequately organising the environment, breaking up skills into small steps, and gradually presenting each step were recommended as well. Most of all, as highlighted in the new definition of PIMD suggested by Bellamy et al. (2010), these efforts are only fruitful when direct support staff form intensive individualised relationship with the person with PIMD.

Participation, interaction, and social roles.

Although literature shows lack of activities and programs that are specifically designed for this population (Maes, Lambrechts, Hostyn, & Petry, 2007; Vlaskamp & Nakken, 2008), providing people with PIMD with “a variety of activities geared to their abilities and limitations and to their interests and preferences” (Petry & Maes, 2007, p. 134) is crucial to promote social inclusion, and support emotional and psychological well-being. When designing activities and programs, considering sensory perception and perception of movement as well as developing sufficiently stimulating and challenging activities are considered important. In this way, they obtain certain knowledge and insights, and expand their options for action. Evaluating an individual’s preference repeatedly over time and offering opportunities to make choices are also recommended. Furthermore, participating in activities can be “a way of building up contacts with support staff and group members” (Petry & Maes, 2007, p. 134).

Health.

The support needs for health can be examined in three areas: *sensory motor functions; physical health; mental health status*. First, people with PIMD often have severe impairments and limitations in sensory motor functions, which result in inability to sit, stand or move without assistance. Accordingly, helping them stay in a good posture, frequently adjusting the posture for them to be comfortable, and maximising their control over their movement are important. In relation to physical health, a variety of issues relating to the digestive system or urinary tract system as well as

epilepsy influence the people with PIMD. These health issues may cause pain and distress, require the people to take medications, which often cause some side effects such as reduced “alertness or habituation and resistance” (Petry & Maes, 2007, p. 136).

In terms of mental health of people with PIMD, although contrasting results have been reported on the prevalence of mental illness in people with intellectual disability, a recent review conducted by Carnaby (2009) concludes that “both the incidence and prevalence of mental illness in people with profound intellectual disabilities is higher than that observed in both the general population and the population of people with intellectual disabilities” (p. 117). The risk factors of mental illness are found to be changes and events in life, which are similar to general public, and individual’s ability to cope with the changes is considered important in maintaining good mental health. However, because of the multiple impairments, disabilities, and the environmental factors they are in, people with PIMD are considered much more vulnerable than general public. Depression, anxiety, and challenging behaviours can be a sign of poor mental health and they may show “increased dependence, psychomotor agitation, irritability, stereotypies, screaming and a worsening of existing behavioural problems such as self-injurious behaviour and temper tantrums” (Carnaby, 2009, p. 119). Therefore, close observation of the affect and mood change is required to monitor mental health status of people with PIMD.

Context.

As people with PIMD need “other people who have an eye for the subtle way they express their needs and wishes and who are able and willing to respond to these needs and wishes” (Petry & Maes, 2007, p. 136), creating a context in *a relational support perspective* is considered important. Establishing a safe attachment with disability support workers is considered important. Moreover, to build the attachment, a support staff’s appropriate attitudes and relational skills are important. Furthermore, as supporting an individual with PIMD involves many people, “a shared responsibility and a full partnership” (Petry & Maes, 2007, p. 137) with each other and open communication and cooperation between parents and professionals, and

between professionals are beneficial for creating maximum environments for people with PIMD.

The specific support needs described by Petry and Maes (2007) provides a comprehensive knowledge and insights for the types of care that people with PIMD require. In particular, the support needs described for the dimension of *participation, interaction, and social roles* could be supported by music therapy interventions. Understanding the level and way people with PIMD process information and learn and develop is also important in designing a specific activity or program. Most of all, establishing a relational support perspective seems beneficial for the clients' general well-being, which is also highlighted and recommended by other researchers (Carnaby, 2004; Mansell, 2010).

Communication with people with PIMD.

People with PIMD are pre-verbal communicators who express pre or proto symbolic communication such as facial expressions, movements, sounds, posture, and muscle tension (Grove, Bunning, Porter, & Olsson, 1999; Hostyn & Maes, 2009; Porter, Ouvry, Morgan, & Downs, 2001). Due to their individual differences, their communication is characterised as idiosyncratic and context-bound (Maes et al., 2007). Accordingly, the role of communication partner who understands each person's unique non-verbal communication behaviours and promotes meaningful communications is important for positive interactions. A number of studies have identified particular strategies used by the communication partners to promote communication with individuals with PIMD such as:

- offering objects and physical help (Olsson, 2004);
- talking, showing, confirming, and reinforcing (Wilder & Granlund, 2003);
- ascribing meaning about a person's behaviour and negotiating the meaning (Forster & Iacono, 2008; Olsson, 2004);
- touching as preferred non-verbal strategies (Forster & Iacono, 2008);

- asking for participation (Olsson, 2004) and monitoring interaction of the person with PIMD (Wilder & Granlund, 2003);
- verbalising questions, comments and opinion (Healey & Noonan, 2007);
- looking attentive and adjusting body posture (Healey & Noonan, 2007).

The importance of coming to know the individual by spending time together has been stressed (Forster & Iacono, 2008; Healey & Noonan, 2007). Moreover, the way in which disability support workers perceive their role may influence the ways in which they interact with people with PIMD as well (Forster & Iacono, 2008). Furthermore, Petry and Maes (2007) explains the process of facilitating meaningful interactions as following:

At first, many of the person's signals have no conscious meaning but support staff attach meaning to them by over interpretation. Through shared attention towards objects and familiar rituals, both partners in communication build up shared meanings to which they may refer afterwards. As such, the person's communicative behavior becomes more direct and goal-oriented and the person gets the opportunity to comment on actions and objects (proto declaratives) or to ask something (proto imperatives). Reciprocity is encouraged by taking turns and by immediate or delayed imitation (p.134).

Consequently, when a communication partner with an appropriate attitude and skill creates meanings related to the non-verbal behaviours on a regular basis, meaningful communications could be facilitated.

Interactions with people with PIMD.

In order to examine the characteristics of the successful interactions between individuals with PIMD and their caregivers, Hostyn and Maes (2009) reviewed 15 studies conducted between 1990 and 2008. As a result of qualitative data analysis, applying three steps of narrative synthesis, the four key elements that were frequently observed in the positive interaction processes such as sensitive responsiveness, joint attention, co-regulation, and emotional component.

Sensitive responsiveness.

Sensitive responsiveness refers to “the way partners perceive each other’s signals accurately and correspondingly and respond to each other” (Hostyn & Maes, 2009, p. 304), which is considered an essential element for a successful interaction (Clegg, Standen, & Cromby, 1991; Forster & Iacono, 2008; Healey & Noonan, 2007; Schepis & Reid, 1995; Wilder, Alxelsson, & Granlund, 2004; Wilder & Granlund, 2003). For example, Clegg et al. (1991) observed interactions between 20 staff-client pairs in various situations. When the staff and clients were sensitively responded to each other, more meaningful and positive responses were created. Similarly, Wilder and Granlund (2003) interviewed seven parents about their perspective on their role in the interaction situations with their children with PIMD. The parents described their role as a sensitive and responsive carer to the child’s needs, and claimed that this sensitivity is important when interacting with these children.

Joint attention.

Joint attention is defined as “the sharing of a focus of attention (eg. object, topic) between two partners” (Hostyn & Maes, 2009, p. 305), and reported as crucial in successful interactions. Congruence in the behaviours of both partners is considered to indicate joint attention in some reviewed studies (Olsson, 2004; Tucker & Kretschmer, 1999; Wilder & Granlund, 2003). However, the clients who showed good ability to share joint attention were usually better functioning clients who have Severe Intellectual and Multiple Disabilities (SIMD). For people with PIMD, sharing the joint attention is generally challenging. The study by Wilder et al. (2004) appears to provide a better picture on this topic as this study compares 91 parents’ perception of their children’s interpersonal interactions. The parents consisted of three different groups:

- Group 1: 30 families with children with PIMD, aged between 2 and 10 years old;

- Group 2: 31 families with healthy infants of 4-16 months of age;
- Group 3: 30 families with children without PIMD, aged between 2 and 10 years.

A telephone interview was conducted with each parent. The 91 parents were asked about the communication abilities and interaction styles of their children. Results indicate that all children, including group 1, display a variety of emotions: curiosity, joy, expectation, anger, fear, irritation, interest, sadness, disgust, approach, avoidance, anxiety, calmness, and excitement. However, the children in the group 1 show more difficulty in expressing complex emotions, such as curiosity and interest than the children in the group 2 and 3. Second, the communication abilities of the group 1 and group 2 match with each other as the children and infants in these two groups have similar developmental age ranges. However, the infants in the group 2 show better attention span and joint attention abilities than the children with PIMD in the group 1. As a result of this short attention span and the lack of joint attention, it is reported that children with PIMD have difficulties in initiating and maintaining interaction and communication.

Co-regulation.

Co-regulation, as represented by *mutuality, reciprocity and turn-taking* (Hostyn & Maes, 2009), is described as matching to each other's behaviours, and altering behaviours based on what is observed. For instance, the study by Wilder and Granlund (2003) conducted home-visit interviews with seven parents with children with PIMD, and analysed parent-child interactions video-taped. Although the parent-child pairs displayed different styles and characteristics in their interactions, the characteristics of successful interactions reported by the parents were similar. In the video analysis, the consistent efforts of the caregivers to optimise the interaction between the parties in the dyad were observed. Mutuality was described as critical to successful interaction and mutual turn-taking responsiveness was mentioned by parents (Wilder & Granlund, 2003).

Emotional component.

Two interview studies demonstrate the importance of sharing positive emotions in the successful interactions (Forster & Iacono, 2008; Wilder & Granlund, 2003). In Wilder & Granlund's (2003) study, parents claim that successful interaction is characterised by feelings of contentment, appreciation, and joy. Similarly, an interview study conducted by Forster and Iacono (2008) found that three disability support workers¹² who cared for a female client with PIMD over a long time reported positive emotions, such as sympathy, warmth, and closeness when interacting with the client. Moreover, the disability support workers' perception of their role as companions was considered critical in creating the intersubjective ways of communication with the client in this study. The factors influencing the positive interactions was also identified, which are "components of ascription of meaning, attachment, touch, movement away from age-appropriateness, learning to interact, and valuing knowledge and existing skills of the carers" (Foster & Iacono, 2008, p.144).

In summary, it is evident that the individuals with PIMD are able to interact, communicate, and build relationships with communication partners who are sensitive and willing to assist the interaction with useful strategies. The notion that sensitive communication partners (*sensitive responsiveness*) assist individuals with PIMD to effectively regulate their own experience (*co-regulation*) through emotional attunement (*emotional component*) and joint attention (*joint attention*) provides useful perspective. However, lack of initiation and maintenance of attention and behavioural states for interaction, and difficulty in expressing complex emotions are identified as challenging issues for persons with PIMD to effectively communicate.

Studies on quality of life.

As the philosophical notion of normalisation became important, the concept of Quality of Life (QOL) and well-being became a popular topic in many fields

¹² One of the disability support workers had worked with the client for two years, and the other two had worked with her for over 15 years at the time of the interview.

including ID (Cummins, 2002; Nakken & Vlaskamp, 2007; Schalock, 2004). Accordingly, various instruments and scales were developed to measure the well-being and QOL of people with ID (Cummins, 2002). In particular, with regard to people with PIMD, because they require high support services, measuring quality of life became one way to measure quality of support, vice versa (Marquis & Jackson, 2000). Many researchers developed useful tools, and some concerned with subjective wellbeing measurement and others concerned with objective wellbeing measurement. To measure subjective wellbeing, Lyons (2005) devised the life satisfaction matrix; Vos, Cock, Petry, Noortgate, and Maes (2010) used an adapted version of Mood, Interest, and Pleasure Questionnaire (MIPQ)¹³. In particular, Vos et al. (2010) compared the wellbeing scores of people with PIMD with people with mild to severe disabilities as well as without disabilities. They found that people with PIMD had lower subjective well-being scores than people with mild ID or without disabilities. Even people with SIMD had better subjective well-being scores. Therefore, Vos et al. (2010) suggested to find ways to improve the subjective well-being of adults with PIMD.

Another group of researchers (Petry, Maes, & Vlaskamp, 2005, 2009a, 2009b) concerned objective wellbeing of people with PIMD and developed a specific QOL tool for people with PIMD called QOL-PMD. Their aim was to develop “a valid, reliable, and useful instrument to measure the QOL of people with PMD” (Petry et al., 2009a, p. 1327). Interviewing 40 parents and 36 direct support workers who take care of people with PIMD provided crucial information to generate an item pool that is geared to the characteristics of people with PIMD (Petry et al., 2005). Then the generated item pool was examined by 45 international experts, revised, and multiply tested (Petry et al., 2009a, 2009b). Consequently, a multidimensional questionnaire was created, “which is composed of 55 items divided into 6 subscales” (Petry et al., 2009a, p. 1397): (a) physical well-being; (b) material well-being; (c) communication and influence; (d) social well-being; (e) development; (f) activities. Internal consistency and construct validity were tested and some relevance between domains was found. For example, the medical condition of the person, the amount of feeding

¹³ The adapted version was developed by Petry, Kuppens, Vos, and Maes (2010) based on original version by Ross and Oliver (2003).

problems and the staffing level of the group were significantly ($p < .05$) related to the objective quality of life of people with PIMD (Petry et al., 2009b). The impact of the staffing level on the QOL highlights the importance of the staff's support strategies on the QOL of people with PIMD. It is also further congruent with some research findings that valued the benefits of interpersonal relationships on the QOL of people with PIMD (Reinders, 2002, 2008; Schalock, 2004).

Interventions for people with PIMD.

We lack a tradition of therapeutic interventions that are specifically designed and developed for people with PIMD. Most therapeutic interventions that are offered to this category of people are originally designed and developed for those with less severe disabilities, and have in some cases been 'modified' by practitioners to fit this specific category (Vlaskamp & Nakken, 2008, p. 335).

In 2008, by surveying service managers of adult daycare centres, Vlaskamp and Nakken (2008) identified 23 therapeutic interventions "that were frequently recommended to practitioners in the Netherlands and the Flemish-speaking part of Belgium" (p.336). Later, seven interventions were removed "as they were primarily designed for use by parents at home (such as Brain Net and Saito Therapy) or demanded specific situations and funding (such as Dolphin therapy¹⁴)" (Vlaskamp & Nakken, 2008, p. 336). Finally, a list of total 16 interventions were generated as follow:

Aromatherapy (Diego, Jones, & Field, 1998), Basic Stimulation (Frohlich, 1991), CranioSacral Therapy (Upledger & Vredevoogd, 1983), Discrete Trial Training (Lovaas, 1987), Gentle Teaching (McGee, 1992), Haptonomy (Veldman, 2003), Equine Therapy/Hippotherapy (Ionatamamishvili, Tsverava, Loriya, Sheshaberidze, & Rukhadze, 2004), Mobility Opportunities Via Education (Bidabe & Lollar, 1990), Shantala Massage (Leboyer, 1987),

¹⁴ "swimming with dolphins makes children with special needs learn up to four times faster and more intensively" (Vlaskamp & Nakken, 2008, p. 334).

Sensory Integrative Therapy (Ayers, 1972), Sherborne Developmental Movement (Loots & Malschaert, 1999), Snoezelen (Hulsege & Verheul, 1987), Tibetan Cymbals (Jansen, 1990), Therapeutic Touch (Courcey, 2001), Touch for Health (Thie, 2005) and Watsu Therapy (Dull, 1997) (Vlaskamp & Nakken, 2008, p. 336).

This list of interventions was sent to 48 service managers, who work in “23 residential care units; 13 day services; 11 special educational centers and one respite care home” (Vlaskamp & Nakken, 2008, p. 335), to report the interventions that were frequently used in their settings. The results show that two interventions including mobility opportunities via education and touch for health were not used at all. In contrast, “snoezelen and sensory integrative therapy are offered in more than half of the participating settings. Snoezelen is used in 87.2% and is by far the most popular intervention” (Vlaskamp & Nakken, 2008, p. 336). Vlaskamp, de Geeter, Huijsmans, and Smit (2003) explain snoezelen, which is also called the multisensory environment in the following:

A multisensory environment (MSE) is an environment designed to stimulate the senses through light, sound, touch and smell. Essentially, it aims to create a feeling of safety, and to provide novel sensations, with stimulation under the user's control. The MSE contains a collection of devices or objects such as ball pools, bubble tubes, optic fibre tail lights and musical effects in one place (p. 136).

As the snoezelen or MSE is used frequently, the effectiveness of this intervention on people with PIMD has been researched and showed a wide range of mixed outcomes (Bunning, 2009; Carnaby, 2004). For example, Vlaskamp et al. (2003) evaluated the effectiveness of MSE on the level of alertness and interaction of 19 people with PIMD. The participants' behaviours were observed in the MSE environment and normal living environment. The participants were more responsive to the stimuli provided by staff than when they were placed in the MSE room. Therefore, the result suggests that in general, the normal living environment is “as good (or as bad) a place as the MSE for promoting alertness and interactions” (p.

135). Consequently, Carnaby (2004) concluded that “the supporter’s desire to build positive relationships and provide pleasant experiences is most likely to be the important factor in the use of these environments” (p.12).

Within this perspective, interventions such as Intensive Interaction (Hewett, 2012), and music therapy, which were not included in the list of the interventions but often used in other Western countries including UK and Australia, need to be investigated extensively as these interventions focus on building meaningful interactions and interpersonal relationships. Intensive interaction “refers to a way of interacting that facilitates social, communication, emotional and all development based on the style of interaction between caregivers and infants that facilitate such development” (Nind, 2009, p. 67). Although this is more an approach or style of interaction rather than an intervention, intensive interaction is often reported as effective in increasing communication and promoting emotional well-being in recent years (Elgie & Maguire, 2001; Jones & Williams, 1998; Kellett, 2000; Lovell, Jones, & Ehpraim, 1998; Nind, 2009).

Similarly, music therapy, which is a professional use of music and musical activities to achieve therapeutic aims, has been used for decades with people with PIMD. Some music therapists describe the benefits of the meaningful interactions and relationships built in long-term intervention (Agrotou, 1994, 1998, 2000; Graham, 2004; Lee & McFerran, 2012; Oldfield & Adams, 1995). Only one case study with two adults with SIMD (Graham, 2004) was recognised by Carnaby (2004) stating “music therapy has been used to establish an interactive relationship by drawing parallels with the spontaneous and instinctive strategies used in early parent-infant communication” (p. 13). Although the case studies have described the benefits of intensive interaction and music therapy, still limited numbers of studies are reported and the number of participants in these studies is usually very low. Therefore, the results cannot be generalized. Consequently, providing robust evidence of effectiveness with larger groups will continue to be critical (Maes et al., 2007; Vlaskamp & Nakken, 2008).

In summary, in recent years, more academics have conducted research studies with people with PIMD. The review of this literature suggests that the most important factor that can improve the lives of people with PIMD is individualised support and care. A relational support perspective (Petry & Maes, 2007) will improve quality of

life in a long term. Using this perspective, the next section now provides a theoretical context for the current study.

A Theoretical Context for the Study

The theories developed from the mother-infant interaction studies seem to provide a useful context for the current study. It is because the developmental age of adults with PIMD is considered similar to the infants in the mother-infant studies, ranging from 1 to 18 months (Clegg et al., 1991; Wilder et al., 2004). Beside, the non-verbal and musical interactions characterised in the mother-infant interactions are also observed in the interactions between music therapists and the adults with PIMD in music therapy. Accordingly, understanding the nature of the non-verbal interactions and relationships seems highly relevant to the current study. In particular, the notion of infant intersubjectivity theorised by Trevarthen (1977, 1979, 1980, 1998, 1999, 2001, 2010) and Stern (1971, 1974, 1985, 1993, 2002) provides a relational perspective to the current study. The following section starts by discussing the theory of innate intersubjectivity.

Innate intersubjectivity by Trevarthen.

In 1979, Trevarthen observed 34 pairs of mothers and their two to three month old infants in a laboratory setting. The infants were seated in infant chairs and the mothers were asked to talk to their babies. The infants displayed vocal sounds, facial expressions, as well as movements of a mouth, a head, hands, and eyes, orienting to or turning away from the mother. The mothers treated these non-verbal behaviours meaningfully and spoke in baby talk, adapting and matching their interactions to the babies' responses. Trevarthen (1979) described the mothers' responses as "stimulating, attentive, confirmatory, interpretive, and highly supportive" (p. 340). The intersubjective nature of interactions between the mother-infant pairs was further analysed, and Trevarthen noticed that the pairs were cooperating with each other to make the interactions meaningful. In contrast, when mothers were asked to stop and freeze their expressions while happily interacting, infants showed signs of distress, anxiety, protest including self-stimulatory, avoiding, and aggressive acts. This experimental study and further studies that investigated the effects of communication

disruption further confirmed the infants' sensitivity (Cohn & Tronick, 1983; Gusella, Muir, & Tronick, 1988; Nagy, 2008). From this observation, Trevarthen developed the theory of innate intersubjectivity, which defines as "the infant is born with awareness specifically receptive to subjective states in other persons" (Trevarthen & Aitken, 2001, p. 4).

Whilst Trevarthen believed that infants are born with this innate ability, the emergent psychosocial ability to sensitively interact with the mothers was not clearly observed until approximately two to three months of age. Therefore, Trevarthen (1979) claimed that the mothers' consistent efforts to arouse and interact with their babies facilitate the infants' development and consequently, labelled this phenomenon *primary intersubjectivity*. This development of primary intersubjectivity is considered significant in the infants' mental growth as this enables infants to build a personal bond with their mothers. In a similar way, the emergence of *secondary intersubjectivity* was observed at approximately nine months old when infants demonstrate joint attention to objects (Trevarthen & Hubley, 1978). The development of secondary intersubjectivity was also considered crucial on infants' development of cultural and language learning in early childhood (Trevarthen, 2010).

The development of four senses of self by Stern.

Stern conducted similar studies to Trevarthen, but observed mother-infant pairs in natural settings (Stern, 1971, 1974). Based on the observations, he suggested that infants develop *four senses of self* while socially interacting and establishing an interpersonal relationship with their mothers (Stern, 1985). First, Stern observed that infants develop *a sense of an emergent self* at around age of two months. Through receiving various sensory stimuli that facilitates physiological regulations and emotional arousal, the infants feel the sense of self. Approximately at the age of two to three months, *the sense of a core self* is developed when the infants find themselves as an effective human being who can influence others. The feeling of *self versus other* naturally becomes *self with other* over time, and infants are getting ready for interpersonal interaction during this time.

Between the seventh and ninth month of life, infants gradually realise that inner subjective experiences, such as an intention for action, feeling state, and focus of

attention can be shareable with others. Through these experiences, infants develop three kinds of intersubjectivity: *inter-attentionality*, *inter-intentionality*, *inter-affectivity*. Definitions are provided by Brinck (2008). *Inter-attentionality* “involves behaviours such as mutual attention-reading, directing gaze, and intention movements that may spread by contagion much like the emotions, but also are deliberately used for the purpose of, e.g., attention-reading and directing gaze” (Brinck, 2008, p. 9). *Inter-affectivity* “consists in the infant’s simultaneous matching of its affects and emotions to those currently displayed by another subject in over behaviour, by posture, facial expression, et cetera” (Brinck, 2008, p. 9). *Inter-intentionality* “is based in the agents’ exchange of information about their respective intentional and referential states as there are made externally accessible in behaviour, e.g., as in declarative pointing. At a more complex level, it involves having higher-order attentions and intentions about one’s own and other’ attentions or intentions” (Brinck, 2008, p. 9).

Among these, inter-affectivity was considered to be “the first, most pervasive, and most immediately important form of sharing subjective experiences” (Stern, 1985, p. 132). This process of inter-affectivity was also called “affect attunement” and Stern (1985) explains that to experience affect attunement, several processes should take place:

First, the parent must be able to read the infant’s feeling state from the infant’s overt behavior. Second, the parent must perform some behavior that is not a strict imitation but nonetheless corresponds in some way to the infant’s overt behavior. Third, the infant must be able to read this corresponding parental response as having to do with the infant’s own original feeling experience and not just imitating the infant’s behavior. It is only in the presence of these three conditions that feeling states within one person can be knowable to another and that they can both sense, without using language, that the transaction has occurred (Stern, 1985, p. 139).

Stern argues that the moments of affect attunement help infants to securely build attachment with the mothers and develop a human-group-psychic-membership,

which further help them to learn language and culture as a human being, which is congruent to Trevarthen's opinion.

While Stern is mainly concerned with the sharing of feelings, Trevarthen focuses on the process of exchanging mental activities and its contents, such as motives and intentions as his definition¹⁵ indicates. As the adults with PIMD are affective communicators, whose intentional communication is not clearly expressed, Stern's view on intersubjectivity, highlighted by the affect attunement, seems more relevant to the current study. Furthermore, the following two theories, communicative musicality and forms of vitality seem to further provide specific and useful views in interpreting the non-verbal communication with people with PIMD.

Communicative musicality.

In 1999, Malloch analysed vocal interactions of three parent-infant pairs: (a) a six-week old infant and her mother; (b) a 12-week old infant and her mother; (c) a two-month premature infant and her father. Then he identified the musical nature in the infant directed speech used by the parents. Through a spectrograph analysis, regular time-intervals were observed in all three interactions, which indicate that the parents and infants have a regular *pulse* in their interactions. They coordinated and negotiated within this regular pulse frame. Malloch then analysed the melodic and timbral contours of the vocalisations, and identified some unique pitch-plots of vocal interactions. The pitch plot indicated the *quality* of the interaction by showing how mothers changed vocalisation such as inviting, affirming, and calming in response to infants' vocalization. For example, the mother of a six-week old infant changed the quality of timbre of her voice by matching its roughness, width and sharpness to that of the infant.

Lastly, vocalisations between a four-month old girl and her mother while singing a nursery rhyme were analysed, and the element of *narrative* was identified. The girl vocalised in time with her mother creating musical jokes, which evoked

¹⁵ Intersubjectivity is "the process in which mental activity including conscious awareness, motives and intentions, cognitions, and emotions is transferred between minds" (Trevarthen, 1999, p. 413).

laughter from the mother. The girl's vocalisation varied with consistency and it appeared that the mother and girl were creating this musical narrative together in a way, which Malloch (1999) described as companionship. Consequently, Malloch (1999, pp. 31-32) states:

The elements of the co-operative and co-dependent communicative interactions between mother and infant combine to make-up what I have called "Communicative Musicality". This term recognizes that the mother and her infant are partners in a musical dialogue. Communicative musicality consists of the elements pulse, quality and narrative - those attributes of human communication, which are particularly exploited in music, that allow co-ordinated companionship to arise.

Based on the result of the study, Malloch further claims that the three elements of communicative musicality are the fundamental basis of all human communication (Malloch, 1999; Malloch & Trevarthen, 2009a, 2009b). He also argues that using these elements of communicative musicality, emotion was communicated and companionships were formed. Furthermore, it was suggested that when this ability to share emotions is impaired, the communication between the partners will be less musical. The role of movements that carries the emotions is also stressed as an important indicator in non-verbal communication (Malloch, 1999). This idea was further developed by Stern in the forms of vitality, which is further explained in the following.

Forms of vitality.

Stern (2010) defines vitality as "a manifestation of life, of being alive [...] as a mental creation, as a product of the mind's integration of many internal and external events, as a subjective experience, and as a phenomenal reality" (p.3-4). Accordingly, Stern argues that by observing one's vitality, we can understand the other person's mental processes and subjective feelings, which enables us to intersubjectively interact with each other. Examples of the dynamic forms are described as "the timing and stress of a spoken phrase or even a word; the way one breaks into a smile or the time course of

decomposing the smile; the shift and flight of a gaze...” (Stern, 2010, p. 6). Consequently, Stern states, “dynamic forms of vitality are the most fundamental of all felt experience when dealing with other humans in motion” (Stern, 2010, p. 8). This notion of understanding each other’s subjective feelings through forms of vitality is highly relevant to the music therapist’s skills and communication strategies when working with adults with PIMD. As these individuals do not initiate interactions and express themselves freely, the first task for the music therapist is to observe these forms of vitality. Stern (2010) claims that the improvisation techniques, such as mirroring, imitating, and matching, require the use of vitality forms to share or interchange experience, as the vitality forms are physical and visible. Consequently, analysing the forms of vitality of adults with PIMD in a micro-levels and developing thick descriptions of the interaction processes may be useful in deepening our understanding of meaningful moments with adults with PIMD.

In summary, this section provided a theoretical context for the present study. The innate intersubjectivity provides the premise that adults with PIMD possess the psychosocial ability to relate and interact with others intersubjectively. Within this framework, exploring the intersubjective psychosocial ability of these individuals becomes natural and a focus of discussion can progress to the exploration of the unique communication nature of these individuals. Furthermore, the theory of forms of vitality, along with the communicative musicality, provides a particular theoretical perspective for music therapists in understanding the non-verbal and musical interactions with the adults with PIMD in micro-momentary levels. Describing these exchanges of vitality forms might be useful. The next chapter now reviews relevant literature that concerns music therapy practice with adults with PIMD.

CHAPTER 3

LITERATURE REVIEW

This chapter reviews the relevant literature to the current study in the field of music therapy. It consists of three parts. In part one, to create a context for the review of literature, definitions of music therapy and music therapists are provided, followed by a brief overview of music therapy development. Then, in the second part, nine existing reviews of literature on music therapy with people with disabilities are overviewed. Specifically, the studies of people with Severe Intellectual and Multiple Disabilities (SIMD) and Profound Intellectual and Multiple Disabilities (PIMD) are discussed to improve understanding of the music therapy practice with adults with PIMD. Lastly, in part three, literature on the lived experiences and meaningful moments in music therapy is reviewed, and the application of phenomenology in music therapy studies is reviewed in order to understand the history of its use in the field of music therapy. At the end of this chapter, research questions are developed based on the results of the literature review.

Music Therapy

Definition.

Music therapy is an international clinical practice that is supported and promoted by the World Federation of Music Therapy (WFMT). Founded in 1985 in Genoa, Italy, WFMT is a non-profit corporation, “led by an international body, with officers, commissioners, and regional liaisons in Africa, Argentina, Australia, Brazil, Canada, China, Finland, India, Norway, Korea, Spain, U.A.E., and the USA” (World Federation of Music Therapy, 2011). While the definition of music therapy by WFMT highlights “the professional use of music and its elements [...] to optimize

their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing” (World Federation of Music Therapy, 2011), each regional liaison has its own definition according to their cultural context. Given that this study is conducted with the music therapists in Australia, the definition of music therapy provided by Australian Music Therapy Association (AMTA) seems most suitable. The following definition and information about music therapy and music therapists are offered to the public by AMTA in their website¹⁶:

- Music therapy is a research-based practice and profession in which music is used to actively support people as they strive to improve their health, functioning and wellbeing.
- Music therapy is the intentional use of music by a university trained professional who is registered with the Australian Music Therapy Association Inc. Registered music therapists draw on an extensive body of research and are bound by a code of ethics that informs their practice.
- Music therapists incorporate a range of music making methods within and through a therapeutic relationship. They are employed in a variety of sectors including health, community, aged care, disability, early childhood, and private practice. Music therapy is different from music education and entertainment as it focuses on health, functioning and wellbeing.
- Music therapists are committed to supporting people of any age and ability regardless of musical skill, culture or background.

Next section briefly overviews the development of music therapy over the last 50 years.

¹⁶ <http://www.austmta.org.au/content/what-music-therapy>

Overview of the development of music therapy.

Although the WFMT was found in 1985, some musicians started their music practice, which might have been similar to music therapy, long before this time. Gary Ansdell (2002) considers its formative beginning as early as the 1890s as musicians played music *to* patients in hospitals to entertain them (recreational model) or for various purposes during medical procedures (medical model). Ansdell argues that this phenomenon continued until the 1940s when the Second World War II ended. He calls this period Stage One in the development of music therapy. With regard to the development history of practice and theory in music therapy, two other music therapists also provide an overview (Aigen, 2014; Choi, 2008). In contrast to Ansdell, who divided the 50 years of music therapy history into four stages, recently Kenneth Aigen (2014) divided them into three stages. Similarly following Aigen's time line, but focusing on the theoretical development in music therapy, Byoung-Cheol Choi (2008) provides an overview, which is relevant to music therapy history. Table 3 shows the stages of music therapy history identified by the two music therapists in order to understand the rough time period that was important to music therapy development.

Table 3.

Development of Music Therapy

Ansdell (2002)		Aigen (2014)	
Stage 1	1890s-1940s		
Stage 2	1940s-1970s	Stage 1	1945-1964
Stage 3	Late 1970s-early 1980s	Stage 2	1965-1981
Stage 4	Beginning at the dawn of 21st century-present	Stage 3	1982-present

Despite some differences in the specified years, the periods are roughly similar, and the difference in time could be explained that the two music therapists have different cultural perspective on music therapy history as being American (Aigen) and British (Ansdell) music therapist. In this review, I follow Aigen's perspective for its currency.

According to Choi (2008), who was trained in US, the Stage One of music therapy development between 1945 and 1964, was led by E. Thayer Gaston because:

he expanded this idea¹⁷ to help establish the music therapy profession in the 1940s. [...] His work was helpful in bringing people's attention to music's power in influencing human behaviour" (pp. 93-94).

Inspired by Gaston, many music therapists rationalised their approaches and found some important theories from psychotherapy (Choi, 2008) and psychology (Aigen, 2014). The most well-adopted theories are behavioural, psychodynamic, and humanistic theoretical orientations, which are still influential and fundamental in music therapy.

According to Aigen (2014), in the Stage Two, "treatment models were developed in practice" by early pioneers. In Britain, Juliette Alvin, who is "widely considered the mother of music therapy in Great Britain" (Hooper, Wigram, Carson, & Lindsay, 2008a, p. 66), founded "The Society of Music Therapy and Remedial Music and, in 1968, the first training at the Guildhall School of Music in London" (Ansdell, 2002, p. 5). Alvin started her clinical work with children with disabilities (1976) and Autistic Spectrum Disorders (1978). At the similar time, Mary Priestley applied psychological model in adult psychiatry and later developed her unique approach, Analytical Music Therapy (1975, 1994). In US, Paul Nordoff and Clive Robbins developed Creative Music Therapy to support children with special needs (1971, 1977, 1983). Their influence has been so great that this is also called the Nordoff-Robbins approach and is specifically trained in particular institutions. Currently, institutions that train Creative Music Therapists are located in New York, Sydney, and London.

¹⁷ The idea that "performing or listening to music would produce something more than arousal or entertainment" (Choi, 2008, p. 93)

The Stage Three began in 1982, and Aigen (2014) explains this time as “beginning of indigenous theories”. Carolyn Kenny opened up a new world in music therapy research by applying qualitative and phenomenological inquiries in understanding clinical practice (Forinash & Grocke, 2005), which later formed her theory Field of Play. Since then, many music therapists have followed the qualitative and reflective approach in their work. In the 1990s, Music and Medicine approach that “seeks to describe music’s therapeutic influences in terms of a scientific knowledge base” (Choi, 2008, p. 95) has been adopted as well. Models such as Bio-medical Music Therapy and Neurological Music Therapy were developed. Including these, Aigen (2014, p. 220) identified over 13 indigenous theories originated from social sciences, arts disciplines, and biological sciences such as:

1. Field of play/Mythic Artery (Kenny, 1982)
2. Bio-Medical Music Therapy (Taylor, 1997)
3. Neurological Music Therapy (Thaut, 1999)
4. Culture-Centered Music Therapy (Stige, 2002)
5. Aesthetic Music Therapy (Lee, 2003)
6. Community Music Therapy (Pavlicevic & Ansdell, 2004)
7. Complexity-Based Music Therapy (Crowe, 2004)
8. Music-Centered Music Therapy (Aigen, 2005)
9. Analogy-Based Music Therapy (Smeijsters, 2005)
10. Dialogical Music Therapy (Garred, 2006)
11. Feminist Music Therapy (Hadley, 2006)
12. Resource-Oriented Music Therapy (Rolvsjord, 2010)
13. Humanities-Oriented Music Therapy (Rudd, 2010)

Since 2000s, music therapists have expanded their work with more broad clienteles and settings moving from hospitals and special education settings to community and society. Various winds of changes have influenced music therapy and facilitated development of new theories or approaches to music therapy such as Community Music Therapy and Feminist Music Therapy. Ansdell (2002) explains it as a result of social change and also that every profession undergoes a paradigm shift every thirty years. Irrespective of the paradigm shifts the work of the early pioneers

in the field of disability continue to influence the work of today. The following section discusses the nine existing reviews of literature undertaken on the studies of music therapy with people who have disabilities before moving onto more focused review for the current study.

Music Therapy with People with Disabilities

The earlier pioneers in music therapy recognised the benefits of music therapy on people with disabilities and provided useful philosophical and theoretical foundations (Hooper et al., 2008a). Accordingly, many music therapists were inspired and reported their clinical and research work with children and adults with various levels of disabilities. In order to understand the way music therapists work, exploring existing reviews of the literature seems useful. I have identified nine literature reviews on this topic (Brown & Jellison, 2012; Hooper et al., 2008a; Hooper, Wigram, Carson, & Lindsay, 2008b; Jellison, 2000; McFerran et al., 2009; Meadows, 1997; Savarimuthu & Bunnell, 2002; Standley, 1996; Wigram, 1993). Table 4 summarises the types, topics, and inclusion years of the reviews.

Table 4.

Literature Reviews on Music Therapy for People with Disabilities

Author/s (Year)	Review type	Topic	Inclusion years
Brown and Jellison (2012)	Systematic ¹⁸ review	Children and youth with/without disabilities	1999-2009
McFerran et al. (2009)	Descriptive review	People with disabilities	1990-2006
Hooper et al. (2008a)	Literature ¹⁹ review	People with intellectual disability: descriptive and philosophical writing	1943-2006
Hooper et al. (2008b)	Literature review	People with intellectual disability: experimental writing	1943-2006
Savarimuthu and Bunnell (2002)	Literature review	People with learning disabilities	Not specified
Jellison (2000)	Content analysis	Children and youth in special education	1975-1999
Meadows (1997)	Literature review	Children with severe and profound disabilities	Not specified
Standley (1996)	Meta ²⁰ analysis	People with various disabilities	1967-1995
Wigram (1993)	Content analysis	Children in special education	1987-1991

¹⁸ “Seeks to systematically search for, appraise and synthesis research evidence, often adhering to guidelines on the conduct of a review” (Grant & Booth, 2009, p. 95).

¹⁹ “Generic term: published materials that provide examination of recent or current literature. Can cover wide range of subjects at various levels of completeness and comprehensiveness” (Grant & Booth, 2009, p. 95).

²⁰ “Technique that statistically combines the results of quantitative studies to provide a more precise effect of the results” (Grant & Booth, 2009, p. 95).

Among the nine reviews, four reviews by Wigram (1993), Meadows (1997), Jellison (2000), and Brown and Jellison (2012) specifically focused on music therapy studies on children and youth, who are aged up to 18 or 21 years old. Particularly, Jellison and Wigram investigated the use of music therapy in special education settings. In 1993, Wigram analysed the content of American and British journals of music therapy between 1987 and 1991, and identified 453 articles that includes 274 articles focused on clinical work, 176 on research, and 30 general articles. After reviewing these articles, Wigram concluded that there was a lack of high quality research in the special education setting, encouraging music therapists to conduct more quantitative designs.

In 2002, Jellison identified 148 studies, consisting of descriptive (n=72) and empirical (n=76) studies, and through a content analysis, found that the music therapy outcomes commonly addressed in special education settings were learning, social, physical, behavioural, and communication skills. She also recommended to conduct more studies in inclusive settings, using language that is used in special education policies and practices. Following up with this review by Jellison (2000) on the studies between 1975-1999, Brown and Jellison (2012) reviewed studies between 1999 and 2009 and compared their results with the Jellison's review. Brown and Jellison found more experimental studies and more studies with children with autism or conducted in special education settings. Particularly, more studies focused on social outcomes when working with children with disabilities.

Uniquely, Meadows (1997) dedicated a review on music therapy for children with severe and profound multiple disabilities. The aim of the review was to identify the goals, methods, and theoretical approaches generally used when working with this group of children. By reviewing classical text books by early pioneers such as Alvin, Bruscia, Boxhill, and Pfeifer, Meadows identified six general goals:

- 1) fulfilling the child's basic needs;
- 2) developing the child's sense of self;
- 3) establishing or re-establishing interpersonal relationships;
- 4) developing specific skills;
- 5) dispelling pathological behaviour;
- 6) developing an awareness and sensitivity to the beauty of music (pp. 4-5).

Four mainly used theoretical approaches: recreational, behavioural, educational, and healing orientations were also identified. In particular the healing orientation, which uses “musical experience and the relationships that develop through them to heal the mind, body, spirit, to induce self-healing, or to promote wellness” (Bruscia, 1989, p.93 as cited in Meadows, 1997, p. 7), seems relevant to my perspective in the current study. Furthermore, Meadows also classified various music therapy methods as: instrumental activities; vocal activities; movement; and receptive methods. Although this review was focused on children, the core aspects and approaches identified reflect the work with adults as well, therefore this review remains highly relevant to the current study.

The other five reviews by Hooper et al. (2008a, 2008b), McFerran et al. (2009), Savarimuthu and Bunnell (2002), and Standley (1996) included music therapy studies concerned with adults with disabilities. Interestingly, the review by Savarimuthu and Bunnell (2002) was undertaken by a student and lecturer in the field of nursing. Savarimuthu experienced benefits of using music for his patients in a clinical placement and was motivated to review music therapy literature. After reviewing descriptive writings, various case studies, and experimental research in music therapy, they concluded that music has potential in improving communication skills and psychological well-being of clients. They also encouraged nurses to change their attitude and perspectives on music therapy and use more music in nursing care.

Hooper et al. (2008a, 2008b) conducted “A Review of the Music and Intellectual Disability Literature (1943-2006)”, which is consisted of two separate investigations on “descriptive and philosophical writings” and “experimental writings”. In the review on descriptive and philosophical writings, Hooper et al. (2008a) identified 292 descriptive articles that discussed active and receptive music therapy techniques and 50 philosophical articles which were mainly earlier examples such as classical texts by Alvin and Nordoff-Robbins. By highlighting the major literature informing the music therapy practice with people with intellectual disabilities, the authors demonstrated “the value of the descriptive and philosophical writing not just as a medium for identifying clinical outcome, but also for informing and advancing clinical practice” (Hooper et al., 2008a, p. 74).

Similarly, in the experimental writing, Hooper et al. (2008b) reviewed the experimental studies that measured the participants' responses to active²¹ (n=71) and receptive²² (n=112) music therapy techniques. After reviewing the studies, Hooper argued, "the experimental research should not be considered in isolation. Instead, it suggests, that along with the descriptive writing, the experimental writing is part of a body of work that captures both the richness of clinical experiences, and the cause-effect relationships underlying those experiences" (Hooper et al., 2008b, p. 80). From this point of view, the knowledge obtained from the meta-analysis by Standley (1996) informs the current study as well. Standley measured the effect of music as reinforcements in educational or therapeutic settings and found that (a) contingent use of music was more effective than continuous music; (b) using music alone was more effective than pairing it with other stimuli. Another interesting finding relevant for the current study was that "adults and infants, compared with other age-groups, responded best to music contingencies (Standley, 1996, p. 125).

Lastly, in 2009, my colleagues and I conducted "A Descriptive Review of the Literature (1990-2006) Addressing Music Therapy with People Who Have Disabilities" (McFerran et al., 2009). 65 quantitative and descriptive research studies were identified, and general treatment goals and music therapy methods used were reviewed. Some streams of focus among music therapists when working with different levels of disabilities were found. For example, music therapists who worked with children and adults who have mild and moderate disabilities usually focused on behavioural, social, or learning outcomes (Colwell & Murlless, 2002; Register, 2001; Rickson, 2006; Toolan & Coleman, 1995). On the other hand, music therapists who worked with severe and profound disabilities mainly focused on communication and physical goals (Agrotou, 1994; Braithwaite & Sigafos, 1998; DeBedout & Worden, 2006; Ford, 1999; Ghetti, 2002; Graham, 2004). Consequently, the review concluded

²¹ In this review, active music therapy was defined as "client produces the musical content, and shares instrumental and/or vocal ideas with the therapist" (Grocke & Wigram, 2007, as cited in Hooper et al., p. 85) including improvisation (n=8) and music activity therapy (n=63).

²² Receptive music therapy was defined as "the client is the recipient of the music experience" (Grocke & Wigram, 2007, as cited in Hooper et al., p. 89).

that there might be some aspects of practice that could be standardized given the high level of consensus, although music therapy is not a prescribed practice. Further reviews based on this review were also recommended.

Although these extensive reviews have generated knowledge and insights, except the review by Meadows (1997), the reviews mostly focused on children with *mild and moderate levels of disabilities*. Although the review by McFerran et al. (2009) included more studies on people with severe and profound disabilities than other reviews, they still did not include most of the literature concerned with adults with PIMD. The fact that the types of disabilities they searched for were *intellectual disability* and *developmental disability*, not including *multiple disabilities*, explains the phenomenon. Accordingly, based on the review conducted by McFerran et al. (2009), in the next section, I now review the literature specifically focused on children and adults with Severe Intellectual and Multiple Disabilities (SIMD) and Profound Intellectual and Multiple Disabilities (PIMD).

Music therapy for people with SIMD and PIMD.

The studies reviewed in this section are recent studies published after 2006 as well as other studies that were not included in McFerran et al. (2009). Table 5 shows the included studies conducted between 1990 and 2012, classifying them according to the age and severity of the disabilities of the clients.

Table 5.

Music Therapy Studies for Children and Adults with SIMD and PIMD

	Children	Adults
SIMD	Raglio, Traficante, and Oasi (2011)*	Warner (2005)* Graham (2004)
	Gilboa and Roginsky (2010)*	Caron, Donnell, and Friendman (1996)
	Kwak (2007)*	Ford (1999)
	de Mers, Tincani, van Norman, and Higgins (2009)*	Lawes and Woodcock (1995)
	DeBedout and Worden (2006)	Ritchie (1993)*
	Wigram and Lawrence (2005)	
	Elefant and Wigram (2005)	
	Rainey Perry and Ri (2005)	
	van Colle (2003)*	
	Elefant (2001, 2002)**	
	Yasuhara and Sugiyama (2001)	
	Rainey Perry (1999a, 1999b, 2003)***	
	Wheeler (1999a, 1999b)**	
	Nowikas (1999)*	
	Braithwaite and Sigafos (1998)	
	Wylie (1996)	
	Boswell and Vidret (1993)	
	Shoemark (1991)*	
PIMD	Ghetti (2002)	Lee and McFerran (2012)*
	Sekeles (1996)*	Watson (2007)*
	Pujol (1994)*	Agrotou (1994, 1998)**
	Silliman, French, and Tynan (1992)	Wigram et al. (1997)*
	Rogers-Wallgren, French, and Ben-Ezra (1992)	Oldfield and Adams (1990, 1995)**
	Salas and Gonzalez (1991)*	

Note: The articles marked with an asterisk indicate studies that were not included in the review conducted by McFerran et al. (2009).

SIMD stands for Severe Intellectual and Multiple Disabilities and PIMD stands for Profound Intellectual and Multiple Disabilities.

Children with SIMD.

As clearly seen in the table 5, many music therapists have reported their work with children who have SIMD. Perhaps this group of children showed more potential to improve in music therapy than children with PIMD. Most music therapists focused on improving communication skills of these children (Braithwaite & Sigafos, 1998; DeBedout & Worden, 2006; Rainey Perry, 1999a, 1999b, 2003; Rainey Perry & Ri, 2005). For example, Braithwaite and Sigafos (1998) as well as DeBedout and Worden (2006) used various musical activities to motivate the children's communication desire, and demonstrated that the children responded more to activities involving music.

Another group of music therapists worked with children with Rett syndrome demonstrated efficacy of music therapy on improving their communication skills and hand use (Elefant, 2001, 2002; Elefant & Wigram, 2005; Wigram & Lawrence, 2005; Wylie, 1996; Yasuhara & Sugiyama, 2001). In particular, studies conducted by Elefant (2001, 2002) and Elefant and Wigram (2005) demonstrated that using children's preferred songs and providing repetitive song-choices improve their choice-making skills. On the other hand, some music therapists focused on the improvement of physical skills by providing programs such as music and movement and gait training (Boswell & Vidret, 1993; Kwak, 2007).

Recently, two music therapists evaluated their music therapy programs specifically designed for children with SIMD. Gilboa and Roginsky (2010) devised a program called the dyadic music therapy treatment (DUET) for children with cerebral palsy and their mothers to use in special education settings. A typology for relationships and communication patterns was formed, and the effect of DUET on improvement of communication and relationship was examined within the dyad. A four-year-old boy who had spastic-hemiplegia and normal cognitive ability attended eight DUET sessions with his mother. Music therapist provided musical materials, and guided the mother and the child to interact with each other effectively. After a half hour session with the dyad, the music therapist offered the mother opportunity to reflect on the session and discuss any issues raised during the musical encounter with her son. The analysis of the interviews with the mother and video footage emphasised the importance of non-verbal communication in facilitating the optimum social development of children who are non-verbal. The communication partners are

recommended to observe silently enough before trying to interact with the children and develop attuned types of interaction (Gilboa & Roginsky, 2010) . The authors also stressed the usefulness of using video analysis technique and claim that wide ranging research involving more dyads is needed.

Similarly, Raglio et al. (2011) developed a tool called Music Therapy Rating Scale (MTRS) to evaluate the relationship between a music therapist and a child with pervasive developmental disorders in music therapy process. Seven children, including two boys with autism, one girl with Rett syndrome, one boy with childhood disintegrative disorder, a boy with Asperger's syndrome, and two girls with developmental disorders, participated in a single music therapy session that facilitated active instrumental improvisation. The sessions were videotaped and two sets of two music therapists rated the Non-Verbal Relationship (NVR) and Sonorous Musical Relationship (SMR) between the music therapist and each participant in 15-second intervals. Spearman's Rho coefficient was calculated to measure the agreement between the two pairs of music therapists. For SMR, 86% (mean $p=0.77$) agreement, and for NVR, 43% (mean $p=0.70$) agreement were obtained. Thus, the authors concluded that the MTRS tool is a useful tool to monitor process of music therapy in a single session as well as over the whole treatment.

Although the clients participating in these two studies were much higher functioning clients than children and adults with PIMD in terms of the degree of intellectual disability, these studies value the intersubjective nature of the music therapy interaction based on mother-infant theoretical notions, and demonstrate benefits on clients' social ability to relate with others and establish meaningful relationships, which is highly relevant to the current study.

Children with PIMD.

A total of eight music therapy studies have been identified, and the main concern of music therapists when working with children with PIMD has been their level of alertness. Ghetti (2002) observed that the children with PIMD often displayed unstable behavioural states, fluctuating between sleep, indeterminate, and awake states in a special education setting. Based on the premise that learning occurs in preferred awake states, Ghetti conducted an experimental study that compared the

effects of three different music therapy conditions on the behavioural states of six children with PIMD. The three different musical stimuli included:

- a) passive rhythmic stimulation that provided bass-drumming sound,
- b) contingent-continuation song singing²³ to facilitate vocalisation, and
- c) the multisensory use of musical instruments, accompanied with well-known folk songs.

Each music therapy condition was provided over three sessions, and three baseline measures were taken just before the beginning of the sessions. Each session lasted for ten minutes, and the behavioural states of the clients in the first five minutes of each session were coded. The comparison between baseline measures and the corresponding three conditions using a one-way within-subjects analysis of variance, ANOVA, test showed no significant difference. The fact that the music therapy session only lasted for ten minutes and did not facilitate interaction with music therapists, and also the music therapy conditions did not reflect individuals' preferences, might have influenced the results of the study.

Similarly, a quantitative experimental study by Pujol (1994) compared the effect of three conditions: a) vibrotactile stimulation, b) instrumentation, and c) pre-composed melodies on the physiological and behavioural responses of fifteen individuals with PIMD, aged between six and forty-six. The participants attended four music therapy treatments individually, and each session provided three different pre-recorded musical stimuli. The two-way ANOVAs test showed no statistical significance between the three comparisons. Similar to Ghetti's (2002) study, this study did not consider individual preferences for music and generally used only pre-composed music. Beside, these studies did not incorporate the potential value of intersubjective experiences in the music therapy processes in relation to the regulation of behavioural states. Therefore, this does not seem to reflect on the benefits of natural music therapy. In contrast, qualitative studies by Rainey Perry (1999a, 1999b, 2003) demonstrated how the natural music therapy interactions positively benefit the children with SIMD to regulate appropriate behavioural states in music therapy. Consequently, conducting a naturalistic investigation reflecting on process and benefit

²³ Two songs were composed for this study.

the actual music therapy seems more useful in understanding the effect of music therapy.

Adults with SIMD.

Almost all studies concerned the adults with SIMD reported that they display challenging/self-injurious behaviours such as teeth-grinding²⁴, mouth-hitting, head-hitting, screaming, cutting, and scratching. Similar to the experimental studies conducted with children with PIMD (Ghetti, 2002; Pujol, 1994), some music therapists experimented with different conditions for adults with SIMD to reduce their destructive behaviours (Caron et al., 1996; Ford, 1999). For example, Ford (1999) experimented with four different conditions: a) contingent blocking, b) music listening, c) water play, and d) instrument playing to a participant who were teeth-grinding, head-hitting, and mouth-scratching. Although visual analysis showed a strong downward trend after music listening for teeth-grinding and the participant responded to water play and contingent blocking by reducing head-hitting, no change was observed over all conditions for mouth-scratching and the participant did not exhibit any pre intervention head-hitting during both music conditions, and therefore showed no change in behavior.

Caron et al. (1996) also conducted a similar experimental study by playing recorded new age music for four males and two females with developmental disabilities, aged between 26 and 41, and reported lack of effect for any of the participants. Consequently, the two evaluation studies of music therapy (Caron et al., 1996; Ford, 1999) were identified as having no effect on the treatment of bruxism in a systematic review that was conducted by a group of researchers (Lang et al., 2009). Among 11 studies reviewed, these were only two studies that had negative outcomes. However, these studies did not reflect the effects of real world music therapy in natural settings, not providing the clients with their preferred music or interactive musical activities. Accordingly, this seems to suggest that music therapy researchers need a more careful approach in conducting this type of experimental study.

²⁴ That is also called bruxism.

In contrast, some British music therapists adopted different approaches to reducing the challenging behaviours (Graham, 2004; Ritchie, 1993; Warner, 2005). They used the psychodynamic improvisation approach and demonstrated the powerful benefits of this approach on the clients. For example, Graham's (2004) qualitative study shows how the improvised use of voices as a medium facilitating engagement and interaction with adults with SIMD living in residential institution. In this study, the process of music therapy with a female with PIMD and a male with autism was described. These two participants often vocalised on their own, and staff considered these challenging behaviours and ignored them. However, Graham considered these sounds meaningful and by imitating and reflecting their voices, she was able to perceive the implicit meanings of the vocal expressions such as sadness and distress. Over time, their vocal interaction became communicative, and interpersonal relationship with the therapist was developed. Graham (2004) described this process such as, "as infants begin to experience themselves within the context of an interactive relationship with their parents, it appeared as though they were beginning to see themselves as emotional and communicating beings" (p.27). Based on the analysis of the vocal exchanges, Graham concluded that the vocal interaction improved communicative and social skills of the two participants. The processes and outcomes described in this qualitative study are highly relevant to the work with adults with PIMD.

Adults with PIMD.

Not many music therapists have reported their work with adults with PIMD. Only five studies are identified between 1990 and 2012. Various studies were reported with this group of people including one evaluation study of a clinical intervention (Wigram et al., 1997); two experimental studies that considered participants' preferences (Lee & McFerran, 2012; Oldfield & Adams, 1990); two clinical case studies (Agrotou, 1994; Watson, 2007); and one qualitative research study (Agrotou, 1998). First, Wigram was mainly concerned with the physical pain and distress experienced by adults with PIMD (Wigram, 1992; Wigram & Möller, 2002). Using Vibroacoustic Therapy, he and his colleagues claimed that the clients were benefited not only physically but also emotionally (Wigram et al., 1997).

The experimental studies conducted by Oldfield and Adams (1990, 1995) and Lee and McFerran (2012) concerned with the effect of music therapy on the improvement of participation and communication. Oldfield and Adams (1990, 1995) compared the effects of group music therapy and play therapy on achieving a set of individual goals of the clients with PIMD. The goals included increasing time spent on holding musical instruments or interacting with staff, and reducing time spent on displaying challenging behaviours. It demonstrated the benefits of music therapy in increasing frequency and duration of the targeted behaviours in music therapy compared to play therapy. Similarly, but using the subjects as their own control, Lee and McFerran (2012) offered song-preference assessment and song-choice interventions to five females and observed the communication improvement. As these studies used naturalistic investigation considering individual clients' preferences and abilities, both studies (Oldfield & Adams, 1990, 1995) demonstrated the improved non-verbal communication skills (Lee & McFerran, 2012).

On the other hand, Agrotou (1994, 1998) and Watson (2007) described how the psychodynamic approach using the improvisational method is beneficial in establishing meaningful interactions and relationships with people with PIMD. The approaches taken in these studies are similar to the other British music therapists, such as Ritchie (1993) and Graham (2004) who reported their work with adults with SIMD. In 1994, Agrotou reported her four years clinical work with a 17 years old institutionalised male client, who was diagnosed with cerebral palsy, severe intellectual disability, and visual/hearing impairments. The client lived in an institution since the age of five and was not provided with any sensory and human touch because carers thought that he was not able to receive these.

By describing the process of the clinical work from two perspectives, that of a music therapist and that of a client, Agrotou explored the areas of difficulty and uncertainty when working with individuals with multiple disabilities. In the early stages, the client presented anxiety in response to the unfamiliar human contact and interaction and accordingly, Agrotou described the initial feelings of despair and fear when she felt that she was not able to reach the client. However, through the piano improvisation that the music therapist created in response to the client's non-verbal responses such as breathing, facial expressions, and bodily postures and movements, connection and interaction began to emerge over time. The client finally discovered

the piano as a source of pleasure and affection. He used his voice musically to interact with the therapist on the piano and this process brought the pair moments of intimacy, connection, and joy. Agrotou confirmed that the client was able to communicate through music and build a relationship with her. Later, Agrotou (1998) conducted four years of psychodynamic group therapy with three females in an institutional setting and again described the benefits of psychodynamic group sessions on fostering meaningful interactions between the clients and staff.

Similarly, but in a form of group case study, Watson (2007) described a group music therapy process with four females with PIMD in an adult learning disability care centre. Weekly one-hour sessions were provided by two music therapists over eight months. The broad aim for the group was to engage the participants in a spontaneous, creative, and expressive communication dialogue in a musical environment. At the initial stage of the group process, the participants initiated little music and therefore, the themes of absence, and rejection of the instruments and contact from the music therapists were observed. In this study, these behaviours were interpreted as regulating behaviours to a new environment. Furthermore, the therapists regarded the non-verbal behaviours, such as clapping, teeth grinding, eye contact, and physical movements, finger tapping, and leg slapping as meaningful and communicative, and incorporated them into the improvisation. They also considered the group members' interactions with each other as intentional. Toward the end of the therapy, the participants and the music therapists were able to make music together, and profound moments of communication and connection were experienced.

Furthermore, Watson (2007) highlighted the importance of music therapists' experiences when working with adults with PIMD who play little music, which has been stressed by other music therapists as well (Oldfield & Adams, 1990, 1995):

The therapist's musical approach may need to be adapted in order to work meaningfully with clients who have profound disabilities and barriers to communication, and who are likely to play little music. [...] When thinking about the meaning and feelings of music and happenings in the session, therapists need to remain aware that these cannot be confirmed with the client as might happen with clients with more verbal facility. The experience of the music therapist is therefore extremely important (p. 102).

To understand how clinical experiences of music therapists have been studied, the following section now reviews the relevant studies.

The Lived Experiences in Music Therapy

With regard to studying lived experiences in music therapy, a variety of themes have been explored. Some music therapists have investigated clinical experience of music therapists working with particular group of clients. The other group of music therapists have explored special experiences or moments in music therapy.

Clinical experiences of the music therapists.

Ghetti (2011) investigated the lived experiences of dual-certified music therapists/child life specialists as more clinicians were obtaining dual certificates to improve their quality of services. She interviewed eight clinicians and their interviews were analysed following Interpretative Phenomenological Analysis (IPA). Similarly, motivated by her profound personal experience working with children with coma, Dun (1999) interviewed five music therapists to better understand their experiences. Conducting descriptive phenomenological analysis, Dun identified 13 common themes. On the other hand, Wheeler (1999a) explored her personal experience of feeling pleasure when working with children with SIMD in special educational setting. Interestingly, except Wheeler, who used heuristic approach in her qualitative video analysis, the other three researchers used qualitative and phenomenological approaches, and interviews were the main data collection method. As a result, these studies provide in-depth knowledge and insight about music therapy work with particular groups of clients.

Moreover, many music therapists explored the special experiences in music therapy such as moments of insights (Amir, 1993); being present to clients (Muller, 2008); being effective as a music therapist (Comeau, 2004); experiencing intuition (Brescia, 2005); experiencing musical countertransference (Dillard, 2006).

Experiences of the special moments in music therapy.

Furthermore, music therapy researchers have investigated small but powerful moments in music therapy to understand therapeutic changes in the clients. Using qualitative approaches, four different moments such as pivotal, significant, meaningful, and spiritual moments have been explored. Table 6 summarises and compares key elements of the studies.

Table 6.

Studies exploring the Special Moments in Music Therapy

Author (Year)	Moment explored	Methodology	Participants	Data used
Grocke (1999)	Pivotal	Phenomenology	Music therapists and clients in Guided Imagery and Music	Interviews, music and imagery
Trondalen (2005)	Significant	Phenomenology and hermeneutics	Young people with Anorexia	Improvised music, Interpersonal dialogues documented in session notes
Amir (1992)	Meaningful	Grounded theory	Music therapists and clients with various experiences	Ethnographic Interviews
Johns (2013)	Meaningful	Ethnography	Children with developmental delays	Improvised music
Marom (2004)	Spiritual	Phenomenology	Music therapists with various clinical experiences	Interviews

By comparing the types of moments, methodologies, participants, data used in the studies, some tendencies are found. First, clients who experienced these moments vary including children with developmental delays and young people with Anorexia.

Similarly, the music therapists also have a variety of clinical experiences in various settings. Text and audio data were collected through interviewing the participants and/or collecting music used during the moments. For example, Grocke (1999) investigated clients' pivotal moments in Guided Imagery and Music (GIM) therapy. By interviewing seven clients and two GIM music therapists, individual descriptions of the moments were developed and the essence of the pivotal moments was explored. Classical music selection and images appeared during the clients' pivotal moments were also analysed to better understand the moments. Inspired by Ferrara's (1984) application of phenomenology to a music analysis, seven procedural steps of Structural Model of Music Analysis (SMMA) was developed to analyse the Bonny GIM music (Grocke, 1999, 2007). Common themes were identified across the individual experiences and the essence of the pivotal moments in GIM therapy was found as: "intense, embodied experiences as the client confronts distressing imagery which is resolved, and this resolution brings about radical change in the person's life" (Grocke, 1999, p. 3).

Similarly, Trondalen (2005) explored significant moments of young adults with Anorexia in improvisational music therapy. The clients and the music therapist selected a piece of improvised music that facilitated the significant moment. Then, three music therapy experts listened to the piece of music and identified a critical part to analyse. Being inspired by Ferrara (1984) and Grocke (1999), both phenomenological and hermeneutic approaches were adopted, and nine steps of a phenomenologically inspired procedure was developed for the analysis of the improvised music (Trondalen, 2005, 2007). The result was later integrated with the interpersonal dialogue exchanged between the client and the therapist in the sessions and resulted in deep understanding of the meaning of the significant moments in the clients' lives. Trondalen (2005) concluded that significant moments "offer an exploration and softening of rigid and "stiffened" patterns of relating leading to new relating experiences through music" (p, 418).

Marom (2004) studied spiritual moments experienced by music therapists. Ten music therapists who have various clinical experiences in United States of America (USA) participated in telephone interviews. Music therapists retrospectively identified one or two sessions in which they felt spiritual moments and described the moments. Six steps of procedural steps were taken to generate the individual

descriptions. Based on the individual results, various aspects of the spiritual moments such as the roles of the music therapists and music, and the therapists' perceptions on the moments were investigated. In conclusion, the ten music therapists believed that the spiritual moments:

led them to feel that they had learned something new and valuable from the spiritual moments they witnessed. Moreover, through these reflections, they felt that the therapeutic relationship gained a new balance in which the clients were viewed as teachers, sent to teach the therapists important lessons about their own spiritual lives (Marom, 2004, p. 65).

Furthermore, two studies have explored meaningful moments in music therapy. The first investigation of meaningful moments were conducted by Amir (1992). Using an ethnographic interview approach, Amir interviewed four music therapists and four clients and used a grounded theory to analyse the interviews. Total of 15 meaningful moments were identified and categorised into various types of moments on two levels. On the intrapersonal level: moments of *awareness and insight; acceptance; freedom; wholeness and Integration; completion and accomplishment; beauty and inspiration; spirituality; intimacy with self; joy and ecstasy; anger, fear, and pain; surprise; and inner transformation* were identified. On the interpersonal level, moments of *physical closeness; musical intimacy; and close contact between client and a significant person* were identified. General characteristics, factors which facilitated these moments, and benefits of these moments on the clients and therapists were discussed as well.

Recently, Johns (2013) micro-analysed meaningful moments with children who have developmental delays. Six children participated in individual music therapy sessions and improvised with Johns who was student music therapist at the time of data collection. Following the descriptive ethnographic approach developed by Holck (2007), Johns described the musical and non-verbal interactions during the improvised music and interpreted the meanings of the experiences for the clients. After analysing six different meaningful moments, Johns concluded that:

Meaningful moments were shared experiences in the co-creation of music, which provided opportunities to foster a responsive interpersonal relationship

between the child and therapist. They occurred because the music provided a framework for structure and change through synchronicity, regularity and flow as well as variation, tension, suspension, expectation and anticipation. They were facilitated by musical elements: rhythm, tempo, pitch, melody, harmony, timbre, volume and dynamics; and musical techniques: imitation, pause, space, repetition, anacrusis and gestural actions (Johns, 2013, p. 32).

Both studies, which explored meaningful moments, used different methodological approaches but resulted in rich understanding of the meaningful moments in different contexts. In particular, Amir's (1992) findings on various types of moments on intrapersonal and interpersonal levels provides extensive knowledge about meaningful moments in music therapy in terms of its depth and scope and are significantly relevant to the current study.

Application of phenomenology in the studies of experiences.

Interestingly, the review of the studies exploring lived experiences in music therapy reveals that all studies used qualitative approaches to describe and understand the moments. Phenomenology was used dominantly (Aigen, 2008), and grounded theory and ethnography approaches were used once each. Particularly, the three phenomenological studies used a procedural and descriptive approach integrating several phenomenological methods (Ferrara, 1984; Forinash & Gonzalez, 1989; Giorgi, 1975, 2009a). As the review reveals, phenomenology enables researchers to study the phenomenon as a whole by contemplating the phenomenon from multiple perspectives and collecting various types of data. The holistic approach of phenomenology has facilitated a comprehensive understanding of the particular moment and the procedural analysis provided a consistent framework for understanding the individual experiences. Therefore, a phenomenological and procedural approach seems useful in exploring the lived experiences in music therapy.

Furthermore, the lived experiences of clients were investigated in some studies (Amir, 1992; Grocke, 1999; Trondalen, 2005). As the clients were able to describe their experiences, text data was obtained through interviews. In contrast, when clients were non-verbal because of their disabilities, their non-verbal communication acts

were valued as an important indicator of their experiences (Johns, 2013). Likewise, the client participants in the current study are non-verbal and cannot describe their experience in words. Therefore, describing the non-verbal behaviours in micro-detail and interpreting the implicit meanings seem useful in understanding the experiences of non-verbal clients with PIMD. The problem of this method is that the clients cannot validate whether the interpretation is right. However, the aim of phenomenological analysis is not to find the truth but to describe the experience. Therefore, using an interpretative phenomenological framework in exploring the experiences of adults with PIMD seems reasonable in the present study.

Gaps in the Literature and Rationale for a New Study

As a result of literature review on people with disabilities and specifically adults with PIMD, the following gaps are identified in the literature:

- The reviews of the literature on music therapy with people with disabilities show that most studies in music therapy have focused more on children than adults (Brown & Jellison, 2012; Jellison, 2000; Meadows, 1997; Wigram, 1993);
- Similarly, more studies have been conducted on individuals with mild and moderate disabilities than severe and profound disabilities (Hooper et al., 2008a, 2008b; Savarimuthu & Bunnell, 2002).
- Adults with PIMD have received little attention, and therefore the field of music therapy needs more research for this group of people for ongoing professional improvement.
- Given that the existing studies on adults with PIMD is now dated, a new study that reflects on contemporary practice is required.
- Experimental studies (Caron et al., 1996; Ford, 1999; Ghetti, 2002; Pujol, 1994) did not consider clients' preferences or therapeutic relationships with music therapists, which are the core aspects of music therapy. Accordingly, they did not produce positive results, and two studies (Caron et al., 1996; Ford, 1999) were identified as having no effect on the treatment of bruxism in a systematic review (Lang et al., 2009).
- The music therapists who work with adults with PIMD describe unique experiences, however, the lived experiences of music therapists have not been studied yet.

Furthermore, the following information identified from the review provides a rationale and general approach to the current study:

- Case studies (Agrotou, 1994; Graham, 2004; Ritchie, 1993; Watson, 2007), that described the natural process of long-term music therapy, provides in-depth knowledge and insights into working with people with SIMD and PIMD.
- The theoretical notion of intersubjectivity is important in understanding the communication with non-verbal clients (Wheeler, 1999a).
- Recently, music therapists focus on the development of social and relationship building capacity of children with SIMD by designing programs and tools from an intersubjective perspective (Gilboa & Roginsky, 2010; Raglio et al., 2011).
- In previous studies, investigating meaningful experience/moment (Amir, 1992; Johns, 2013) provided in-depth information and insights of the therapeutic interpersonal relationships, which seems useful to be studied further with adults with PIMD.
- Methodologically, phenomenology has been dominantly used in the field of music therapy to explore the lived experiences of music therapists working with particular clientele or experiencing special phenomena or moments in music therapy sessions.

Research Questions

Consequently, based on the gaps in the literature and rationales for a new study identified, research questions for the current study were developed. The main research question is:

“What are the experiences of interpersonal relationships for five music therapists who work with adults who have PIMD?”

Sub-questions are:

1. How do the five music therapists describe *their experiences of building relationships* with adults with PIMD?
2. How can the *meaningful moments of music therapy sessions* identified in single music therapy sessions by the music therapists be described and interpreted?
3. Are there *any common features for the experiences* described by the music therapists and illustrated in their musical encounters with adults who have PIMD?

The following Chapter Four presents the study design, methodology, and methods used to answer the research questions.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

This chapter discusses the study design and methods used in the current study. The first part of the chapter provides rationales for selecting the qualitative flexible study design, and discusses the application of phenomenology in the current study. Phenomenology as philosophy and methodology is discussed, and differences between two contrasting phenomenological approaches, descriptive and interpretative, are compared. The second part explains the methods used across the different stages of research, providing rationales for using them.

Study Design

In this study, a qualitative study design informed by phenomenology was used. Carter and Little (2007, p. 1316) define qualitative research as “social research in which the research relies on text data rather than numerical data, analyzes those data in their textual form rather than converting them to numbers for analysis, aims to understand the meaning of human action”. As the aim of the current study was to understand essence and meanings of the music therapists’ experiences by generating rich descriptions, designing a qualitative study was appropriate. Moreover, as a constructivist, I agree with this particular epistemological view on the way we conceive knowledge: “we are shaped by our lived experiences, and these will always come out in the knowledge we generate as researchers and in the data generated by our subjects” (Lincoln, Lynham, & Guba, 2011, p. 104). Accordingly, I valued the music therapists’ experiences as a source of knowledge, and believed that the research question, “what is the experience of the interpersonal relationships between five music therapists and their adult clients who have PIMD?,” would be best answered by the music therapists who have experienced this phenomena. Furthermore, in a similar context, phenomenology, a study of lived experiences, provided a specific philosophical and methodological guidance over the progress of the research.

In the early stage of designing the current study, three general strategies of qualitative research, “*naturalistic inquiry, flexible emergent design, and purpose*

sampling” (Wheeler & Kenny, 2005, p. 64), were considered important. *Naturalistic inquiry* and *purposeful sampling* were useful in my general approach to data collection. Under these strategies, I planned to invite authentic pairs of music therapists-clients who had been practicing music therapy over several years, and therefore had established interpersonal relationships. I also planned to interview the music therapists, and video record the music therapy sessions in their natural settings such as clients’ homes and adult disability daycare centres. Accordingly, the current research was designed to be “relevant to what music therapists actually do” (Wheeler & Kenny, 2005, p. 64).

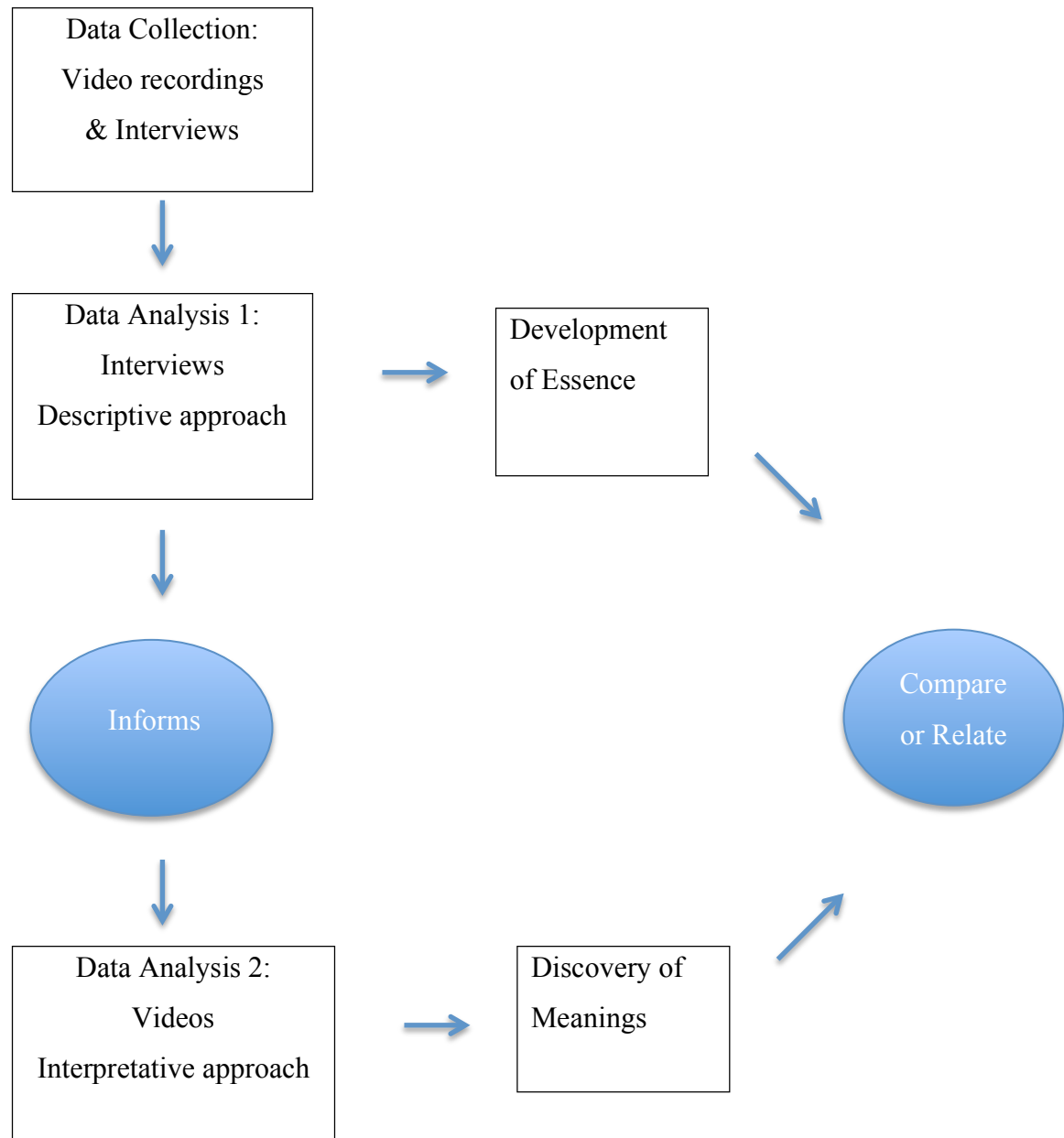
In addition, I used the flexible and emergent design strategy over the course of the current study. Robson (2011, p. 5) describes *flexible designs*, in contrast to *fixed designs*, as “while there may be a considerable amount of preliminary planning, details of procedure are not fixed in advance and the focus is liable to change as the research proceeds. Here the detailed design evolves as a result of what is found out in the early stages.” Similarly, Wheeler and Kenny (2005, p. 64) explain it such as:

An important aspect of qualitative research is that its design is not set and inflexible and may change based on the information that emerges and what the researcher learns during the research process. The researcher pursues new areas as they emerge so that the research evolves, taking advantage of what is learned in its earlier stages.

In the current study, following the nature of the flexible study design, I allowed the phenomenon of the study to guide me in the course of two separate data analyses. A critical moment occurred when I completed the interview analysis using an empirical descriptive approach. As I obtained new information about the phenomena of the interpersonal relationships, using the information in the subsequent video analysis was necessary and useful. Consequently an interpretative analysis approach, which is contrasting to the descriptive approach was used, a distinctive study design has emerged as result. Figure 2 shows the study design of the current study.

Figure 2.

The Emergent Flexible Qualitative Design of the Current Study



Particularly, in the field of phenomenology, mixing two different approaches such as descriptive and interpretative was not recommended (Finlay, 2014; Giorgi, 2006). However, each data required using a different and unique approach. Moreover, because I understood the differences between the two approaches in relation to their philosophical origins, the analysis methods were used for two separate and independent studies. They were also used progressively, using the descriptive analysis method first before conducting the interpretative analysis method. Therefore, the application of two phenomenological analysis methods in the current study was appropriate and also innovative.

Obviously, phenomenology made a significant impact on the current study. In order to understand it more in detail, in the next section, I explain the rationale of choosing phenomenology among the diverse qualitative methodologies and methods. Then the development of phenomenology as philosophy and methodology is discussed. The differences between the descriptive and interpretative approaches are highlighted as well.

Rationale for choosing phenomenology.

In qualitative research, a wide range of methodologies and methods are available. Phenomenology, discourse analysis, grounded theory, ethnography, and participatory action research, and furthermore, new types and variations of these keep emerging in the field of social science, such as anthropology, sociology, and psychology (Lincoln et al., 2011). Each of the different qualitative methods has unique aim and analysis method (Starks & Trinidad, 2007). For example, the aim of phenomenology is to describe the lived experiences of the participants to better understand the phenomenon. Grounded theory aims to generate a theory concerning a phenomenon - not only how it occurs, but also what are its elements as well as its meanings. The aim of ethnography is to describe cultural phenomenon in a way this provides rich contextual description. Discourse analysis aims to “understand how people use language to create and enact identities and activities” (Starks & Trinidad, 2007, p. 1373). Accordingly, depending on the characteristic of phenomenon and the researcher’s interest, researchers can select the most appropriate approach.

Among the various approaches, I chose phenomenology because it provides a specific epistemological stance when studying a phenomenon. Bruscia (2005, pp. 136-137) explains how challenging it is to acquire this particular stance when conducting qualitative research:

The real challenge of doing qualitative research is not so much in the *doing* as it is in the *being*. [...] It is an approach to human inquiry and discovery that can only emerge from a particular way of being in the world. That way of being is that of a discoverer who is exploratory, observant, open, flexible, creative, and committed to learning.

In phenomenology, this way of being is described as having “a *phenomenological attitude*”, which is “questioning the natural attitude instead of taking it for granted” (Finlay, 2011, p. 49), by writing *Epoche* (Finlay, 2008, 2011). Providing the specific guide to getting a certain epistemological position is the most distinguishable feature of phenomenology among the various qualitative approaches (Finlay, 2014). Moreover because of this benefit of phenomenology, Edwards (2012) also recommended it to novice researchers.

Furthermore, another reason that I chose phenomenology lies in its methodological strength. Modern day psychologists have developed various ways to apply phenomenological philosophies into social science research. For example, Finlay (2011) identifies six distinct phenomenological approaches such as: 1) Descriptive Empirical Phenomenology; 2) Hermeneutic Phenomenology; 3) Lifeworld Approaches; 4) Interpretative Phenomenological Analysis (IPA); 5) First-Person Approaches; and 6) Reflexive-Relational Approaches. I was intrigued by the history of phenomenology as philosophy as well as its impact on the contemporary social research. Consequently, I believed that phenomenology had the power to guide me philosophically and methodologically in conducting the current study.

Phenomenology as philosophy.

Phenomenology has a rich history that is originated from the early 20th European philosophies (Starks & Trinidad, 2007). Long before this time, philosophers, such as Goethe (1749-1832), Hegel (1779-1831), and Brentano (1838-1917) provided important contexts for phenomenological ideas (Lewis & Staehler, 2010). They claimed that human experiences should be studied as a whole as they were experienced. However, it was not until Edmund Husserl, that the world of phenomenology opened up to another level. Husserl articulated the concepts of phenomenology as a “philosophical viewpoint” (Forinash & Grocke, 2005).

Edmund Husserl (1859-1938).

At the end of 20th century, science based on positivism rapidly developed with the modernism, and the positivists argued that human experiences could also be studied like natural science (Lewis & Staehler, 2010; Reiners, 2012). Husserl disagreed with the positivists’ views, and was concerned that these approaches will make the society dehumanised. With his famous rallying cry, “Zu den Sachen selbst!” (Back to the things themselves!) (Finlay, 2011, p. 3), Husserl asserted that “researchers should return to study phenomenon within the natural world” (McFerran & Grocke, 2007, p. 274). He also stressed the importance of reflecting the world with *consciousness*. He believed that the world exists independently without our interaction and we should see how the objects appear to our consciousness rather than what the objects are. In this point of view, he valued subjectivity and tried to pursue the true meaning of the object. Husserl systematically developed these notions into a mainstream philosophy by publishing series of books, such as “Logical Investigations” in 1911; “Ideas I and II”²⁵; “Cartesian Meditations” in 1931; and “The Crisis of European Sciences and Transcendental Phenomenology” in 1936 (Finlay, 2011; Lewis & Staehler, 2010). Important concepts discussed by Husserl are: *epoche*; *phenomenological reduction*;

²⁵ The full title is “Pertaining to a Pure Phenomenology and to Phenomenological Philosophy.”

consciousness; intentionality; intersubjectivity; and essence. Husserl became “the founder of modern phenomenology” (Finlay, 2011, p. 44).

Martine Heidegger (1889-1976).

Another important philosopher to understand in the world of phenomenology is Martine Heidegger. He was Husserl’s student and later became his colleague. Heidegger was well versed in Husserl’s phenomenology, however, later he drifted away and developed his unique approach to phenomenology. Heidegger refuted epoche in phenomenology, which was one of the most crucial concepts suggested by Husserl (Reiners, 2012). He asserted that one’s ontological stance is more important than his/her epistemological stance, and accordingly one should consider *being-in-the-world (Dasein)*, and dwell-in-the-world of oneself in order to understand and perceive the subjectivity of the phenomenon (Finlay, 2011). In short, Heidegger believed that one’s existence naturally gives the person a point of view and philosophical stance, thus removing one’s *fore-understandings* on the phenomenon is not possible. Therefore, instead of eliminating the *fore-understandings*, Heidegger claimed that the researcher should actively use it when the phenomenon invites him/her to have a deeper and critical understanding (Smith, 2007).

Difference between Husserl and Heidegger.

The difference between Husserl and Heidegger has influenced modern day psychologists differently (Finlay, 2011; Lopez & Willis, 2004; Reiners, 2012; Wojnar & Swanson, 2007). As a result, two contrasting approaches that are descriptive and interpretative have been developed. Understanding the critical differences of the two approaches with regard to their philosophical roots is extremely important when conducting phenomenological research (Finlay, 2009; Giorgi, 2006). Table 7 compares contrasting concepts of the two philosophers.

Table 7.

Difference between Husserl and Heidegger

	Edmund Husserl	Martine Heidegger
View on epoche	Advocate epoche by bracketing one's pre-assumptions and biases	Reject the concept of epoche
Method of analysis	Phenomenological reduction	Inductive inquiry with interpretations
Intended outcome	Developing essence of the phenomenon	Idiographic: seeks participants' unique lived experiences

First, the most important difference between Husserl and Heidegger was on *epoche* as discussed previously. Second, the difference lies in their views on the processes and intended outcomes of the phenomenological investigations. Husserl believed that by reducing the phenomenon into its essentials, known as *phenomenological reduction*, one can develop an essence of the phenomenon. In contrast, Heidegger believed that individual's unique experiences should be studied by interpreting the phenomenon using his/her fore-understandings.

Phenomenology as methodology.

For a long time, phenomenology has remained as philosophical concept in Europe (Giorgi, 2009a). In early 1960's, American psychologist, Amedeo Giorgi began to seek a practical method that would enable researchers to apply phenomenology into psychological research studies. In the introduction of his late book, "The Descriptive Phenomenological Method in Psychology: A Modified Husserlian Approach", Giorgi (2009a) explains how he made his journey to Europe in search of someone who knew phenomenological research methods. Academics referred him to various people and places, however he could not find anyone who knew the method. When he returned,

he began developing his own method with his colleagues, by organising seminars and classes, at Dusquesne University in United States of America. Consequently, Giorgi's method is known both as being in the *Duquesne Tradition* and *Descriptive Empirical Phenomenology* (Finlay, 2011). Later in 1996, to complement the limitations of the descriptive approach, Jonathan Smith developed an interpretative approach called "Interpretative Phenomenological Analysis (IPA)." The following section describes these two approaches as well as the differences between the two.

Descriptive phenomenological method by Amedeo Giorgi.

I want to make clear that the phenomenological method was initiated by Husserl (1983) and its development pre-existed me by a long shot. All I did was adapt a pre-existing philosophical method in such a way that it could be used for studying psychological phenomena within a scientific context (Giorgi, 2008, p. 34).

Based on Husserl's philosophical principals, Giorgi created a procedural model of analysis and kept developing this unique method throughout the 1970's (Giorgi, 1975). Its step-by-step approach enables the analysis process to be feasible while providing an effective framework for demonstrating the credibility and transparency of the analysis. Therefore, it has been used predominantly by music therapy researchers so far (Forinash & Grocke, 2005). As it is rooted in Husserl's transcendental phenomenology, descriptive empirical phenomenology considers identifying and bracketing one's pre-assumptions and biases, known as *epoche*, a significant and crucial step before conducting the research. Three interlocking steps of the descriptive approach are: a) phenomenological reduction, b) description, and c) search for essence (Finlay, 2009).

Interpretative phenomenological analysis (IPA) by Jonathan Smith.

Jonathan Smith is a psychologist in the United Kingdom who introduced the term IPA and its particular approach to health psychology in 1996 (Smith, 1996). Smith (2011, p. 9) defines IPA as “the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience.” Three central theoretical notions of IPA are phenomenology, hermeneutics²⁶, and idiography (Smith & Eatough, 2007; Smith et al., 2009; Smith & Osborn, 2008). Particularly, the hermeneutic principals such as *double hermeneutics* and *hermeneutic circles* as well as the ideas of *grammatical* and *psychological interpretations* critically have been incorporated into IPA (Smith, 2007). Although it was initially developed to support some limitations of the descriptive approach developed by Giorgi, researchers soon identified its value in creating unique meanings. Accordingly, within a decade, “it has become one of the best known and most commonly used qualitative methodology in psychology” (Smith, 2011, p. 9).

Difference between descriptive and interpretative methods.

Academics in the field of nursing have been prolific in articulating the critical differences between the descriptive and interpretative methods in relation to their philosophical roots in Husserl and Heidegger (Lopez & Willis, 2004; Reiners, 2012; Wojnar & Swanson, 2007). Table 8 summarises the differences.

²⁶ “the philosophy of interpretation” (Reiners, 2012, p. 1)

Table 8.

Difference between Descriptive and Interpretative Approaches

	Critical question	Interested in	Shortcoming	Credibility of the results
Descriptive Edmund Husserl	Epistemology: What do we know as persons?	Participants' rich description of the lived experiences (Participants' voices)	How to completely conduct bracketing?	Going back
Interpretative Martine Heidegger	Ontology: What is being?	Participants' interpretation of the lived experiences (Researchers' voices)	How to manage the personal influence on the results of the data and how to prove the credibility and trustworthiness of the data?	Not going back

Note. This table was created mainly based on the article by Reiners (2012).

As discussed previously, the descriptive approach is based on Edmund Husserl's transcendental phenomenology, whereas IPA is rooted in Martine Heidegger's phenomenology. Husserl was interested in the epistemological question, "what do we know as persons?" (Reiners, 2012, p. 1), and highlighted writing *epoche* and obtaining *phenomenological attitude* characterised by open, fresh, and wondering eyes. In contrast, Heidegger considered one's ontological question as more important, and therefore he denied *epoche* but recommended using one's *fore-understandings* in interpreting the phenomenon. Consequently, the descriptive approach is lead by participants' voices, focusing on their descriptions of the experiences, whereas, the interpretative approach focuses on the critical interpretations made by researcher's voices. In this way, descriptive phenomenologists let the phenomenon appear and speak for themselves, and

interpretative researchers take an active role in finding the meanings. (Lopez & Willis, 2004; Wojnar & Swanson, 2007)

Furthermore, because of the distinctive characteristics of each approach, criticisms become apparent. The descriptive approach is criticised for their use of epoche. “How to completely bracket one’s pre-assumptions and biases?” is the key question asked of the descriptive approach. A critical question of the interpretative approach is “how to manage the personal influence on the results?” In terms of methods showing the credibility of the results, the descriptive approach urges researchers to go back to their participants. This is not advocated by Giorgi (2006) but after Colaizzi (1978) suggested this method, many researchers used it. In the interpretative approach, interpretations are made by the researchers and they do not go back to their participants. Instead, they use other methods to show the validity such as using *the independent audit* which refers to “following the chain of evidence” (Smith et al., 2009, p. 183).

In summary, the two different phenomenological approaches have distinct philosophical orientations and unique methodological differences. Although there is no right or wrong way between these two approaches, it is crucial that researchers should understand the important differences before selecting the appropriate approach.

Methods

This section presents the methods of the current study as conducted in the stages of preparation, data collection, and data analysis in the order that was progressed along the study. In the preparation stage, I obtained approvals for a) ethics from the university and b) data collection from a community disability organisation. Then I recruited participants, wrote epoche, and created an interview guide for data collection. In the stage of data collection, I collected video footage of single music therapy sessions and then interviewed music therapists. In the data analysis stage, I analysed text data first obtained from interviews using the descriptive phenomenological analysis method, and then I analysed video data using the interpretative phenomenological analysis method. The following section provides details.

Ethics approval.

Obtaining ethics approval was essential before recruiting participants. Particularly, as adult clients with PIMD were not able to provide informed consent due to their limited intellectual and cognitive abilities, it was important for me to ensure that they were fully protected from any aspect of the research process. In writing an ethics application, I followed the guidelines of “National Statement on Ethical Conduct in Human Research” (Commonwealth of Australia, 2007-Updated February 2013) published by the Australian Government. The guideline provided important rules when engaging with participants with intellectual disabilities. For example, it suggested that I provide sufficient information to a parent or legal guardian of a client before seeking a formal written consent from them. It also recommended that I stop collecting data if any participant shows negative responses while I video record his/her music therapy session. I submitted the ethics application to the Human Ethics Committee at the University of Melbourne. The committee requested me to provide more information on some literature in music therapy and suggested minor corrections in inclusion criteria of adults with PIMD. After responding to these suggestions, the ethics approval was obtained for the current study (# 1136760, see Appendix A).

Approval for data collection.

To recruit potential music therapists who might have the experiences of building interpersonal relationships with adult clients with PIMD, a not-for-profit community organisation that has the biggest music therapy department in the State of Victoria in Australia was an important place to engage with for the purposes of this study. Their main clients are adults with a wide range of disabilities including PIMD, and the music therapy team usually consists of seven or eight music therapists. Accordingly, recruiting some music therapists from this organisation was reasonable and efficient. Before contacting the music therapists, I submitted a request for approval for the research study to the organisation and received the letter of approval.

Recruitment of participants.

As phenomenological investigations require in-depth analysis of participants' experiences, only a small number of participants are recommended (Englander, 2012). Some scholars have interpreted a small number to be between three and six participants, which is often the amount that seems feasible to researchers. I initially intended to recruit six pairs of music therapists and clients.

Inclusion criteria for the participants.

The inclusion criteria for the music therapist was a person who:

- a) was qualified or registered as a music therapist with the Australian Music Therapy Association and,
- b) had work experience of more than a year with the client who had PIMD.

When a music therapist agreed to participate, s/he was asked to recommend his/her client who they believed to have interpersonal relationships. The inclusion criteria for the adults with PIMD were a person who:

- a) was aged between 19 and 60 and diagnosed with profound levels of two or more major disabilities/impairments in physical, intellectual, sensory, and medical areas and,
- b) had been attending music therapy sessions for more than a year with the participating therapist.

Recruiting music therapists.

As I sought people who have particular experiences in building interpersonal relationships with an adult client with PIMD in music therapy, a *purposeful sampling strategy* (Patton, 2001) was used for recruiting the participants for the current study. First, I contacted music therapists who specialise in adult disability in my professional network in Melbourne. At the time of recruitment, I was working in the not-for-profit community organisation where I obtained the approval of research study. Therefore, I was familiar with the music therapists and their work. In a team meeting, I provided them verbal information about my research study and also provided written information in a form of plain language statement (see Appendix B) and a consent form (see Appendix C). Initially, four music therapists met the inclusion criteria and showed interests in the study. Then, I suggested they recommend their clients who met the inclusion criteria. The four music therapists immediately identified a client. To recruit more music therapists, I contacted two music therapists I met at music therapy conferences. One music therapist was running a private music therapy practice and experienced in this clinical area for over 15 years. The other music therapist was working in an institutional setting in Sydney. I invited the music therapists to the study via email and personal communication. Both of them willingly accepted the invitations.

Secondly, I searched Australian Music Therapy Membership Directory 2012 (Australian Music Therapy Association, 2012) to identify music therapists who stated that they specialised in adult disability. A total of 12 music therapists were found, and I contacted them via emails and phone calls. I was familiar with some music therapists who were practising in Melbourne, but unfamiliar with some music therapists who were practicing in other states of Australia. Most music therapists

declined their participation for various reasons. Some music therapists were not practising at the time, and some were busy with other work. As I was recruiting them in November, some of them were busy in preparing Christmas concerts in December. Consequently, I recruited a total of six music therapists consisting of four music therapists from a community organisation and two music therapists through my professional network.

Recruiting adult clients with PIMD.

The music therapists who agreed to participate in the study explained their participation to the parents or legal guardians of the clients. When the parents or legal guardians showed interest or gave verbal consents, the music therapists provided me with their phone numbers. In the follow-up phone call, I briefly explained my study and asked for their interest. If they show positive responses, then I asked their addresses to post an information sheet (see Appendix D) and a consent form (see Appendix E). I also asked for their preferred time for data collection. Most parents and legal guardians positively responded to me in the phone conversation. Later, I visited the pairs of music therapists and clients in their natural music therapy settings to video record a single music therapy session. When I arrived at the session, I provided a demographic survey form (see Appendix F) for the parents to complete. Information of the client such as date of birth, diagnoses, music therapy history, and communication methods was asked in this form.

A withdrawn pair.

Initially, a total of six pairs of therapists-clients were successfully recruited. However, later during the data collection, a pair from the community organisation had to withdraw from the study because the client became sick and could not participate in music therapy for a period of time over several weeks. Finally, only five pairs completed the data collection.

Participant information.

The information about the five pairs of participants is provided in table 9. Left section of the table shows information about the Registered Music Therapists (RMTs) including name, gender, age, and number of years of clinical experience. Right side of the table shows the information of the clients, such as name, gender, age, and diagnoses. All names are pseudonyms and these will be used throughout the study so that a sense of identity becomes connected to these names. This is in preference to the objectivist tradition of allocating numbers to participants so that no sense of the individual is revealed.

Table 9.

Information of the Participants

	RMT	Gender/ Age	Clinical experience	Client	Gender/ Age	Diagnoses
Pair 1	Frances	F/40s	6 Years	Amy	F/19	Rett syndrome, Epilepsy
Pair 2	Steve	M/30s	3 Years	Eva	F/22	Moya moya brain disease, Cerebral palsy (Spastic quadriplegia), Epilepsy
Pair 3	Erica	F/50s	15 Years	Mark	M/22	Cerebral palsy (Spastic quadriplegia), Renal failure - Blinded right eye
				<u>Lyn</u>	<u>F/28</u>	Rett syndrome, <u>Epilepsy</u>
Pair 4	Darren	M/30s	6 Years	Mia	F/29	Mitochondrial cytopathy, Movement disorder, Epilepsy, Metabolic disorder
Pair 5	Owen	M/30s	5 Years	Nelson	M/46	Cerebral palsy, Severe developmental delay, Epilepsy, Arthritis, Oesophageal dysphagia

Note: RMT is abbreviation of Registered Music Therapist, which is the official term for a music therapist in Australia.

Collectively, average years of the clinical practice across the five pairs were four years at the time of data collection. It was the mothers of the clients who positively responded to the recruitment process and willingly provided consent for their adult children to participate in the current study. The following section introduces each pair of music therapist and his/her client, and describes the recruitment process.

Frances and Amy.

Frances was the coordinator of the music therapy team at the community organisation at the time of the data collection. In a team meeting, when I invited her, Frances agreed to participate in the study and immediately recommended Amy. Later, she explained her participation in the study to Amy's mother. Because the mother agreed for Amy to participate in the study, Frances provided me the contact number of Amy's mother. Then, I made a phone-call to her to find out the address of the Amy's place, and the plain language statement and consent form were sent to her. Frances and Amy had been working for over four years at the time of data collection. Amy's carer, Judy, also had been attending music therapy to assist Amy's participation, and therefore video-recording a natural music therapy session including Judy was appropriate when collecting data.

Steve and Eva.

Steve was one of the music therapists working at the community disability organisation. He usually conducted weekly group sessions in an adult day care centre. For the current study, Steve chose Eva among the group of clients because Eva showed good musical responses and he believed that they developed a good relationship over two years. Getting an approval for video recording of a group session from the centre manager was priority in this case. After receiving a contact detail of the manager from Steve, I made a phone call to her to explain the research project. The manager approved the data collection to be conducted in the centre and suggested sending a plain language statement and consent form to her, which then were sent to Eva's mother.

Erica and Mark.

I had known Erica from a music therapy conference. As the most experienced music therapist, Erica was interested in conducting a research project. When I met her in another conference, I explained her about my study and invited her to participate. She willingly accepted the invitation and immediately recommended Mark to participate in the study with her. It was because they had been practising music therapy for over six years and Erica felt that they had been establishing a meaningful relationship. As Erica requested, I had sent two sets of plain language statement and consent form: one for Erica and one for Mark's mother. On the day of video recording of the session, Mark's mother provided me the signed consent form and also completed the demographic survey form. She was sitting in the music therapy room reading a newspaper for the first half of the session as she does usually, but later joined the session to encourage Mark to vocalise.

Darren, Lyn, and Mia.

Darren was working at the community organisation and the only music therapist who participated in the study with two female clients. As the two clients had been receiving music therapy together for over eight years, I thought that it would be natural to study the dynamics of the relationships in this small group. After agreeing to his involvement, Darren explained his participation to the mothers of Lyn and Mia, and they agreed to participate. Then, Darren provided me the contact number of Lyn's mother and I made a phone-call to her to explain the study and obtain their addresses for sending plain language statements and consent forms. We also scheduled an appropriate date for video recording. On the morning of the video-recording day, the two mothers provided me the signed consent forms and completed demographic survey forms.

Owen and Nelson.

Owen was the only music therapist practising at a residential institution in Sydney at the time of data collection. I emailed Owen and invited him to the study. He explained that he was not in the music therapy position at the time of contact but he was planning to return to it by the time of data collection, so he was willing to involve in the study. When I asked about a client who is suitable for this study, Owen immediately thought of Nelson as they had been practicing music therapy over six years and Owen felt special connection with him. Nelson's case manager in the ward organised receiving written consent from Nelson's mother. To collect data, I flew to Sydney and due to time restraint; I video recorded the music therapy session in the morning and then interviewed Owen in the afternoon.

Before collecting data, creating epoche, and *an interview guide* were essential steps in the process. The following section explains how I conducted these two tasks.

Creating epoche.

“The epoche is a suspension of judgement; the Greek *epechein* means to suspend, refrain, and bracket. Specifically, the phenomenological epoche means a suspension of judgement regarding the being of the world which is neither affirmed nor denied” (Lewis & Staehler, 2010, p. 14). In Husserlian phenomenology, creating epoche is considered a crucial step before collecting data (Finlay, 2011; Giorgi, 2009a; Moustakas, 1994) and it required bracketing one's pre-assumptions, biases, and prejudices about the phenomenon under study. Finlay (2008, p. 2) describes how this process of epoche enables the researcher to obtain the *phenomenological attitude*:

The “phenomenological attitude” involves a radical transformation in our approach where we strive to suspend presuppositions and go beyond the natural attitude of taken-for-granted understanding. It involves the researcher engaging a certain sense of wonder and openness to the world while, at the same time, reflexively restraining pre-understanding.

In order to achieve this phenomenological attitude through development of the epoche, I searched for a method by reading several text books in phenomenology. Although they all discuss what epoche is and how it is important, there was no single paper providing a step-by-step guide on how to write an epoche or a good example. Accordingly, I decided to conduct it by literally writing all my accumulated experiences and knowledge about the phenomenon of the study. I reflected on my experiences as a music therapy clinician and researcher while working with adults with PIMD. I also reviewed the literature that may have informed some of my pre-conceptions. By writing them down, I was able to articulate them and then psychologically put them aside during the data collection and analysis process. Box 1 shows my epoche²⁷ for the current study.

²⁷ A summary of epoche is presented on page 129.

Box 1.*Epoche for the Current Study***My experience as a music therapist working with adults with PIMD.**

In June 2006, I completed a graduate diploma course in music therapy at the University of Melbourne. Honestly, I did not have a particular interest in any specific field to work and just hoped to get any position as a professional music therapist. Luckily, my university friend, Carol who graduated in the previous semester suggested me to take over her position when she went overseas travelling. The music therapy manager at Able Australia Services sent me a text message to schedule an interview. When the interview was completed, I was successfully offered with the position. I worked for five full days and one of the places was an adult day-care centre. I did not have a clinical placement experience with adult with PIMD so I was very worried on the night before my first day. I had to call Carol and asked her advice. She said to me, “don’t worry. Just relax and see what you can do.”

The following morning, I went to the centre with the manager who had worked in that daycentre for six years as a music therapist. The first impression of the centre was chaos. There was no space between people in the crowded house. Many clients were in wheelchairs, appeared deformed, and produced weird sounds. Thankfully, the staff was nice and friendly. They showed me a small room with an organ where I could work. As it was a very small room, I was able to take only several clients at a time. Initially I was not sure what to do, as the clients seemed not able to understand what I was doing, and also I did not understand what they were doing. I felt there was no meaningful response at all for six months. I felt worried, doubted, and questioned about my work, whether I was doing alright. When I reflect on those days, I think that I might have not been confident about what I was doing as a beginner music therapist. Although I attended monthly meetings with my colleagues for peer supervisions, which helped me in general, having an intense individual supervision with a senior music therapist who has experience in working with adults with PIMD might have helped me more in understanding my clients.

Nevertheless, I had passion and energy to do something great as a professional music therapist. I was the one who came all the way from South Korea,

the other side of the world to be a good music therapist. I started reading each client's profile that consists with diagnosis, result of music therapy assessment, preferred song list; and music therapist's session notes. Everything was well documented and the most of it was the music therapist's record of observed responses and behaviours of the clients. Based on that information, I tried a variety of songs and activities to make our music sessions fun and interactive.

Fortunately, after about six months later, the day-care centre moved to a new place in early 2007. This new place was a big house with a separated small building. These buildings had a typical home structure so there were kitchens, toilets, a lounge, and small rooms. We also had a multi-sensory room with a vibroacoustic bed. This new place was spacious and as spaces were separated, small groups of clients were gathered in one place and participated in different activities for a day. Also, several other groups went out for outdoor activities, such as swimming, bowling, or visiting parks. The new organised environment made the centre look like a heaven. I felt happier as the clients appeared more comfortable and relaxed in the new place.

Discovery of enjoyment and preference of the clients.

In the new place, I started noticing that the clients were actually attentive to what I was doing. They started to show their enjoyment through rocking their body rhythmically, displaying smiles, and bursting laughs. This gave me such a surprise and pleasure. One day, a female client, Liz, was sitting on the ground in the front garden enjoying sunshine. I thought that I better sing a song for her as she did not participate in the group session as a result of being outside alone. After observing her mood and talking to her, I sang the song "Rock around the clock" (Freedman & Myers, 1954). Surprisingly, she fully enjoyed the song vigorously rocking her upper body, making an eye contact with me and smiling. This was a very impressive moment and I instantly knew that Liz loved this song very much.

After that, whenever we had a music therapy session, I sang "Rock around the clock" for Liz and Liz looked at my eyes, then big smile was spread across her face, and she actively rocked her upper body with hands shaking back and forth. Liz showed the exact responses whenever I sang this song to her. I noticed that other clients also had their song-preferences. They would not respond to other songs but

only to particular songs. Then I thought that preference is very important for this population, and this is a good motivator for them to initiate participation and communication. I was able to see their improvement by observing the level of engagement, interaction, the participation and enjoyment in the session. Consequently, I went to see Dr McFerran to discuss whether I can conduct a research project with my clients to examine whether they improve communication skills through song-choice in individual music therapy.

Masters research study and reflection.

I was very passionate and enthusiastic about proving the positive effect of music therapy on my clients as I observed my clients' happiness when we had music therapy sessions and I thought possible benefits of the sessions relating to their general wellbeing might be so valuable. However, there was little literature in the field of music therapy articulating on this topic, and I did not feel that our work with adults with PIMD was respected enough. The manager and staff at the day-care centre were very supportive of my work and this was helpful for me to conduct my first music therapy research project (Lee, 2009). I designed song-preference assessments and song-choice intervention sessions in order to investigate whether participating in these sessions improved communication skills of five females with PIMD. A total of 13 individual sessions were conducted.

The results were encouraging. Two out of five participants refined their choice-making skills, such as selecting a song-card out of two cards, and alternating eye-gaze between a song-card and me. Three clients actively interacted with me during the song-choice process using their facial expressions and vocalisations but due to their visual impairment and limitation of their hand-use, they did not develop any typical choice-making skills. However, regardless of developing choice-making skills, their general interactions with me seemed improved as I felt that I was able to understand their idiosyncratic choice-making behaviours.

Most of all, the enjoyment and interaction while sharing their preferred songs were meaningful and seemed more important than the development of choice-making skills. I realised that there are clear limitations for some of the clients who cannot develop typical communication skills but we can develop interpersonal relationships and share meaningful time interacting with each other and this might be the main

purpose of therapy for them. As the clients display non-verbal idiosyncratic communication behaviours, the unique interaction/communication/relationship patterns have intersubjective characteristics. The concept of 'intersubjectivity' emerged from 'mother/infant' studies (see chapter 2, pp. 41-42) and this seems to have high relevance to each other.

My own interpersonal relationships with adults with PIMD.

It is challenging to select only one client to describe an interpersonal relationship. I have developed these interpersonal relationships with the five clients who participated in my previous research study. Among them, I would like to particularly describe the relationships with Grace and Liz. Grace was a female with Italian background in her late 20's. She was diagnosed with cerebral palsy, profound intellectual disability, and cortical vision impairment. In the triple C checklist²⁸ (Bloomberg & West, 1999; Bloomberg, West, Johnson, & Iacono, 2009), Grace was in stage two out of six stages. She was very expressive, sociable, and generally happy with being with others. She communicated with facial expressions producing affective sounds, and sometimes produced speech-like sounds. As she loved listening to various songs, responding expressively to different songs, I enjoyed working with her very much.

In time, I noticed that she understood most of what I said to her because she responded well by producing appropriate facial expressions and vocalisations. With a suggestion of a speech therapist, I started to let her produce vocal sounds in the certain parts of familiar songs. For example, while singing a song Mamma Mia (Andersson, Anderson, & Ulvaeus, 1973) by Abba, whenever I paused after "Mamma," she would vocalise the part of "Mia." She would produce sounds, such as "Ah~!" and "Ooh~!" Sometimes, she would say "Mia" and this sounded very much like "Mia." I usually responded back to her immediately saying "Wow, well-done Grace" or "Wonderful." I also clapped for her after singing to praise her for producing such fantastic sounds in songs. Grace would laugh, producing exciting

²⁸ It is an assessment tool that evaluates communication abilities of adults with SIMD and PIMD.

sounds. Singing with her and watching her being very happy made me feel so happy and I felt that we were connected and understood each other, sharing the same feelings through music.

We often sang Abba songs in this manner in group sessions. Grace was distracted from the sounds from the group due to her vision impairment and did not vocalise for a while. However, I tried to consistently give her opportunities whenever we sang in a group session, after about one year, she started to vocalise with me in group sessions. This impressed staff and after that staff often went to Grace and would sing “Mamma,” encouraging her to vocalise after them. Grace usually laughed in these situations. I felt so proud of her.

I would like to also describe my interpersonal relationship with Liz as well. She was in stage 3 in triple C Checklist (Bloomberg & West, 1999; Bloomberg et al., 2009) and often displayed self-injurious behaviours when she first came to the centre in 2007. Staff explained that when she was in a crowded place, she would yell, hit a staff near her, or hit a wall with her elbow. Liz never vocalised or produced any sounds in music therapy session but when she was distressed she yelled for a long time yelling “Ah!, Ah!, Ah!, Ah!...” This vocalisation was produced for every second for as long as she was in distress.

In music therapy sessions, however, she was very quiet and happy, making eye contact, smiling, and rocking her body vigorously. I thought that Liz only used vocalisation to let others know that she was distressed so I should not expect her to vocalise in the music therapy sessions because that meant she was not happy. Another thing I noticed from the research study, she communicated with her eyes. She seemed to understand what I said to her when I spoke in a simple sentence, repeating it several times, she would make an eye-contact with me and this meant “yes” or “I like that.” Thus, whenever I communicated with her, I just observed her eyes. Also, whenever I heard her yelling, I went and tried to take her out of the situation and provided a quiet and spacious place. I felt like I knew her very well and when I considered the reason of her behaviours within different contexts I was able to understand her.

From the reflection on the two interpersonal relationships, I realised that having an interpersonal relationship with someone might mean that you know and understand each other very well and two people have built their unique ways of interaction and communication.

Pre-assumptions about other music therapists' experiences.

I believe that other music therapists have their own stories with adult clients with PIMD. This will be highly related to their personal background, belief, and any particular situations. With a combination of the complexity that each client brings in therapy sessions, the experience of interpersonal relationships will be unique for each case. However, on the other hand, I believe that there might be some common or shared characteristics of the experiences among the six music therapists who work with clients with PIMD. It can be challenging to articulate or describe their intersubjective experience to anyone but to the music therapy researcher who has similar work experience to them and it might be easier to talk.

Working with adults with PIMD who have limited abilities in most areas and who are non-verbal, requires patience, consistency, and respect for the clients. I want to know how the other music therapists have been feeling and dealing with the negative feelings caused initially from the lack of communication. Also I want to know when they experience the intersubjective relationships with their clients and how they felt. From my experience, working with adults with PIMD is not easy, it is a guessing game that requires a lot of patience and intuition in many situations and the music therapists have to follow their instincts and believe in their therapeutic skills. However, once a successful relationship is established, the feelings of joy, happiness, connectedness, and togetherness are enormous and huge. I believe that appropriate interview questions can facilitate all this information as described by the participating music therapists.

Creating an interview guide.

The research interview is defined as “a conversation with a structure and a purpose; it involves careful questioning and listening with the purpose of obtaining thoroughly tested knowledge” (Kvale & Brinkmann, 2009, p. 327). A guideline for a phenomenological interview discussed by Englander (2012) was useful in generating important questions. The book, “Interviews: Learning the Craft of Qualitative Research Interviewing” by Kvale and Brinkmann (2009), also provided useful information while preparing an interview guide. Particularly, conducting thematizing, was recommended, which “refers to the formulation of research questions and a theoretical clarification of the theme investigated. The key questions when planning an interview investigation concern the why, what, and how of the interview” (Kvale & Brinkmann, 2009, p. 105). Table 10 shows how I structured the in-depth interviews, concerning what (question), why (purpose of the question), how (type of the question).

Table 10.

Types and Purposes of the Interview Questions

	Types of question (how)	Question (what)	Purpose (why)
Part I	Introducing question	Q1. Can you tell me about your clinical experience in general, and then specifically with adults with PIMD, like places you've been working and how long?	Warm-up/ Background information about the music therapist
Part II	Structuring question	Q2. So, can you tell me about [the client's name]?	Warm-up for Part II/ Background information about the client
	Direct question	Q3. Now, please reflect on any specific moment or session in which you felt you have a meaningful relationship with [the client's name]. And can you go back into that moment or session, and describe in as much detail as possible? What happened and how did you know that that was meaningful?	To obtain detailed description of the music therapist's perception on the interpersonal relationship with the client
Part III	Structuring question	Q4. Can you recall any specific moment that may be worthwhile to talk about first?	Warm-up for Part III/ Asking the music therapist's opinion on any specific moment
	Direct question	Q5. As we watch the session, can you pause at any moment that you think is meaningful?	To identify a meaningful moment in the music therapy session
	Specifying question	Q6. Can you describe what happened and why you choose this moment meaningful?	To understand the music therapist's perception on the moment and reason of choosing the moment

The overall aim of the interview was to obtain descriptions of interpersonal relationships and meaningful moments of a video-recorded session. Accordingly, I divided the interview into three parts and generated one or two questions depending on the purpose of each part (why and what). Creating appropriate questions was important. Among the eight different types of interview questions suggested by Kvale and Brinkmann (2009), *introductory*, *direct*, and *structuring questions* were considered essential, as introductory questions “may yield spontaneous, rich descriptions where the subjects themselves provide what they have experienced as the main aspects of the phenomena investigated” (Kvale & Brinkmann, 2009, p. 135). Likewise, structuring questions were important when moving onto the next part of the interview. Following these questions, sub-questions that may help the process of the interviews such as *follow-up*, *probing*, *specifying*, *direct*, *indirect*, *interpreting questions and silence* were also considered, and some useful phrases that prompted me during the interviews were developed and included in the interview guide. Box 2 shows the *Interview Guide* prepared for the current study.

Box 2.**Interview Guide****Introduction**

Thank you so much [RMT's name] for allowing me to interview you. I am interested in how music therapists and adults with Profound Intellectual and Multiple Disabilities interact and build relationships in music therapy. It is because having meaningful relationships with close others is important for everyone to maintain a good quality of life. So I would like to listen to your experience as an experienced music therapist.

This interview will be divided into three sections. The first part of the interview will be about your experience as a music therapist working with adults with PIMD in general. In the second part of the interview, I will ask you some questions about the client who is participating in the current study with you. And then finally, we will have a look at the video clip of your music therapy session and discuss about some moments. You can ask me any questions and freely say anything in between questions. So shall we start?

Part I

Q1. Can you tell me about your clinical experience as a music therapist in general, and then specifically with adults with PIMD, like the places you've been working and how long?

- *What do you mean by "... "?*
- *When you said, "... " that seems important to me. Can you tell me more about that?*
- *How did that feel like?/What did it feel like?/How did that make you feel?*
- *Could you say something more about that?*
- *Do you have further/similar examples of this?*

Part II

Thank you. Now I would like to talk about [client's name]. Because you reported that you know and understand the client well and also you said you feel connected with her/him in music therapy, so I believe that he/she has developed a good relationship with you.

Q2. So, can you tell me about [the client's name]?

Q3. Now, please reflect on any specific moment or session in which you felt you have a meaningful relationship with [the client's name]. And can you go back into that moment or session, and describe in as much detail as possible? What happened and how did you know that that was meaningful?

Or if they find it difficult to answer:

Can you please describe in as much detail as possible a situation in which you experienced the most meaningful moment you remember in your work with this client?

- *What do you mean by "...”?*
- *Can you tell me more about "...”?*
- *When you said, "...” that seems important to me. Can you tell me more about that?*
- *How did that feel like?/What did it feel like?/How did that make you feel?*
- *Can you give me a more detailed description of what happened?*
- *Is it correct that you feel that...?*
- *How do you feel /think about this relationship?*
- *Can you tell me how this moment or session influenced your relationship with [the client] in music therapy?*

Is there anything more to comment about your clinical work with the client? (any information, feelings, and thoughts about your experience with the client in music therapy?)

Part III

Now, let's have a look at the video footage of your music therapy session with [client's name].

Q4. Can you recall any specific moment that may be worthwhile to talk about first?

If "yes," watch that part of the video footage, and go to Q6,

If "no," play the video footage from the start and ask this question:

Q5. As we watch the session, can you pause at any moment that you think is meaningful?

Q6. Can you describe what happened and why you choose this moment meaningful?

- *What did you do? Why did you do that?*
- *How did you feel?*
- *What did you think?/How did it make you feel?/What did that make you think?*
- *Is this your typical interaction/communication patterns?*
- *What's your approach/method when interacting with [the client's name]?*
- *What do you think about it?*
- *What is your opinion of what happened?*

Thank you so much, now, before you finish, do you have anything more to say about anything? Please feel free to do so, if you have any.

Thank you very much. This interview was very helpful for me to understand your work with [the client's name]. Your time and effort are very much appreciated. The recorded interview will be transcribed and then this will be emailed for you to verify the contents. So thank you so much again. Bye.

Data collection.

Data triangulation, which refers to “the use of more than one method of data collection (e.g. observation, interviews, documents),” was used in the current study “to enhance the rigour of the research” (Robson, 2011, p. 158). Among various data collection methods such as surveys, questionnaires, and various types of interviews; in-depth phenomenological interview (Englander, 2012) and video observation were chosen to gather *data on experiences* of interpersonal relationships and *data on persons* experiencing meaningful moments in music therapy sessions (Bruscia, 2005).

Settings.

As the current study was conducted as a naturalistic investigation (Lincoln & Guba, 1985), data was collected in natural settings such as clients’ houses, day-care centre, and therapists’ studios. Table 11 reports the settings.

Table 11.

Settings for the Data Collection

	Place for the session recording	Place for the interview
Frances & Amy	Amy’s home	Music therapy office
Steve & Eva	Adult day-care centre	Music therapy office
Erica & Mark	Erica’s music therapy studio	Erica’s music therapy Studio
Darren, Lyn, & Mia	Lyn’s home	Darren’s home
Owen & Nelson	Nelson’s bedroom in a residential institution	Owen’s music therapy office

Equipment used.

To video-record the music therapy sessions, the following equipment was used:

- Sony digital video camera recorder “Handycam” Model No. DCR-SR42E
- Sony wide conversion lens $\times 0.7$ VCL-HGA07
- Inca tri-pod AT3530

To record interviews, the following equipment was used:

- Audio recording device 24-bit WAVE/MP3 recorder “Edirol R-09” made by Roland.
- Samsung Digital Audio Player “yepp” YP-T8

An extra audio recording device was used just in case of any faulty occurring with the primary device.

Procedure of data collection.

Stage 1. Video recording of the music therapy sessions.

I visited the pairs’ music therapy sessions to video-record a single session. From the descriptive phenomenological perspective, I assumed that a single session would reflect the pairs’ typical interactions and essence of their music therapy sessions. However, the music therapists were informed that if they felt the session did not reflect their typical sessions, recording extra sessions were recommended.

When I visited their music therapy sessions, my role was *the observer-as-participant* who “is someone who takes no part in the activity but whose status as researcher is known to the participants” (Robson, 2011, p. 323). When I arrived, I greeted the music therapist, the clients and their carers, and set up the video recording devices. While placing the recording devices, I tried to create enough space between the participants and me in order not to interrupt them. During the session, I tried not

to affect the participants and remained silent. However, because each place was different, in terms of the size of the room and condition of the light, I had to keep re-adjusting the position of the recording device or controlling the light, using curtains or switches, and this sometimes caught their attention²⁹ as seen in the video footage as a result. The average of session times was 30 minutes. The following explains how I conducted the video collection with each pair.

Frances and Amy: I visited Amy's house. Her support carer, Judy welcomed me to the house. Judy participated in the music therapy session as usual.

Darren, Lyn, and Mia: I visited Lyn's house. Mia was living in the next house and came to Lyn's house to participate in the music therapy session. The mothers welcomed me to the house.

Erica and Mark: I visited Erica's music therapy studio that was part of Erica's house. Mark's mother brought him to the music therapy session and stayed in the same room for the session. For the first 20 minutes, the mother was reading a newspaper as usual but because Mark did not seem actively participating in the session, the mother joined the session towards the end of the session.

Owen and Nelson: I flew to Sydney. The session was conducted in Nelson's bedroom in a residential institution.

Steve and Eva: Music therapy session was conducted in Eva's day-care centre. On the first day when the data collection was planned, Eva was not able to attend the centre because of her sickness. She was unwell for several weeks so consequently the actual recording of a music therapy session was occurred in the week of Christmas. Therefore, the group music therapy session, in which Steve and Eva usually meet with each other, became a big party session where people sang various carols with much excitement and pleasure. Accordingly, many clients, disability support workers, as well as musical instruments played by them produced lots of sounds. Therefore, I suggested to Steve to conduct a short individual session with Eva after the group session.

In this way, the quality of the video clip was ensured and five single music therapy sessions of each pair were recorded and saved securely as computer files in my laptop and external hard drive.

²⁹ This issue is fully discussed on Chapter 7, page 251 and 252.

Stage 2: Interviewing the music therapists.

Referring to the *interview guide* (Box 2, see pp. 106-108), I conducted phenomenological interviews with each of the music therapist. Before starting the interviews, I set up the audio equipment in appropriate positions and also prepared a laptop to watch video recorded sessions in the last part of the interviews. When the music therapist was ready for the interview, the audio recording devices were switched on and I began the interview. It was divided into three parts and the questions were asked as follow:

Part I

Question 1: “Can you tell me about your clinical experience as a music therapist in general and then specifically with adults with PIMD, like the places you’ve been working and how long?”

After providing a general introduction as written in the guide, I asked the very first question. Music therapists actively started talking about their clinical experiences. Most of them described their clinical experience after being registered as a music therapist. Then I freely asked subsequent questions to clarify some facts of what the music therapist was talking or facilitate more information. “Can you tell me more about that?” was the most frequently asked question. Then, when I felt that I had understood enough about their clinical experiences as music therapists and working with adults with PIMD in general, I moved on to the Part II to talk about the participating client.

Part II

Question 2: “Can you tell me about [client’s name]?”

The second question encouraged the music therapist to start describing his/her client. They provided background information about the client, such as age, diagnoses, characteristics, idiosyncratic behaviours, and typical participation in music therapy

sessions. They also reflected on the process of building interpersonal relationship with the client in music therapy. The music therapists described their work over the last several years. They appeared passionate and enthusiastic. When I felt that I understood enough of their relationships, I asked the third question.

Question 3: Now, please reflect on any specific moment or session in which you felt you have a meaningful relationship with this client. And can you go back into that moment or session, and describe in as much detail as possible? What happened and how you knew that that was meaningful?

This third question appeared to catch some of the music therapists by surprise. Frances and Erica were not sure about this question and took a long time to answer. After the interview session, Frances said that every moment with Eva was meaningful so she was not sure how to answer the question. Similarly, Erica appeared flustered on this question. She looked at the session notes where she documented each and every session, and started looking for a specific session that was meaningful for her. She found a special session that she had with Mark on the week of his 21st birthday. It seemed to be a memorable session for Erica, but obviously it was not a good example of ideal music therapy session for Erica as she explained. In contrast, Darren, Owen, and Steve appeared comfortable with this question and immediately answered.

Part III

Question 4: “Can you recall any specific moment that may be worthwhile to talk about first?”

Question 5: “Can you describe what is happening, and explain why you choose this moment meaningful?”

In Part III, the music therapist and I watched the video recorded session. Before watching it, I asked the music therapists Question 4, whether they could identify a meaningful moment in the recorded session without having to watch the entire session. Except Frances, who pointed out a moment straight away, most music

therapists wanted to watch the entire session and then decide a meaningful moment. While watching the entire session, the audio device kept recording the conversations between the music therapists and myself. When they felt that they found a meaningful moment, they asked me to pause the video footage and I asked the final question about describing the situation and explaining the reason they chose the particular moment. After soliciting the descriptions of the video footage, I asked the music therapists for their final comments on the topic we had discussed and the interviews ended. The average time spent in the interviews was 82 minutes.

Data analysis.

After collecting two different types of data, I analysed the interview data first using a descriptive analysis method. When I finished analysing the interviews and writing the results in an article for a journal, I then moved on to the video analysis using the interpretative analysis method. Conducting these two different types of the analysis separately and progressively was extremely important in this study as these two methods have different philosophical roots. The following section explains the procedure in detail.

Procedure of the data analysis.

Stage 1: Analysing the interviews.

A phenomenological microanalysis method, described by music therapy researchers (McFerran & Grocke, 2007) was used to analyse text data obtained from the interviews. The aim of using this method was “to elucidate the experience in a way that captures its essential meaning to the person who is describing the event” (McFerran & Grocke, 2007, p. 273). Some elements of three descriptive research methods developed by Giorgi (2009a), Moustakas (1994), and Colaizzi (1978) were incorporated into the seven steps of this method. Giorgi’s procedural step-by-step approach, Moustakas’ extended stages of imaginative variations (noema-noesis), and Colaizzi’s suggestion about going back to the participants with the outcome of

analysis were all integrated. In order to follow the seven steps and recommendations offered by McFerran and Grocke, I also returned to the original textbooks by Giorgi and Moustakas in detail. Furthermore a textbook and academic articles written by Finlay (2008, 2009, 2011) guided me along the analysis process.

Seven-Steps Microanalysis (McFerran & Grocke, 2007, p. 275)

- Step 1. Transcribing the interview word for word
- Step 2. Identifying key statements
- Step 3. Creating structural meaning units
- Step 4. Creating experienced meaning units
- Step 5. Developing the individual distilled essence
- Step 6. Identifying collective themes
- Step 7. Creating global meaning units and the final distilled essence

A detailed account of the analysis process is presented in Chapter Five. The results of step 2 and 3 are reported in the appendices (see Appendix G for Steve; Appendix H for Frances; Appendix I for Darren; Appendix J for Owen; Appendix K for Erica). The interview transcripts and the raw data analysis can be also found on the accompanying data disk³⁰ in the folder titled “Interview Analysis.”

Stage 2: Analysing the video data.

Conducting the descriptive analysis for the interviews during the first stage provided me with a great deal of information about the clients and their relationships with the music therapists. Because of the flexible study design, the information I acquired from the previous stage allowed me to develop a deeper understanding at this second stage of analysis. Moreover, the type of data I was analysing was video footage that contained various information such as auditory, visual, spoken languages, and the non-verbal behaviours of the adult participants with PIMD. Describing this complex information required me to adopt an interpretative perspective. Consequently, I

³⁰ Please find an accompanying CD submitted with the thesis for examination.

applied IPA to my video analysis, and IPVA (Interpretative Phenomenological Video Analysis), which is a method of analysing video data utilising IPA, was developed over the course of the current study. IPVA involves six stages:

Six Stages in Interpretative Phenomenological Video Analysis (IPVA)

- Stage 1. Understanding the moment
- Stage 2. Understanding the whole
- Stage 3. Deciding a scope of analysis
- Stage 4. Describing what and interpreting how
- Stage 5. Looking at other parts
- Stage 6. Integrating parts and whole

The video footage of five meaningful moments and the raw data of microanalysis are presented in the accompanying data disk in the folder titled “Video Analysis.” A detailed account of the analysis process as well as a rationale for developing this method are reported in two articles in Chapter Six.

Credibility of the study.

In order to enhance the credibility of the results of this study, I have utilised various procedures during the analysis process. For transparency, I used step-by-step approaches in the interview and video analyses. For validation and verification of the interview analyses, I used member-checking strategies. I also regularly consulted with peers and experts in the field of music therapy.

Use of step-by-step methods for data analyses

For transparency within the two data analysis stages, step-by-step approaches of analysis were undertaken with both interview and video analyses. In particular, each of the analytic methods included multiple steps and this assisted in ensuring that each

individual analysis was conducted with rigor and quality. Because of this, each individual analysis was conducted in exactly the same way.

Use of member-checking methods

A method of *member-checking* (Lincoln & Guba, 1985; Robson, 2011), also known as *member-validation* (Kvale & Brinkmann, 2009), was used for verifying the analysis results. This strategy “involves returning (either literally or through correspondence, phone, e-mail etc.) to respondents and presenting to them material such as transcripts, accounts, and interpretations you have made” (Robson, 2011, p. 158). This strategy was used twice during the course of interview analysis. First, when I completed transcribing all the interviews, I asked the music therapists to validate their own interview transcriptions by emailing them. They were encouraged to correct any errors, and suggest different words or phrases if they needed changing for clarification. Second, when the individual distilled essence of each interview was developed, each description was sent again to the music therapists for verification. This follows Colaizzi’s (1978) suggestion that a letter of request (see Appendix L for an example) that explains the analytic process be sent, including the final individual description. The main question asked was “how do my descriptive results compare with your experience?” Only one music therapist suggested changing some words, questioning two of my interpretations of her meaning. The details of this case are reported in Chapter Four.

Consultation with peers and experts

All the analytic processes were regularly examined by my primary supervisor and also by a group of music therapy researchers at National Music Therapy Research Unit (NaMTRU). NaMTRU is based in the music therapy department of the University of Melbourne and consists of graduate music therapy researchers who are enrolled in Masters or Doctoral courses. The group meets each fortnight for graduate seminars and I reported regularly on the progress of the analyses. I also provided regular presentations to seek critical feedback and advice from the NaMTRU

members, known as *peer validation* (Kvale & Brinkmann, 2009), as well as from academic experts from overseas who visited bi-annually.

In conclusion, the current chapter has presented the study design and methods used for the current study. Specifically, the whole process of conducting the current study from designing the study to analysing the collected data has been explained in detail. The following two chapters present the analysis methods and results of the study:

Chapter Five presents the methods and results of interview analysis answering the sub-question 1 of the current study, “how do the five music therapists describe *their experiences of building relationships* with adults with PIMD?”;

Chapter Six reports the methods and results of video analysis answering the sub-question 2, “how are the *meaningful moments of music therapy sessions* identified in single music therapy sessions by the music therapists described and interpreted?”;

Chapter Five and Six answer the sub-question 3, “are there *any common features for the experiences* described by the music therapists and illustrated in their musical encounters with adults who have PIMD?”

CHAPTER 5

INTERVIEW ANALYSIS: METHODS AND RESULTS

This chapter presents the first article published from the current study. This article reports the methods and results of the interview analysis and was published in July 2014. The PDF file of the published version is inserted from the next page.

Paper 1

Lee, J. (2014). A phenomenological study of the interpersonal relationships between five music therapists and adults with profound intellectual and multiple disabilities. In D. Keith (Ed.), *Qualitative Inquiries in Music Therapy: A Monograph Series* (Vol. 9, pp. 43-86). University Part IL: Barcelona Publishers.

A PHENOMENOLOGICAL STUDY OF THE INTERPERSONAL RELATIONSHIPS BETWEEN FIVE MUSIC THERAPISTS AND ADULTS WITH PROFOUND INTELLECTUAL AND MULTIPLE DISABILITIES

Juyoung Lee

INTRODUCTION

In my early years as a music therapist, working with adults who have Profound Intellectual and Multiple Disabilities (PIMD) brought me a range of emotions and questions. Without any previous experience with this group of people, I was shocked at the severe impacts of multiple disabilities on the lives of the clients. I also felt challenged to engage with them because I could not understand the idiosyncratic non-verbal behaviors. While interacting with them regularly over time, however, I realized that most people with PIMD also experience various emotions through music just like the other people without disabilities. From then on, I was able to share in their emotions by playing various songs, and these shared emotions enabled us to communicate better.

I wondered, then, whether music therapy was helpful in improving the communication skills of my clients. To answer this question, I conducted a research project (Lee, 2009; Lee & McFerran, 2012). While trying to answer the research question, I also wanted to show that music therapists provide an important service to adults with PIMD, and that the effects of music therapy are beneficial. Furthermore, I personally felt that our work in the field of disability was not acknowledged enough. In the community settings where I worked, the disability support workers or parents often called me “music teacher,” and some of them seemed to consider me as an entertainer. Working environments for my colleagues and me were not ideal as well. The organization that employed us did not seem to treat us as health professionals. Many of my colleagues were soon disappointed and left. All these factors motivated me to challenge the question. For me, conducting the research was to have a hope for a better future so that our music therapy sessions are acknowledged and valued as an essential therapeutic intervention for adults with PIMD. While I was satisfied with the results of my research project, I realized that a single research study is insufficient to demonstrate the value of music therapy.

After working with same clients for over six years, I still face various questions. However, I feel like I am in a different position now. I feel more confident as a clinician and I experience more pleasure, joy, and happiness when I go to meet my clients and their caregivers. I believe that the relationships that I have established with each of them over a long time have made a positive difference to us. These interpersonal relationships

seem to support the clients' emotional and social needs and ultimately help them improve their quality of life. In the present study, I explore other music therapists' experiences to find the meanings and essence of our experiences. The findings of this study will also provide fresh knowledge and insight to others who support clients with PIMD, such as parents, disability support workers, allied health professionals, and service providers.

LITERATURE REVIEW

The Need for Specific Care

The disability rights movement started in the United States of America (USA) and the United Kingdom (UK) in the late 1960's, and has positively influenced the lives of people with disabilities (Mertens, Sullivan, & Stace, 2011). Groups of people with disabilities or family members of the disabled persons gathered to fight for the basic human rights of people with disabilities. Advocating organizations were formed and they influenced governments' social policies. For example, in UK, the *Fundamental Principles of Disability Booklet* (Union of Physically Impaired Against Segregation, 1976); the green paper *Care in the Community* (UK Department of Health, 1981); and the white paper *Valuing People* (UK Department of Health, 2001, 2009) were published. The disability paradigm shifted from the medical model to the social model (Mertens et al., 2011). Under the medical model, having a disability is considered a problem that would lead an individual to seek medical treatment. In contrast, the social model, developed in the 1970s, views a disability as part of the human condition that is the responsibility of the society (Carson, 2009). The social model expounds the view that people have impairments, not disabilities. When the society makes barriers between people with and without disabilities, the affected people experience disabilities in those situations.

In 2006, the United Nations declared *the Convention on the Rights of Persons with Disabilities* (United Nations, 2006), which had the worldwide impact of increasing public awareness of the rights of people with disabilities. Recently, the World Health Organization (World Health Organization, 2011) published the *World Report on Disability*, summarizing the current status of the lives of people who have disabilities and highlighting the importance of conducting more research and investing in specific interventions and services. Despite the major improvements in general attitudes towards the disability, people with PIMD still are "the most excluded and little valued people" (Watson, 2007, p. 99) and "an ignored minority" (Samuel & Pritchard, 2001) in our society. This is demonstrated by the fact that most guidelines on disability focus on people with mild and moderate intellectual disabilities and fail to articulate the complicated and specific care needs of people who have PIMD (PMLD Network, 2003). To promote social inclusion and participation of everyone including people with PIMD and their families, more sensitive and comprehensive views and approaches to them should be provided.

Terminology and Definition of PIMD

The number of people with PIMD is increasing 1.8 % every year and is expected to be just over 22,000 by 2026 in the UK (UK Department of Health, 2010). Although the demand for more services is significant (Parrott, Tilley, & Wolstenholme, 2008), the use of a range of terminologies, and lack of clarity or a generally agreed-upon definition of PIMD causes some issues in identifying the individuals who belong to this group and planning service delivery (Bellamy, Croot, Bush, Berry, & Smith, 2010; UK Department of Health, 2010). Terms such as, “Profound Intellectual and Multiple Disabilities (PIMD)”, “Profound and Multiple Learning Disability (PMLD),” “Profound Multiple Disabilities (PMD),” and “Profound Intellectual Disabilities and Multiple Impairments” are used interchangeably to refer the same group of people (Carnaby, 2004). Two essential words common to these terminologies are “profound” and “multiple.” These must be included in the definition as they define the severity and complexity of the condition (Carnaby, 2004). In 2008, the term PIMD was recognized as the most accurate way of describing the group (Pawlyn & Carnaby, 2009) and used by the Profound Intellectual and Multiple Disability Special Interest Research Group (PIMD-SIRG) formed by the International Association for the Scientific Study of Intellectual Disability (IASSIS) (Forster, 2011). Therefore, I prefer using the term PIMD.

To study a range of definitions and develop the most appropriate definition of PIMD, the researchers at the Joint Learning Disability Service in Sheffield, UK (Bellamy et al., 2010) interviewed 23 caregivers, service managers, and health professionals who take care of people with PIMD. The participants were asked to compare ten different definitions of PIMD and choose the most appropriate definition, providing a reason of their choice. Based on the participants’ feedback on the most chosen definition¹ by Samuel and Pritchard (2001), the researchers suggest a new definition as follows:

People with profound and multiple learning disability (PMLD):

- have extremely delayed intellectual and social functioning
- may have limited ability to engage verbally, but respond to cues within their environment (e.g. familiar voice, touch, gestures)
- often require those who are familiar with them to interpret their communication intent

¹ Children and adults with profound learning disability have extremely delayed intellectual and social functioning with little or no apparent understanding of verbal language and little or no symbolic interaction with objects. They possess little or no ability to care for themselves. There is nearly always an associated medical factor such as neurological problems, physical dysfunction, or pervasive developmental delay. In highly structured environments, with constant support and supervision, and an individualized relationship with a carer, people with profound learning disabilities have the chance to engage in their world and to achieve their optimum potential (which might even mean progress out of this classification as development proceeds). However, without structure and appropriate one-to-one support such progress is unlikely. (Samuel & Pritchard, 2001, p.39)

- frequently have an associated medical condition which may include neurological problems, and physical or sensory impairments.

They have the chance to engage and to achieve their optimum potential in a highly structured environment with constant support and an individualized relationship with a carer. (Bellamy et al., 2010, p. 233)

Although this definition uses the term PLMD, not PIMD, I find this definition useful as it effectively explains the impairments, abilities, as well as support needs of people with PIMD. It stresses that the context and individual relationships with caregivers are important for people with PIMD, and highlights that they are able to respond to familiar voice, touch, and gestures rather than merely stating the possible impairments.

Interpersonal Relationships and Quality of Life

As stressed in the above definition, people with PIMD are dependent on others for daily living; hence their Quality of Life (QOL) is dependent on others. Accordingly, some researchers are interested in measuring the QOL of people with PIMD to evaluate the quality of services provided to them (Petry, Maes, & Vlaskamp, 2005, 2009a, 2009b). As QOL is affected by multi-dimensional factors, Schalock (2004) reviewed 16 QOL studies and found the top eight domains that affect QOL. These are interpersonal relations, social inclusion, personal development, physical well-being, self-determination, material well-being, emotional well-being, and rights. "Interpersonal relations" was found as the most referenced indicator of QOL. In short, having meaningful relationships with close others can be an indicator of good QOL.

Building an interpersonal relationship, however, takes time as it is determined by "the history of all the separate interactions" (Stern, 2002, p. 117). For people with PIMD, who have many challenges interacting with others due to the non-verbal nature of their communication, building interpersonal relationships can be limited to certain people and to certain contexts. To understand the nature of their relationships, Hostyn and Maes (2009) reviewed 15 studies that examined the interactions between individuals with PIMD and their caregivers. Video observations and interviews were the most frequently-used data collection methods in the reviewed studies. The studies were qualitatively analyzed using narrative synthesis. As a result, four key elements, which were frequently observed or reported in positive interaction processes, were found: sensitive responsiveness; joint attention; co-regulation; and emotional component. Being sensitive to a person's needs, preferences, and wishes, and sharing a repertoire of utterances and affective cues as joint attention were essential elements for successful interactions. Co-regulation was represented by mutuality, reciprocity, turn-taking, matching each other's behaviors, and altering them. Attunement was also found to be a form of co-regulation.

With regard to the emotional component, some parents claimed that a successful interaction was characterized by mutual feelings of contentment, appreciation, and joy. Similarly, three disability support workers described their relationships with one female

client with PIMD and reported emotions, such as sympathy, warmth, and closeness in a phenomenological study (Forster & Iacono, 2008). Attachment and emotional bonds were also mentioned to support these feelings. Furthermore, the study by Hostyn and Maes (2009) revealed the influencing factors on the interactions and relationships with the people with PIMD were: the personality of persons with PIMD and their responses to the interactions, the communication partners' interactive strategies, perception of their roles, and knowledge of interaction in general and the particular person with PIMD.

The Experiences of Music Therapists

Music therapists are a group of health professionals who have supported various needs of people with disabilities since the 1950's. Using clients' preferred music and non-verbal interactive strategies, they often successfully report the benefits of music therapy for people with PIMD (Agrotou, 1994, 1998, 2000; Elefant, 2001; Ghetti, 2002; Graham, 2004; Lee, 2008, 2009; Lee & McFerran, 2012; Oldfield & Adams, 1990, 1995; Pujol, 1994; Ritchie, 1993; Watson, 2007; Wigram, 1992, 1996; Wigram, McNaught, Cain, & Weekes, 1997; Wigram & Möller, 2002). "Vibroacoustic therapy", a therapeutic method using music and vibration, has been reported to support the physical needs of people in institutional settings (Wigram, 1992, 1996; Wigram et al., 1997; Wigram & Möller, 2002). Some research studies have demonstrated positive outcomes, such as improved non-verbal communication skills (Lee, 2009; Lee & McFerran, 2012), increased attention span, and improved participation in musical activities (Oldfield & Adams, 1990, 1995).

Intensive individual and group case studies also have been reported using qualitative approaches (Agrotou, 1994, 1998, 2000; Graham, 2004; Ritchie, 1993; Watson, 2007). These studies describe nonverbal and musical interactions, and the long-term effect of these on the client-therapist relationship over several years. By sharing their feelings with the music therapists, clients who were isolated in institutional settings gained social abilities, including interacting with other people and successfully participating in social activities in the community. The music therapists claim that a humanistic and psychodynamic approach is beneficial for the clients with PIMD, as this approach values clients' non-verbal communications such as facial expressions, sounds, and movements by interpreting them musically or verbally.

Researchers have described the emotional difficulties that music therapists experience in the early stages of relationships. For example, Agrotou (1994) felt despair and fear that she might not be able to reach the client. Graham (2004) felt sadness and distress from two clients while musically vocalizing with them. Similarly, Watson (2007) described that the clients showed absence and rejection to the instruments and music therapists in group sessions. She further stresses the importance of the music therapists' experiences, stating "the therapist's musical approach may need to be adapted in order to work meaningfully with clients who have profound disabilities and barriers to communication, and who are likely to play little music" (p.102). So far, however, there is no empirical study exploring a group of music therapists' lived experiences working with clients who have PIMD. Providing the details of these experiences would provide knowledge and insight to some music therapists who do not have any experience with people with PIMD.

To explore the lived experiences of music therapists in clinical practice, phenomenological approaches have been applied. Phenomena explored are various such as, “experiences of music therapists working with children in coma (Dun, 1999); “being effective as a music therapist” (Comeau, 2004); “being present as a music therapist” (Muller, 2008); “the spiritual moments in music therapy” (Marom, 2004); “pivotal moments in music therapy” (Grocke, 1999); and “music therapists’ dual roles” (Ghetti, 2011). Interviews were used to obtain rich descriptions. These studies explored particular experiences that are personal, implicit, and remain in the non-verbal areas (Stern, 2002), and resulted in deep understanding of the experiences of the music therapists. Similarly, but using an heuristic approach, Wheeler (1999) explored her personal experience of pleasure from working with nine children with severe disabilities. By analyzing *exciting spots* in seven video recorded sessions, Wheeler identified four factors leading to a therapist’s feelings of happiness: *intentionality, emotionality, communication, and mutuality*. Based on her findings, Wheeler highlighted the intersubjective nature of non-verbal interactions and argued that music therapists’ subjective feelings could be considered as a reflection of clients’ feeling states in an intersubjective perspective. On the other hand, some studies explored the experiences of the clients (Forinash, 1990; Grocke, 1999; Hogan, 1999; McFerran, 2001; Trondalen, 2005) which provided valuable insight; however, the client participants in the current study could not verbalize or express their opinions in a formal way. As an interpersonal relationship is a shared experience between two people, exploring the music therapists’ experiences may also be helpful in understanding the clients’ experiences.

In summary, the review of the relevant literature indicates that people with PIMD need more specific care; interpersonal relationships are an indicator of good QOL; and there are key elements and influencing factors on the positive interactions and relationships between people with PIMD and their caregivers. In the field of music therapy, some music therapists have described the processes of building meaningful relationships with the clients in detail (Agrotou, 1994, 2000; Graham, 2004; Ritchie, 1993). However, the context of music therapy practice has also changed since these studies were published, and there is no empirical study exploring the expertise of music therapists in contemporary practice. Methodologically, it has been demonstrated that qualitative approaches facilitate rich descriptions and foster deep understandings of the phenomena. Particularly, phenomenological approaches have been often used insightfully in investigating the lived experiences of music therapists. Consequently, I chose a qualitative and phenomenological approach for the current study.

Purpose Statement

The purpose of the current study is to explore five music therapists’ experiences of interpersonal relationships with adults who have Profound Intellectual and Multiple Disabilities (PIMD). Five music therapists, who are qualified and registered in Australia, participated in this study with their clients. The five pairs had been practicing music therapy together for over a year before being involved in the study. In-depth face-to-face interviews were conducted with the therapists to solicit rich descriptions of the lived experiences. The main research question guiding the study is:

“What is the experience of the interpersonal relationships between five music therapists and their adult clients who have PIMD?”

Sub-questions are:

1. How do the five music therapists describe their experiences of building interpersonal relationships with adults who have PIMD?
2. Are there any common features underlying the experiences described by the music therapists?
3. What meanings and essence could be distilled using the phenomenological methods?

METHOD

Study Design

The current study takes the form of a qualitative inquiry informed by phenomenology. Phenomenology, a method of examining lived experiences, is the most common qualitative approach used in the field of music therapy (Aigen, 2008). Aigen (2008) assumes that this is because phenomenology is closely related to psychology and explores inner experiences of people. It is also claimed to be suitable to “studies of complexities and mysteries of life that require thoughtful, reflective approaches” (Forinash & Grocke, 2005, p. 324). In the current study, phenomenology was used as both philosophical and methodological guide to find meanings and essence of the music therapists’ lived experiences. As a philosophical approach, phenomenology suggests a researcher look at a phenomenon with open, fresh, and wondering eyes by identifying and putting aside any pre-assumption and bias (Finlay, 2011; Lewis & Staehler, 2010). As a methodology, phenomenology seeks rich descriptions of individual experiences to explore implicit and explicit meanings, and find the essence of the experiences. Phenomenological methods have been applied to studies in the fields of psychology, education, and social science, and six distinct methods of phenomenology are developed: descriptive empirical phenomenology; hermeneutic phenomenology; life world approaches; Interpretative Phenomenological Analysis (IPA); first-person approaches; reflexive-relational approaches (Finlay, 2011). In the current study, the descriptive empirical approach (Giorgi, 2009) has been taken to describe the music therapists’ lived experiences in detail and find similarities in them.

Ethical Precautions Taken

This study required the participation of adults who have profound levels of intellectual disabilities. As they could not make their own decisions to participate in the study, a careful and considerate approach was taken with them and also with their legal guardians

and parents. Ethics clearance was obtained (# 1136760) from the Human Ethics Committee at the University of Melbourne. The five music therapists and the parents and legal guardians were provided with a plain language statement and consent form. A request for a study approval was also submitted to the not-for-profit organization, which hosted the study with four pairs of music therapists and their clients. One pair withdrew from the study due to illness during data collection.

Recruitment Process

As the focus of the study was on the music therapists' lived experiences, selecting the music therapists who had the interpersonal relationships with adults who had PIMD was the priority of the participant selection process. The inclusion criteria for the music therapists were a person who: a) was qualified or registered as a music therapist with the Australian Music Therapy Association, and b) had work experience of more than a year with a client who had PIMD. Any music therapist who did not meet these two inclusion criteria was not invited to participate. Applying purposeful sampling strategies (Patton, 1990, 2001), I used my professional contacts from clinical networks and professional meetings. I also searched for music therapists through the "Australian Music Therapy Membership Directory 2012 (Australian Music Therapy Association, 2012)". I identified a total of 12 music therapists who stated their areas of practices as "adult disability" or "adults with special needs" in the membership directory, and I contacted them through emails and phone-calls.

Once a music therapist agreed to participate, I asked him or her to identify a client who met the inclusion criteria. The inclusion criteria for the adults with PIMD were a person who: a) was between 19 and 60 years old and diagnosed with profound levels of two or more major disabilities/impairments in physical, intellectual, sensory, and medical areas; b) had been attending music therapy sessions for more than a year with the participating therapist; and c) was reported to have an interpersonal relationship with the music therapist. Any adult client who did not satisfy these inclusion criteria was not invited to participate. Once a client was identified, I contacted parents and legal guardians of the client through phone calls to provide information about the study. If they were interested or agreed to participate, I sent them a plain language statement and consent form via post. Most parents and legal guardians willingly supported their adult child or client to participate in the study. The adult clients attended a single music therapy session with their own music therapist whilst I recorded it. Finally, a total of five pairs of music therapists and clients were successfully recruited during November and December 2012.

Participants

Collectively, the average number of years that the five pairs had been practicing together was four years. Only one music therapist participated with two clients who have been practicing small group sessions together over many years. Table 1 shows the details of the five pairs at the time of data collection in December 2012 and January 2013. All names are pseudonyms.

Table 1
Information about the Participants

	RMTs	Gender/ Age	Clinical Experience	Clients	Gender/ Age	Diagnoses
Pair 1	Frances	F/40s	6 Years	Amy	F/19	Rett Syndrome, Epilepsy
Pair 2	Steve	M/30s	3 Years	Eva	F/22	Moya Moya Brain Disease, Cerebral Palsy (Spastic Quadriplegia), Epilepsy
Pair 3	Erica	F/50s	15 Years	Mark	M/22	Cerebral Palsy (Spastic Quadriplegia), Renal Failure - Blind right eye
Pair 4	Darren	M/30s	6 Years	<u>Lyn</u> Mia	<u>F/28</u> F/29	Rett Syndrome, <u>Epilepsy</u> Mitochondrial Cytopathy, Movement Disorder, Epilepsy, Metabolic Disorder
Pair 5	Owen	M/30s	5 Years	Nelson	M/46	Cerebral Palsy, Severe Developmental Delay, Epilepsy, Arthritis, Oesophageal default

Data Collection

Once I received the written consent forms, I contacted the music therapists to arrange the interviews. The interviews took place at the most convenient time and place for the music therapists. Most music therapists suggested their music therapy office or studio and one music therapist preferred his home. I used two recording devices to record interviews: Roland audio recording device 24-bit WAVE/MP3 recorder “Edirol R-09” and Samsung Digital Audio Player “Yepp YP-T8.” The former was the main equipment and the latter was used as a backup for unexpected situations. The average interview time was 82 mins.

Epoche

An epoche was undertaken before collecting data. The word “epoche” originates from a Greek word “epochein”, and it means “suspend, refrain, bracket” (Lewis & Staehler,

2010, p. 14). In phenomenology, constructing an epoche requires the researcher to identify his/her “prejudgments, biases, preconceived ideas” (Moustakas, 1994, p. 85) about the phenomenon of the study, and to suspend and bracket them from influencing the processes of data collection and analysis. In the current study, I identified my pre-assumptions and biases about the interpersonal relationships with adult clients who have PIMD in music therapy, which had developed through my own clinical work, research project, and knowledge from the literature. The following two ideas are a summary of the full epoche, and I assumed that these key ideas might appear in the interviews:

1. Most music therapists may recall that working with adults who have PIMD is challenging and emotional. However, they may report that once the inter-subjective communication routines are established, the interactions with them provide the music therapists and the clients rewarding and positive emotions.
2. When asked to describe their experiences with the clients, the music therapists may describe the characteristics found in successful relationships, such as sensitive responsiveness to each other, joint attention, co-regulation, and emotional component (Hostyn & Maes, 2009).

Phenomenological Interviews

Interviews are the most common method for collecting data in phenomenological studies (Englander, 2012; Forinash & Grocke, 2005; McFerran & Grocke, 2007). I conducted in-depth face-to-face interviews (Kvale & Brinkmann, 2009) to obtain rich descriptions of the five music therapists’ experiences within this study. For this study, I developed an interview guide, which was divided into two sections. In section one, I asked, “can you tell me about your clinical experience as a music therapist in working with adults with PIMD?” In section two, I asked two questions: “can you tell me about the client?” and “can you reflect any specific moment or a session in which you felt you have a meaningful relationship with the client?” The first question was used as a warm-up question that opened up the conversation. By asking a general, broad, and undirected question about the clinical experience, the music therapists entered the conversation freely. This enabled them to talk about when and where they had been working. The first question prompted the therapists to talk about the clients, which naturally evolved into the second and third questions being asked. I often commented by summarizing their views to confirm what they were talking about and I also asked subsequent questions to prompt more information (Kvale & Brinkmann, 2009). Some questions such as “can you tell me more about that?” and “how did you feel about that?” were frequently asked to get more detailed descriptions of the lived experiences.

Data Analysis

The aim of the descriptive empirical approach used in the current study was to develop detailed individual descriptions of the experiences to find implicit, explicit meanings and essence of the experiences. Finlay claims “there is no clear-cut recipe explaining how to

engage phenomenological analysis, although guidelines are available (2011, p.28)." I followed the seven steps developed by McFerran and Grocke (2007) for phenomenological music therapy studies. The seven steps generated are based on the ideas of Giorgi's (1975) procedure model of analysis, Colaizzi's (1978) method of verification of the analysis, and Moustakas' (1994) use of terminologies (McFerran & Grocke, 2007). All of these are rooted in the philosophy of Edmund Husserl (Husserl, 2002). The details of the seven-step microanalysis (McFerran & Grocke, 2007, p. 275) are below:

Seven-Step Microanalysis

- Step 1. Transcribing the interview word for word
- Step 2. Identifying key statements
- Step 3. Creating structural meaning units
- Step 4. Creating experienced meaning units
- Step 5. Developing the individual distilled essence
- Step 6. Identifying collective themes
- Step 7. Creating global meaning units and the final distilled essence

The aim of the first five steps was to develop an individual distilled essence for each music therapist's experience. The last two steps comprised a group analysis through which I identified common themes and developed global meaning units. The aim of the last two steps was to arrive at a final distilled essence of the phenomenon. The following section explains how I conducted each step.

Step 1. Transcribing Word for Word

After completing the interviews with each of the five music therapists, I downloaded the audio files into the computer software "Express Scribe" (NCH Software, 2013). This software helped me to manage the audio files, control the talking speeds of interviewees, and dictate the words into the system. Once I completed the transcriptions, I saved them as Microsoft Word files and emailed to the interviewees to read and amend any incorrect use of words or sentences. Most interviewees corrected some spelling and grammar errors, which were minor changes. These amended versions of the transcriptions were fixed as raw data, as recommended (Giorgi, 2009).

Step 2. Identifying Key Statements

I read the transcriptions again and again to identify key statements. Moustakas (1994, pp. 120-121) calls the key statements *invariant constituents* and suggests testing each statement according to two requirements: a) does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it? and b) is it possible to abstract and label it? Any repetitive and overlapping statements were removed, and any statements that were complicated or unclear in meaning were also removed or amended

appropriately. The following example from Frances's interview is a good example for the latter case.

Original statement:

"So it can be really challenging because you are not getting that... you...you sometimes not getting that feedback. Umm...to know whether you are doing right thing or not. Umm...yes that's the thing I found most challenging with working with this particular group." (Frances)

In this statement, Frances talks about the most challenging aspect of her work. However, as she spoke, her thoughts were developing over several sentences and I thought this idea could be succinctly put into a sentence such as:

Changed statement:

"The most challenging thing is not getting some feedback from the clients because I don't know whether I am doing right or not." (Frances)

Dwelling on the transcriptions by repetitively reading each statement and letting the important statements appear (Finlay, 2011) produced several updated drafts for each transcription. Each time, a number of key statements were removed. After several attempts, when I intuitively felt that I had undertaken sufficient *phenomenological reduction*, I moved to the next step.

Step 3. Creating Structural Meaning Units (SMUs)

In this step, I categorized the key statements identified in Step 2 into meaning units. With the guiding question "*what* was the interviewee talking about?," I identified that each meaning unit consisted of several key statements which described similar experiences. For example, the following statements were classified into a structural meaning unit:

"I think that familiarity is ultimately the core of the relationship, which is being familiar with what goes on in the session, the therapist, the music and a familiar routine; "Ok let's play this song, I know you like this song, you're gonna have this reaction. And we will do that every session to establish that strength of relationship." So once you understand the person, you're building on that strength of relationship, and then just making that deeper and delving in a little bit deeper and finding out more while evolving the relationship." (Steve)

"It's always gonna be challenging to work with the profoundly lower functioning people as it's just less to work with. But in the middle stages of the relationship, once you understand the person more, they

know what you are doing and are familiar with that. You're building on that relationship to make it more solid and really creating familiar ground for them, a familiar relationship for them." (Steve)

"Familiar is the word I like to use. Once you establish the relationship, then it's about making it more familiar routine to them. That's less of a challenge than the initial start phase." (Steve)

I titled this meaning unit as "familiarity is the core of the relationship and it's built in the middle stage of the relationship development" to represent all the statements. When I titled the meaning units, I used interviewees' direct words as recommended by McFerran and Grocke (2007). Through the iterative processes, I produced several updated drafts of SMUs for the data from each interview. In Steve's individual analysis, seven meaning units were created as follows:

- SMU 1: Working with adults with PIMD is always challenging.
- SMU 2: I'm looking for any reactions as an engagement when working with adults with PIMD.
- SMU 3: It takes different stages over time to build relationships with adults with PIMD.
- SMU 4: Familiarity is the core of the relationship and its built in the middle of the relationship.
- SMU 5: Meaningful moments with Eva are those familiar moments in every session.
- SMU 6: Significant moment is when something new, unexpected, and pivotal happens.
- SMU 7: I believe that our relationship is definitely obvious, positive, and meaningful to both of us.

Step 4. Creating Experienced Meaning Units (EMUs)

The purpose of analysis in Step 4 was "to seek possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles or functions." (Moustakas, 1994, p. 97) This process is called *imaginative variation* and considered a significant aspect in eliciting meanings of the experiences in phenomenology (Finlay, 2011; Moustakas, 1994). With a guiding question "*how* did the interviewee experience the phenomenon?" I tried to re-live the interviewee's experience as suggested by Finlay (2011). As I had over six years of clinical experience as a music therapist with adult clients who have PIMD, I was able to put myself into the interviewee/music therapist's position, and feel the natural emotions induced by the described situations. For example, the following two statements, one from SMU 5 and the other from SMU 7 were selected and contemplated:

“(It is also meaningful for me) as a music therapist absolutely. It’s validating to know that what you do is important, and has repercussion far beyond the session that you were involved with. In my view, I’m helping her, I’m improving her quality of life and that’s a really obvious thing.” (SMU7)

“Just also finding out from her mom that there was change in her as soon as she found out that she had music that day. She was bit tired or something, then when she found out about music, she got more excited. That was a nice moment to know about because there’s anticipation of the session as well, which means she’s familiar with it, she knows what to expect, it’s comfortable, it’s familiar and it’s an environment that she can be free to express herself.” (SMU 5)

The statement of SMU 7 made me think that being validated is important for Steve and SMU 5 made me think that it describes a good situation where he most likely felt the validation. Steve said that it was a nice moment but I believed that it could be a validating moment as well. Therefore, a statement, “Steve feels that his work is validated when Eva’s mother explains Eva’s positive reaction to music therapy” was developed and became Steve’s EMU 10. In this way, I considered several statements from different SMUs via multiple perspectives and contemplated them as a whole. It enabled me to explore implicit meanings of the experiences that were not said and hidden in the unconscious level. I also adopted an element of Giorgi’s (2009) method in this step by articulating the statements in the third person. Instead of using *I* in the titles of the meaning units, the name of the interviewee was used when creating the titles of EMUs. In this way, I was able to indicate that the interviewees’ experiences were now viewed and analyzed from my point of view. For Steve, a total of ten EMUs were developed from seven structural meaning units as follows:

- EMU 1: Steve believes that the initial stage is the most challenging time because of the low functioning levels when working with adults with PIMD.
- EMU 2: Steve notices that no matter how much they are disabled, adults with PIMD receive music well and display observable reactions.
- EMU 3: Steve looks for any reaction in the initial stage of the relationship, but as he understands the client more, Steve identifies certain reactions as key behaviors.
- EMU 4: Steve believes that meaningful relationships with adults with PIMD can be established while finding a way to understand the person better.
- EMU 5: Steve thinks the relationship with Eva is in the middle stage because they have created a familiar routine.
- EMU 6: Steve believes that the familiar vocal interactions with Eva are the core of their relationship.

- EMU 7: Steve identifies that meaningful moments and significant moments are different; meaningful moments are when the interaction is familiar and significant moments is when the interactions is unexpected.
- EMU 8: Steve believes that Eva enjoys his attention in music therapy because it is not feeding or toileting.
- EMU 9: Steve finds the staff's support helpful in establishing meaningful relationships with clients with PIMD.
- EMU 10: Steve feels that his work is validated when Eva's mother explains Eva's positive reaction to music therapy.

Step 5. Developing Individual Distilled Essence

"The interweaving, the rhythms of noema-noesis, creates a harmony and an integral understanding of an experience" (Moustakas, 1994, p. 74). In this statement, *noema* refers to SMUs, and *noesis* refers to EMUs in the current study. By following Moustakas' explanation, the titles of SMUs and EMUs were integrated to form the individual distilled essences. The following is the first paragraph of Steve's individual distilled essence.

For Steve, the interpersonal relationships with adults who have PIMD are experienced while finding a way to understand the person better and it takes different forms over time. Although it is always challenging because of the low functioning level, Steve considers the initial stage the most challenging time. Steve looks for any reaction as an engagement in this initial stage of the relationship because he believes that no matter how much they are disabled, adults with PIMD receive music well and display observable reactions. As he understands the client more, Steve can identify certain reactions as key behaviors.

The full versions of Steve's distilled essence and the other four music therapists' essences can be found later in the result section. All the individual distilled essences were examined by my primary supervisor. She compared the titles of structural and experienced meaning units with my epoche and validated that the results of the individual analysis were not forced or influenced by my pre-assumptions and biases.

Step 6. Identifying Collective Themes

In this first step of collective analysis, I examined the titles of EMUs of all the five interviews, and searched for *common*, *significant* and *individual* themes. McFerran and Grocke (2007) define each theme as follows:

- Common theme: Experiences that all the five music therapists described.
- Significant theme: Experiences that several music therapists described.
- Individual theme: An experience that only one music therapist described.

The nature of qualitative research is not to value agreed perspectives any less than individual perspectives, hence each type of collective theme was considered to be meaningful. The following section explains how I identified a common theme. After browsing the titles of EMUs of all five interviewees, I found that all the five music therapists described the impacts of settings and supports from staff and family on their experiences of interpersonal relationships. Erica stated why she preferred an individual setting to a group setting:

"In an individual session, I have the time, and I can follow their lead much more."

"Getting to know someone in depth isn't quite possible in a group situation."

Darren explained why the family setting was important for him when establishing the interpersonal relationships with Lyn and May:

"The family support is an important factor."

"So every time when you walk in, you feel like you are part of the family."

"There are few examples that are quite interesting. The way they communicate with me (smiles) makes me feel...it's creating this atmosphere. So it makes me feel that "Ok, you are part of this little family". Not like the real family, but you are like one of the important, not just a therapist or other medical staff. That's the difference. It's lots of relationships going on there, so that's the experience."

Steve and Frances described how they found it helpful to receive the staff and disability support workers' assistance in the community and home settings:

"I'm always happy to receive information from them (staff) and they are always very helpful making me understand these people better."
(Steve)

"Having Julia, supportive worker in music therapy is really positive for me because she's enthusiastic and supportive. I've built up a relationship with her as well which has been good for me." (Frances)

Owen was the only music therapist working in an institutional setting, and he explained how he perceived the negative impacts of this setting on the staff attitudes toward the adult clients with PIMD:

“Change is a very gradual process here. People get very established. And that largely would be part of the institutional setting. It’s very structured so introducing something new takes quite a while.”

“When I first meet someone, I will try and work out what type of music they actually like. Because the standard response when I do my regular intake survey is “Oh, just play them Abba” because everyone loves Abba here and they always have.”

“I guess no one’s found something else for him that he gets so involved in.”

After identifying the common theme, I searched for appropriate academic and professional language in the related academic literature that could precisely label all the collective descriptions. Not taking one interviewee’s language in this step was important in this step (McFerran & Grocke, 2007). The word “context” was selected for referring to the settings and the supports from staff and families. The phrase “the quality of interpersonal relationship” was also used for the title of the common theme 1, which is “the context in which music therapy happens impacts the quality of interpersonal relationship for all the music therapists.” In this way, I identified two common themes, six significant themes, and one individual theme. The details are reported in the result section.

Step 7. Creating Global Meaning Units and the Final Distilled Essence

In this final step, I categorized the nine collective themes identified in the step six into global meaning units. I applied *imaginative variation* similarly to the way it was used in the creation of EMUs in step 4. For example, the following two themes were categorized into one of the global meaning units:

- The context in which music therapy happens impacts the quality of interpersonal relationship for all the music therapists. (Common theme 1)
- Two music therapists believe that the degree of profound disability will always impact the quality of interpersonal relationship. (Significant theme 5)

The music therapists described the significant impacts of the settings, supports from family and disability support workers as well as the severity of disability on their relationships. Consequently, global meaning unit 1 was titled “the conditions, such as contexts and severity of disability, exert significant influence on the quality of interpersonal relationships.”

To create the final distilled essence, the titles of the global meaning units were integrated appropriately. The global meaning units and final distilled essence are reported in the results section.

Verification and Validation of the Analysis

To validate and verify the results of individual and group analysis, I used two methods. First, I used a *member-checking* process (Lincoln & Guba, 1985; Robson, 2011). The five music therapists/interviewees were asked to validate the interview transcriptions by reading and amending any errors. In addition, each was invited to verify his or her individual distilled essence. This idea of returning to the participants with the analysis result is recommended by Colaizzi (1978) and adopted in the phenomenological seven steps analysis (McFerran & Grocke, 2007). The music therapists were encouraged to provide feedback on the individual distilled essence and suggest different words or phrases to replace any part of the original essence. In this way, they became members who actively participate in constructing the meanings of the phenomenon of the present study. Second, I asked experts in the field of music therapy to verify the processes and outcomes of individual and group analysis. My primary supervisor supervised all the processes of analysis and entered into a dialogue about the accuracy and transparency of the individual and group analysis. A group of music therapy researchers at The National Australian Music Therapy Research Unit also provided critical feedback and advice throughout the analysis process.

RESULTS AND DISCUSSION

This section reports and discusses the results of individual and group analyses. First, I will present the five individual distilled essences and the results of the member-checking verification. Then, I will report the results of the group analysis, discussing collective themes and global meaning units. At the end, I provide the final global distilled essence and a brief conclusion.

Individual distilled essences

Steve

For Steve, the interpersonal relationships with adults who have PIMD occur while finding a way to understand the person better, and they take different forms over time. Although building interpersonal relationships with adults with PIMD is always challenging because of the clients' low functioning level, Steve considers the initial stage the most challenging time. In this stage of relationship, Steve looks for any reaction as a sign of engagement. He believes that no matter the level of disability of adults with PIMD they receive music well and display observable responses. As he understands each client better, Steve can identify certain reactions as key behaviors.

According to Steve, familiarity is the core of the relationship and it is built in the middle stage of relationship. As Steve and Eva have created a familiar routine, he believes that their relationship is in the middle stage. Steve considers that *meaningful* and *significant* moments in the interpersonal relationships are different: meaningful moments are when interactions are familiar and significant moments are when interactions are

unexpected. Therefore, the meaningful moments with Eva are those familiar moments in every session and the familiar vocal interactions with Eva are the core of their relationship. Steve believes that Eva enjoys attention that is meaningful rather than functional, like feeding or toileting. When Eva's mother explained how Eva reacted positively to attending music therapy, Steve felt that his work was validated. He also finds the staff's support helpful in establishing the meaningful relationships with Eva. For Steve, the experience of the interpersonal relationship with Eva is definitely obvious, positive, and meaningful for both of them.

Frances

For Frances, the experience of building an interpersonal relationship with an adult who has PIMD is like a journey. When there is no response from a client, Frances feels confused and lost, not knowing where to go. However, when she finally gets small responses, such as eye contact and smiles, she feels relieved and it is like she is getting somewhere. For Frances, the journey is rewarding as much as challenging. It also takes a long time and the progress is gradual.

The experience of the interpersonal relationship with Amy is a positive experience for Frances. She finds working with Amy easier than other clients because Amy offers so many recognizable responses. Amy's progress has been gradual over the years, and Frances never expected that she would experience this remarkable progress with Amy. Frances feels grateful for the support of Amy's caregiver in music therapy sessions because it is helpful in Amy's progress. Frances cannot pinpoint a particular meaningful moment with Amy. However, when Amy offers lots of eye contacts and smiles, Frances finds these small interacting moments as meaningful. Once when Amy was really sick, Frances realized that her condition was degenerating, and she was reminded that one day it would have to end either because Amy becomes sick or Frances leaves the organization. Although Frances is aware that getting attached to a client is a natural process in this journey, Frances tries not to get overly attached.

Erica

For Erica, building interpersonal relationships with adults with PIMD is enjoyable and fascinating in individual settings. As a result of years of experience, she is now much more patient, relaxed, and confident about the process. Erica also has learnt that music therapists should be both quick and alert yet patient when documenting the small changes upon which a fluid relationship can be built. The experience of the interpersonal relationship with Mark is a process of getting to know him deeply by working out and trying different things with him. Erica believes that it is possible because they have individual sessions that allow time and space for Mark to reveal who he is. In the initial stage of the interpersonal relationship, Erica did not underestimate Mark and observed the behaviors and responses to understand his communication. Erica then discovered that Mark could vocalize in the tonality of the music and anticipate certain points in songs.

Erica now knows Mark's various behaviors and the meanings in different situations. It is helpful for Erica to understand which songs Mark prefers and when he

wants to vocally interact with her. Accordingly, Erica believes that her role is to find those preferred songs and particular parts that excite Mark to vocally interact with her. She considers this part of her role is a key difference to the role of an entertainer. One meaningful session with Mark was his last birthday session as Mark enjoyed listening to all of his preferred songs. But Erica thinks that it was an unusual session because she didn't meet him at an intellectual or cognitive level but more like an entertainer. There are still things Erica wants to achieve within the relationship with Mark. For example, Mark's behavior of keeping her at arms' length seems like a defensive behavior and Erica believes it is because he doesn't trust her enough. Although it seems unrealistic, Erica wants to help Mark overcome this behavior. Erica wishes the relationship with Mark would develop into more fluid and equal relationship in the future.

Darren

For Darren, the experience of interpersonal relationships with adults who have PIMD can be influenced by clients' physical conditions. When a client's physical condition is good, the client and Darren have ongoing interactions and he feels very rewarded. When a client is ill however, both Darren and the clients can be frustrated because they cannot control these things. Accordingly, Darren believes that maximizing opportunities to make choices and control over the environment is important for adults with PIMD.

Darren's experience of the interpersonal relationships with Lyn and Mia in a home setting is different from and more positive than his previous experiences in hospital and aged care settings. Because of the 8 years of music therapy experiences together, Lyn, Mia, and their families are one of the most understanding people. The way they communicate with Darren makes him feel like he is part of this little family. For example, when walking into the house for sessions, Darren feels like he is their brother rather than a therapist. This makes him feel happy. Therefore, Darren believes that the family support is a crucial factor in building the interpersonal relationships with Mia and Lyn. In the family setting, the parents willingly assist him anytime whenever there are difficulties. The family's introduction to Lyn and Mia's non-verbal behaviors was really helpful for Darren as well because it reduced the time understanding them. Darren believes that communicating with each other through two-way interactions is important when building the interpersonal relationships. He is learning their language and they are also learning his language. Darren has learnt to read Mia's emotional expressions and he feels great to know her in person. Meaningful moments with Lyn and Mia have similarities. They were so sick that they could not participate in music therapy for a period of time. Darren felt worried and realized that he was emotionally attached to them. When they became well and actively participated in the session he was relieved from the worries and it became meaningful sessions. For Lyn and Mia, music therapy now has become a part of their lives. Darren feels lucky to have this valuable experience with them.

Owen

For Owen, the experience of building interpersonal relationships with adults who have PIMD is about trying different things slowly over a long time and getting to know each client's interest and preference better. Depending on a personality and mood, each client needs a unique interactive approach and they can be sociable and independent in interactions. Owen believes that people with PIMD need human interactions and socialization in addition to personal cares although the profound level of physical disability limits what the adults with PIMD can do. In the institutional setting, staff do not seem to consider each individual differently and the experience of developing and learning new skills is missing for clients. Consequently, he believes that the rigid institutional environment is not ideal for adults with PIMD. Owen works differently from other staff in the institution and finds it interesting when some staff and parents are very surprised by the progress that the adults with PIMD achieve in music therapy.

The experience of the interpersonal relationship with Nelson is difficult for Owen to explain, but certainly he has a special connection with Nelson. Owen prioritizes Nelson over other clients because he is isolated. Nelson also has impressed Owen as he continued to develop his musical expression and the capacity as a drummer even after he became very sick. Meaningful moments with Nelson occur each time when Owen returns after being away overseas for his holiday. Nelson shows his particular cheeky facial expression that looks as if asking Owen, "Where have you been?" Interpreting the behaviors of the non-verbal clients and judging how much is his subjective imagination are challenging. Sometimes it is difficult for Owen to keep motivated to work because it is not musically rewarding. However, at the same time, Owen feels proud of his professional skills when he sees the progress of the clients. Owen believes his role as a music therapist is different from a musician playing in a pub because he is conscious of how to play music and meet a client in a therapeutic relationship.

Member-checking

I emailed the individual distilled essence and a letter requesting to verify the document to each music therapist. I asked them to comment on the distilled essence and suggest any other word or phrase for replacement if a change was needed. Table 2 presents the music therapists' feedback on their individual results.

Table 2

Music Therapists' Feedback on the Individual Distilled Essences

Frances	<i>What I read is pretty accurate, and reflects what I remember we discussed during the interview.</i>
Darren	<i>What I have read is very accurate. I believe that the video recording of music therapy session will also help to confirm the small details of communications and any unclear descriptions of the experiences.</i>

Steve *As for the distilled essence, I feel that you interpreted my experience well and have detailed the process accurately. Key words like familiarity, key behaviours, challenging and meaningful relationship have been included and are explained well. The idea of a process is true, and put in the context of music therapy as a process, then assessment, treatment (familiarity) and then evaluation (progress) would be the three stages of the process with Eva. You didn't include much about the third stage, but I would say it's the progression of familiar routines, so that the repetition/familiarity is varied slightly in order to produce a positive development of behaviours.*

Owen *I find it interesting to see other's perception of my view. I do come across very critical of the established culture within my workplace. I guess I do find the institutional culture extremely challenging, perhaps I haven't completed the institutionalization process yet, many of the staff I work with have worked at the same facility with the same clients in excess for 20 years, a few longer than 40 years. Your distillation captures my underlying goal of accessing people on an individual level and providing more than the basic (though very important) needs of shelter and food. This is something which I find challenging to implement in such a medical environment.*

As can be seen, most music therapists replied that the essence well captured what they described in the interview. Therefore, none of the original essence was changed. Erica was the only music therapist who suggested changes of some words and questioned some parts of her essence.

Erica's Suggestions

Erica suggested changing two phrases to make them more appropriate. For example, she suggested changing the phrase "as an experienced music therapist" to "as a result of years of experience" and "at the initial stage of interpersonal relationship" to "at the initial stages of the interpersonal relationship." As these minor suggestions were reasonable, they were incorporated into Erica's individual distilled essence. Erica, furthermore, commented on two sentences:

Original sentence 1: Erica thinks that Mark's behavior of keeping her in his arms' length is a *clear negative* behavior, and believes it is because he doesn't trust her enough. Erica commented:

"I'm really not sure of this statement though I know that this was in the interview. Being at arms' length is a saying meaning not letting someone get too close. As for it being a negative behavior, it really is a defensive behavior on his part but I don't take it personally. I hesitate

on reading this, to extrapolate his intention because really he lacks so many skills to express closeness and he is also tactile defensive.”

Original sentence 2: Although it seems *unrealistic*, Erica wants to help Mark overcome this *negative* behavior. Erica commented:

“Is this in your opinion or in mine? It isn’t an aim of mine for his therapy at all and in fact I am happy to see him happy and vocalizing as he arrives, evidence that he knows where he is coming and enjoys the experience. I don’t know if you can pull this statement or not but it really isn’t accurate overall though I know I said it at the time. I think I was ‘Clutching at straws’ at the time of the question.”

Erica seemed uncomfortable about those underlined words such as *negative* and *unrealistic*. Erica asked whether these are her opinion or my opinion. The word “negative” was not said by Erica, however, she stated that she classifies Mark’s behaviors into positive, negative, and neutral. Through utilizing *imaginative variation* in step 4, I assumed that the particular behavior of keeping her at arms’ length is more likely a negative behavior. In this particular case, however, Erica mentioned the word “defensive” in her comment and this word seems more accurate than the word “negative.” Consequently, I changed the word “negative” into “defensive” in the final distilled essence.

With the second inquiry, Erica admitted that she did speak the word “unrealistic” but explained that she was “clutching at straws” in the interview. The process of analysis was all based on what Erica said during the interview, and the aim of the analysis was to find the hidden meanings of the experience in the interviewee’s unconscious. Giorgi (2009) argues that the interviewees often cannot understand the result of the analysis because they do not know how the researcher has analyzed the transcriptions with a *phenomenological attitude*. Therefore, considering this fact, accepting only a reasonable suggestion seems appropriate and I decided only to remove the word “negative,” as decided when discussing the first enquiry.

Results of the Group Analysis

By analyzing the EMUs of the five music therapists as a group, I identified nine collective themes and developed three global meaning units and a final distilled essence.

Collective Themes

The nine collective themes consist of two common themes, six significant themes, and one individual theme. The following section presents these collective themes.

Common themes

Common theme one: The context in which music therapy happens impacts the quality of interpersonal relationship for all the music therapists.

The music therapists described how the settings and assistance from the family members and disability support workers influenced their relationships with the clients. The details of the identification of this theme are explained in the method section. Frances and Darren were working at their clients' homes and described how the family members and a disability support worker assisted them to understand the clients better. Steve was working at the community day-care centre and reported that the staff helped him to understand Eva better by providing information. Erica believed that the individual setting was important for her to develop the relationship with Mark because it provided them enough time and space. Owen was the only music therapist working in the institutional setting and reported his negative perspective on working in this environment. He believed that the rigid environment and negative staff attitudes in the institution are not ideal for adults with PIMD. In conclusion, all the music therapists perceived the environment where the music therapy happened significantly influenced their relationships with the clients. It appears that the home and community settings create better environment for the long-term benefit of music therapy to develop than the institutional setting in this study.

Common theme two: All the music therapists are heartened by the clients' commitments in music therapy.

The music therapists reflected on the clients' progresses over the several years and explained how they were heartened by the clients' commitments in music therapy. For example, Owen stated:

"He's one guy at that point he would play really anything. But he was really quite actually felt more, at times with Nelson it was almost like colleagues in terms of musicians. And he was actually more accurate in terms of tempo and articulation. He was probably the most accurate drummer that I had working with here, I actually probably working with about 15 different drummers at the time."

It appears that Owen was impressed by Nelson's musical achievement as a drummer. Frances reflected Amy's progress that she never expected:

"It's interesting to see how things have progressed and now she is gotten older. When I first started there, we were singing the wiggle songs and now we are singing more adult stuff. We have moved through so that's been an interesting part of the relationship as well. Because of her condition, I've never expected to see huge changes and I think it's about improving the quality of life."

Similarly, Darren explained how his clients taught him to read their emotional expressions:

“I was actually learnt to read their emotional change from them. At the very beginning, I didn’t know them well so I didn’t know what to expect. So it was hard for me to read their language. Then the longer I spent time with them I knew their personalities and characters. Now, I know when they respond in particular ways what that means. So actually I know them in person.”

For Erica, describing Mark’s progress over the last six years was a pleasure. She kept smiling while comparing their interactions in the past and present:

“In the past I moved away from encouraging him to touch the instruments. Then I’ve worked a lot of encouraging him to indicate that he wants more of a song, so whether was ‘more’ or ‘not’ and then also turn-taking or that vocal interplay of singing one after another or harmonizing together. He moves into the tonality of the pieces so it’s nice to change the keys.”

“There’s sense of he is listening, he is still, he is upright, and then he might throw his head back, sometimes he will move his arms or he might move his legs and there is a whole blurting and ‘Ah~!!’s. Often he will do it after the song as well. If he’s really enjoyed it he will sing and he does blurting and he vocalises ‘ah~~’ and ‘um~~’ if he’s really enjoying it.”

“I get that anticipation at the start, I play and I can see he’s getting short of breath and anticipation just because he takes a little gasp in. Then he will maybe blurt, or maybe smile comes in to his face. Maybe he will start moving his arm around and I’ve got some singing happening and then I just can sustain it. When I just sustain the interaction and that connection in the music and I just keep going with it until the end. Even then if I have the end, I might ask him if he wants some more and it will be a sigh and then I play ‘Dreamer’ all over again (smiles).”

In these statements, it is obvious that Erica changed her strategy to interact with Mark in the past. Now she knows when Mark is ready for the vocal interplays, and this development in their relationship gives her joy. In a similar way, Steve explained the nice moment when he found out the fact that Eva was excited about attending music therapy:

“Just also finding out from her mom that there was change in her as soon as she found out that she had music that day. She was bit tired or something then when she found out about music she got more excited. That was a nice moment to know about because there’s anticipation of the session as well which means she’s familiar with it she knows what to expect, it’s comfortable, it’s familiar and it’s an environment that she can be free to express herself.”

In the above statements, it is evident that all the music therapists reflected with pleasure on the clients’ progress, which induced positive feelings in them. Nelson became an accurate drummer; Amy developmentally progressed into adulthood; Lyn and Mia taught Darren how to read their emotional expressions; Mark now displays when he is available for vocal interplays; Eva was excited about attending a music therapy session. In addition, the music therapists seem to have heart-warming feelings such as feeling impressed and proud (Owen), pleasantly surprised (Frances), grateful (Darren), excited (Erica), and nice (Steve) for their clients’ commitments in music therapy. Consequently, I found “heartened” the most appropriate word for describing the music therapists’ general feelings.

Significant themes

Significant theme one: Four participants believe that music therapists have unique roles in meeting the psychological needs of their clients.

Owen, Darren, Steve, and Erica described their roles of being music therapists. For example, Darren stated:

“The adults with PIMD have a very few skills to connect with other people. So it is our job to maximise and enlarge their potential abilities and improve their quality of life through music.”

Erica described her role as being patient to document clients’ small changes and finding appropriate songs that motivate the clients to interact:

“It just takes time for the person to reveal themselves and for you to actually develop that relationship where they are going to express themselves fully. So I found it a very slow process of being very patient to try to record and document the small changes that are happening and building upon those.”

“So then I try and work out whether he will vocalise in particular parts of the pieces where he gets a bit of a thrill out of it, and I can tell when he gets some thrills and he will go ‘Oh, yes that’s my favourite bit.’”

"It's really up to me to find those songs which are going to stimulate those moments again and again. So that's why I play the same songs over the several weeks and encourage it at certain points. I know he's going to sing at that point."

Steve claimed that Eva enjoys his attention in music therapy because it is different from personal care:

"I think it's definitely a positive relationship for her. I think she has a meaningful engagement with me as a therapist. And I think she values the times we have and she benefits from that. I think she's happy to get some different attention that's not feeding or toileting."

Similarly, Owen argued that Nelson needs not only personal care but also human interaction and socialization:

"It's isolation and he's not going to recover if he is isolated.' So that became the key thing. Establishing some contact with him that wasn't personal care. It wasn't just feeding, toileting, and shaving."

"Obviously his physical situation always needs someone to help feeding and bathing that sort of basically daily skills. I think he would've been more independent in his interactions and socially."

In summary, the music therapists defined their roles as maximizing clients' potential abilities and improving their quality of life (Darren); being patient to record small changes and finding appropriate songs to motivate interactions (Erica); providing a different attention that is not personal care (Steve and Owen); and providing human interaction and socialization (Owen). Most of these roles are related to improving psychosocial wellbeing of the clients.

Furthermore, three music therapists compared the role of a music therapist with a classical music player (Darren); an entertainer (Erica); a musician playing in a pub (Owen) to distinguish the unique role of being a music therapist. For example:

"As a classical music player in background, what I cared was 'how this music sounds? how do I make the music sounds beautiful?, or how do I please people with my music?'. But as a music therapist, I'm more into 'what can I do for the clients through music?'. What we can do is to maximise their choices, help them to get more control, assist them to manipulate anything they want to do, and make the things become closure to their ideal outcome." (Darren)

"I suppose just giving Mark all of his favourite stuff is a nice thing to do for his birthday but again it's bit like turning on the switch, anyone

can put on his favourite music. That's not satisfying for me overall and potentially it would be satisfying for him, but then what are we doing in the therapeutic sense for him? Are we being therapists or being entertainers? So that's bit a conundrum for me.” (Erica)

“I guess if I did that all the time, I would feel like I was there just being any musician or being an entertainer, isn't challenging or exploring other avenues what they are capable of. So that session isn't how I would potentially always want to work. I know a lot of people want me to just provide them with a joyful experience and that can be valid too but as a therapist I want to explore, challenge, meet other needs within that person as well or give them an opportunity for choice.” (Erica)

“I'm obviously not playing for me cause I'm a therapist. I actually meet that person in that therapeutic relationship. I have to be very careful about how I play. If I play just for fun, it won't have that same quality of interaction, they might like it but then they might get that on Monday night Disco. So to get that high quality interaction I really have to be careful and conscious about how I execute the music. So the Bossa I played with Nelson this morning would be very different from a Bossa that I would play in a pub.” (Owen)

The critical fact to consider in the above statements is that the three music therapists have dual roles. In short, Darren plays a violin as a classical music player, Owen plays in a pub as a Jazz guitarist, and Erica teaches piano. Accordingly, it is clear that they do not underestimate other musicians' roles in comparison to the music therapists' roles. Rather, these statements show how clear and strong their professional identities are and how seriously they perceive their roles in meeting clients in the therapeutic relationships. Moreover, as Erica mentioned, *“I know a lot of people want me to just provide them with a joyful experience,”* the music therapists seem aware of the expectations from others to provide entertainment. They claim that their roles are not only to provide joyful experiences but also to explore and maximize the clients' potential developments and to support their psychosocial needs. The frequent misperception of music therapy by the public seems to be the main reason that they articulated and stressed their roles so strongly by comparing them with public expectations or closely related roles. Promoting awareness of the benefits of music therapy for adult clients with PIMD and providing education about the therapeutic roles of the music therapists to people who take care of the clients—including parents, disability support workers, and service managers—would be crucial for positive improvement in the future.

Significant theme two: Three music therapists experience emotional bonds and attachments with the clients.

Frances, Owen, and Darren reported that they experienced emotional bonds and attachments with the clients. They explained how their clients became special for them:

“Although Amy has a profound disability I like working with her because she does give you response. A lot of the time, I know when she likes a song.” (Frances)

“I’m not sure exactly what it is but there is some connection and the nurses comment on that. They always laugh cause whenever I’ve come back, I always set up and say ‘How’s Nelson?’ I don’t know if he is my favourite but certainly someone that’s always on top of the list and someone in clinical perspective, I do prioritise because of his isolation. He only really goes from his bedroom to the lounge room. The same six people he lives with and there is a pool of nurses that come through but there is no other environment and no other stimulation. He isn’t actually my favourite, I don’t think. It’s inappropriate at any point in the relationship. Perhaps it is because I’ve seen him so long.” (Owen)

“Lyn and Mia are one of the most understanding clients due to their previous experience. They have been receiving music therapy since 2008, so they had seven or eight music therapists. They are fully aware of what music therapy is and what this can do for them. So they’ve been very supportive, which is very valuable experience for me. It’s very difficult to find clients like these two.” (Darren)

In addition, Darren and Frances explained how they felt emotionally attached to the clients when they were sick:

“Especially when they were sick or in hospital, I found myself getting worried: ‘Oh, what is happening?’ ‘Is she gonna be all right?’ I find it interesting because from my previous experience in an aged care, I did have that feeling but because it’s run by a facility, I didn’t approach the family members directly. I didn’t share with them or I didn’t get attached to them that close. But Lyn and Mia are in a different setting. It does bring some personal relationship into it. But of course, as a professional, you won’t really show them that. This is like a personal experience that I share with other therapists. That’s something that I find quite fascinating too.” (Darren)

“The flip side of the relationship with Amy is that one day it will have to end, either because she gets sick or I leave the organization. Especially last year when Amy has got really sick, it has reminded me that it may happen one day. So I’m careful not to get attached but it’s a part of my job. I do get attached in a way and that’s natural.” (Frances)

The music therapists used the phrases such as “like working with her,” “get attached” (Frances); “some connection,” “my favourite,” “always on top of the list,” “I do priorities”

(Owen); “get attached,” “got worried,” “personal experience,” “difficult to find clients like these two” (Darren). These expressions clearly show the strong emotional bonds and attachments between the music therapists and clients.

Furthermore, from these statements, it is evident that the three music therapists responded differently to the attachment issue. For example, Frances admitted that she was getting attached to Amy. She revealed her worries of ending the therapeutic relationship with Amy one day, and then stated that this attachment was “*part of her job and it is natural*”. Similarly, Darren accepted the fact that he was emotionally attached to Lyn and Mia, and explained how it was different from his previous experiences in different settings. Later, however, he stated, “*as a professional, you won’t really show them that. This is like a personal experience that I share with other therapists.*” Thus, it is obvious that Darren believed that showing his emotions to his clients is not a professional behavior.

In contrast to Frances and Darren, who admitted their emotional bonds and attachments to their clients, Owen expressed a strong denial about getting attached to a client: “He isn’t my favourite, *I don’t think. It’s inappropriate at any point in the relationship. Perhaps it is because I’ve seen him so long.*” Owen, however, seemed to experience some minor internal conflicts, because other times he stated: “*I’m not sure exactly what it is but there is some connection and the nurses comment on that.*” and “*I don’t know if he is my favourite but certainly someone that’s always on top of the list.*” I assume that the fact that Owen worked in the institutional setting placed him in a difficult situation to discuss this attachment issue because it is against policy. Considering the fact that Frances and Darren were employed by the community disability organization and worked in the clients’ homes seemed to make this difference among the three music therapists.

Significant theme three: Two music therapists consider the inter-subjective interactions meaningful in their relationships.

Frances stated:

“It’s hard to say any particular moment when I feel we have a meaningful relationship. I get that feeling just in general from when I work with her rather than any specific moment.”

“I get a lot of eye contact from her. I show all the pictures and she’s looking at the picture and me. I also get big smiles when I arrive to have a session. Especially when I come back after some period due to break or sickness, she knows ‘it’s all again’. I love that side because it’s clear she not only recognizes me but also recognizes what that means.”

According to these statements, Amy used eye gaze to indicate her choice of a song and smiled to express her happy feelings when Frances comes to have a music therapy session. By receiving these intentional or affective responses in particular

situations and contexts, Frances seems to understand the implicit meanings hidden behind Amy's non-verbal responses. For instance, the following statement demonstrates that: "she knows 'it's all again.' [...] it's clear she not only recognizes me but also recognizes what that means." Frances felt she knew what Amy was thinking and feeling by observing her smiles and demeanours. Similar interactions are also described in Steve and Eva's experiences:

"Meaningful moments with Eva are those familiar moments. I don't think there's been any really huge moment with Eva. Because I think vocalisation is significant in it, but that happens every session or I try to get that to happen every session. I don't think there's a really huge moment where you go 'Wow, that's above and beyond than expected'. It's just more about that familiar relationship and familiarity of what goes on."

"I think that familiarity is ultimately the core of the relationship, which is being familiar with what goes on the session: the therapist, the music, and a familiar routine, 'Ok, let's play this song. I know you like this song, you're gonna have this reaction. And we will do that every session to establish that strength of relationship.' So once you understand the person, you're building on that strength of relationship and then just making that deeper, delving in little bit deeper, and finding out more while evolving the relationship."

"So as for moment, those are the moments where she will vocalise. Just the other week, she was doing two syllables, 'I-yee-yha', 'I-yee-yha'. It's something that's usually different. Usually it's high-pitched vocalisation like 'Ah- Ah- Ah'. And I always say, 'Ah, you're gonna sing for me today. Ah, it's good to hear you singing Eva. Playing shaker and singing! Oh! good to hear you.' So they are the moments that I guess really define the relationship. It's the interaction and then vocalising, making eye contact, and trembling. Then interaction increases during the hello and good-bye songs and there are more reactions as well."

Eva used vocalizations and eye contact to intentionally communicate with Steve and also displayed affective responses such as trembling of her whole body to express her excitement. The kind of interactions described by Frances and Steve can be referred as intersubjective communication. In the field of developmental psychology, Trevarthen (1999, p. 413) defines intersubjectivity as "the process in which mental activity including conscious awareness, motives and intentions, cognitions, and emotions—is transferred between minds." Stern (2010, p. 43) defines intersubjectivity as "the sharing of another's experience" and further argues, "the sharing of another's vitality forms is probably the earliest, easiest, and most direct path into another's subjective experience". According to Trevarthen and Stern, the inter-subjective interactions described by the music therapists

clearly show how the intersubjectivity is experienced with the adult clients with PIMD in music therapy. Through matching and mirroring each other's behavior and sharing affect attunement, they exchange each other's emotions and intentions successfully. The sharing of the vitality forms is the essential element of the intersubjective interactions and evidenced by the four key elements in successful interactions: sensitive responsiveness, joint attention, co-regulation, and emotional component (Hostyn & Maes, 2009). As the benefits of these intersubjective interactions are considered crucial for infants to develop physically, psychologically, intellectually, emotionally, and socially, the adult clients with PIMD also receive significant benefits from these interactions. So far, viewing the interactions with the adults with PIMD from the intersubjective philosophical framework has not been discussed in the field of music therapy. Consequently, more studies on these inter-subjective moments would improve our understanding of the meaningful relationships with adults who have PIMD.

Significant theme four: Two music therapists have struggled before developing confidence in the relationships.

Frances described how she felt confused and lost at the initial stages of the relationships:

"Working with adults with PIMD is confusing at times because you are not sure where to go. But you do feel getting something out of it anyway."

"(When I do get the response), It's like 'Oh yeah, I'm getting somewhere... something'"

"Working with adults with PIMD is challenging when there is no response all the time. But it's also rewarding to work with adults with PIMD when you do get a response after a long time. Sometimes you suddenly get some eye contact, you might get a rocking in response to music, or you might see a smile."

Similarly, Steve compared how it was different working at the initial and middle stages of the relationships:

"I think at the start it's always hit and miss, it's very difficult at the initial stage. But as the relationship goes on, it's definitely a lot easier to tell certain behaviours are the key behaviours you're looking for."

"Not having a lot to work with is the challenge, and then while trying to find a way in to work with that person you can get a meaningful relationship established."

"In the middle stages of the relationship, once you understand the person more, they know what you are doing and are familiar with that."

You're building on that relationship to make it more solid and really creating familiar ground for them, a familiar relationship for them."

Table 3 summarizes Frances and Steve's statements.

Table 3
Changes in the Initial and Middle Stage

	Initial stage	Middle stage
Frances	Confused	Relieved
	Feeling lost	Getting somewhere
	Getting no response	Getting some responses
	Challenging	Rewarding
Steve	Hit and Miss	Certain behavior became a key behavior
	Very difficult	A lot easier
	Unfamiliar	Familiar
	Not having a lot to work with	Finding a way in to work with that person

As presented in Table 3, Steve and Frances generally felt confused and found it difficult in the initial stages of the relationships because the clients with PIMD did not respond to them. However, with regular and consistent engagements, the clients slowly began to show responses, such as suddenly making eye contact and smiling, which made the music therapists feel relieved. These particular behaviors became key behaviors, and by facilitating these moments again and again when the clients displayed these key behaviors, the music therapists were able to build familiar interaction routines and develop meaningful relationships while building the inter-subjective interaction routines over several years. These descriptions seem very helpful in understanding what happens during the initial and middle stages of building relationships with adults who have PIMD.

Significant theme five: Two music therapists believe that the degree of profound disability will always impact the quality of interpersonal relationship.

Steve stated:

"Working with adults with PIMD is always pretty challenging, the less functioning someone has, the less interaction there can be in a way."

"It's the different functioning levels that make it challenge right throughout the whole relationship."

Similarly, Owen explained difficulties when working with non-verbal clients who have intellectual disabilities:

"Not every session is so clear that it's a successful session. Some sessions and clients I really gotta think, people with this type of disabilities can be difficult to read and judge how much is my own subjective opinion. You might think that it was great, then you talk to someone and they say, 'Ah - they do that all the time.' So a lot of it is really trying to get to know someone better over time so you know what's good and what's not."

"The people I work with here often don't have a level of insight where we can discuss things with like other areas of work. I don't get to deconstruct things with my client, what could this mean in other areas of life, because often they don't have the communication skills to have that discussion."

Steve explained how the severely limited physical and intellectual abilities of the person facilitate less interaction and challenge the whole process of building the interpersonal relationships. Owen also described how non-verbal communications sometimes caused confusion and frustration for him. He raised an important issue about getting conflicting opinions on clients' non-verbal behaviors with other staff. This is a practical issue that will persist when working with non-verbal clients in the world outside of institutions. A provision of peer de-briefing or supervision from experienced therapists would be helpful in managing these issues.

Significant theme six: Two music therapists think that adults with PIMD are more capable than they appear.

Erica described how she believes that adults with PIMD have potential abilities:

"I always try to assume that the person, especially someone like Mark who's got cerebral palsy, has got the ability too. I try to remember that how that person presents isn't potentially what they're fully capable of for whatever reason. They might not be able to express what they are capable of or they might not trust you enough to reveal all of his capacity as well."

Similarly, Steve also described the clients' capacities to display observable reactions:

“There’s always receiving going on. Sometimes you don’t see and it’s not very obvious, and you think they are not listening. But it’s hard to turn your ears off.”

“Eye-contact is usually a good one, movement of arms, limbs towards the therapist if you’re not facing that direction. They are smiles, laughs, and vocalizations. It’s always good if it is a purposeful vocalization that is a direct result of music cause they are not there otherwise.”

Steve and Erica stressed the clients’ hidden abilities such as having intact hearing abilities; displaying affective responses such as smiles and laughs; presenting intentional behaviors using eye contact and vocalization. Erica furthermore explained the possible reasons why the clients do not show their full abilities in the initial stage of the relationship: *“they might not be able to express what they are capable of or they might not trust you enough to reveal all of his capacity as well.”* Consequently, it seems important for the music therapists to be patient and provide sufficient time and appropriate atmosphere for the clients to reveal their hidden and potential abilities.

Individual themes

Individual theme one: One music therapist wishes the interpersonal relationship with her client to keep growing further in the future.

Erica was the only music therapist who expressed the wish for the interpersonal relationship with Mark to keep growing further in the future:

“There are still things I would like to do within the relationship to make it. If I can say that he would allow me to help him or overcome his tactile defensiveness I feel it really. But that’s actually unrealistic probably.”

“Certainly now he says ‘more’, but there are still things I want to achieve with him, so it’s not as fluid as I still really like it to be. I still feel like I’m working on the relationship too. I still feel there’s things we could do together.”

Erica and Mark spent six years in individual music therapy and Erica used the word “still” five times in the above two statements. It is obvious that Erica really wishes their relationship to grow further and progress to the next level where she described it as a “fluid” relationship. Erica’s attitude toward the future seems very clear and determined when compared to the other music therapists. Despite their emotional bonds and attachments with the clients, Frances, Darren, and Steve were considering leaving the organization in the future at the time of data collection because of the poor work environment. In a similar way, Owen did not think his work environment was ideal for

him, and the institution was expected to be closed in the following year. Hence, these music therapists were not actively planning their future with the clients. Consequently, improving the work environment for music therapists seems like a critical issue to be addressed, in order to promise a better future for the clients with PIMD as well as the music therapy profession.

Global Meaning Units (GMUs)

Based on the collective themes, three global meaning units were created.

Global meaning unit one: Conditions such as contexts and severity of disability exert significant influence on the quality of interpersonal relationships.

GMU 1 was created based on common theme 1 and significant theme 5. The development of this meaning unit was explained in the method section. These two themes indicate the factors that positively and negatively influenced the quality of relationships. According to the five music therapists, the positive contexts were the home (France and Darren), community (Steve), and individual settings (Erica). The factors that negatively influenced the relationships were the institutional setting (Owen) and the severity of physical and intellectual disabilities (Steve and Owen). With regard to the institutional setting, many clients in Melbourne have been already relocated into small group homes. Owen was in Sydney and his institution was also about to be closed in the time of data collection (January 2012). It is anticipated that many other institutions around the world will close in the near future. Therefore, discussing the negative impact of institutions might not be worthwhile at this time. However, more studies should be conducted to investigate how to work effectively in the small group homes, clients' private homes, and the community settings. The relationships with the clients' caregivers, including parents and disability support workers, are an influential factor as well in these settings. For example, in the current study, the music therapists working in the clients' homes and community settings reported positive relationships with the caregivers and its positive effect on their relationships with the clients.

Furthermore, two music therapists (Steve and Owen) expressed the difficulties working with clients who have severe levels of physical and intellectual disabilities. Obviously, inexperienced music therapists working with adults with PIMD for the first time seem to undergo various emotional distresses as well as some practical challenges, such as understanding idiosyncratic non-verbal behaviors. In Australia, these issues do not seem to be addressed in music therapy training and there is little literature discussing these issues. More studies of successful and unsuccessful case examples might help our understanding of these issues. In addition, guidance and support from experienced music therapists could help new music therapists have more meaningful experiences when working with adults who have PIMD.

Global meaning unit two: The process of building an interpersonal relationship requires mutual efforts over time.

This meaning unit was created based on the following four collective themes:

- Two music therapists struggled before developing confidence in the relationships. (Significant theme four)
- Two music therapists think that adults with PIMD are more capable than they appear. (Significant theme six)
- All the music therapists are heartened by the clients' commitments in music therapy. (Common theme two)
- One music therapist wishes the interpersonal relationship with the client to keep growing further in the future. (Individual theme one)

These collective themes indicate how music therapists perceived the process of building interpersonal relationships. Frances and Steve described how they struggled at the initial stages of relationships. Erica and Steve explained how they believed that the clients were more capable than they appear. All five music therapists described how their clients made great efforts and showed commitment and progress. Erica wished her relationship with Mark to keep growing in the future. These themes seem to indicate a general tendency in the process of building the relationships with the adults with PIMD such as:

1. Struggling to understand each other at the initial stage;
2. Getting to know each other more, then realizing that the clients are more capable than they appear;
3. Recognizing the clients' commitments and feeling heartened; and
4. Getting pleasure from the relationship and wishing to grow the relationship further.

Another critical fact to notice in this meaning unit is that the interpersonal relationships had been built not only by the music therapists' efforts but also by the clients' efforts. The clients' interests in musical activities and the trust established with the music therapists seemed to be the most important factors for successful relationships in music therapy.

Global meaning unit three: Inter-subjective interpersonal relationships foster the psychosocial wellbeing for clients, and music therapists play a significant role in promoting these benefits.

GMU three was created based on the three collective themes:

- Three music therapists experience emotional bonds and attachments with the clients. (Significant theme two)

- Two music therapists consider the inter-subjective interactions meaningful in their relationships. (Significant theme three)
- Four participants believe that music therapists have unique roles in meeting the psychosocial needs of their clients. (Significant theme one)

These collective themes stress that the interpersonal relationship is characterized by emotional bonds and attachments and familiar inter-subjective interactions between the pair. Feeling connected, being together, becoming special persons to each other, and having meaningful moments definitely foster the psychosocial wellbeing of the clients. Moreover, these positive relationships with the clients seem to promote psychosocial wellbeing for the music therapists. I observed the music therapists' non-verbal behaviors and emotional responses during the interviews. It was obvious that all the music therapists expressed joyful and excited feelings when talking about their clients and their inter-subjective relationships. Smiles and laughter were frequent. For instance, Frances smiled when she stated, "she's such a sweetie." Darren kept smiling while describing how the clients and their parents made him feel like a part of their families. Erica was excited as she explained moments of musical interplay with Mark. Owen was enthusiastic while explaining Nelson's progress and the development of their relationship in music therapy although he was critical about the institutional setting. Steve was also excited when describing familiar vocal interactions with Amy in group music therapy sessions. Furthermore, the music therapists expressed their positive relationships with the clients' parents and disability support workers. Consequently, the psychosocial benefits of the interpersonal relationships for everyone involved in music therapy are apparent, and the significant roles of music therapists seem crucial when understanding the experiences of interpersonal relationships with adults who have PIMD.

Final Global Distilled Essence

Based on the three global meaning units, the following global distilled essence was developed for the interpersonal relationships of the five pairs of music therapists and the clients with PIMD:

For the five music therapists, the experience of interpersonal relationships with adult clients who have profound intellectual and multiple disabilities is a process that requires mutual effort over time. The interpersonal relationships foster psychosocial wellbeing for the clients, and the music therapists play a significant role in promoting these benefits. Conditions such as context and the severity of disabilities also exert significant influence on the quality of interpersonal relationships.

In conclusion, the present study explored five music therapists' lived experiences of building interpersonal relationships in music therapy with adult clients who have PIMD. In-depth, face-to-face phenomenological interviews were facilitated to obtain rich descriptions of the lived experiences. The individual and group results show that the

music therapists have unique roles in establishing interpersonal relationships. However, for the continuing development of the quality of music therapy services in the future, music therapists should have a more active role in managing their contexts, communicating with staff and family members effectively to maximize the benefits of music therapy, and collaborating with other health professionals.

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CHAPTER 6

VIDEO ANALYSIS: METHODS AND RESULTS

This chapter contains two articles that present methods and results of the video analysis conducted in the current study. The first article (paper 2) presents the video microanalysis method, Interpretative Phenomenological Video Analysis (IPVA), which was developed over the course of the study. This article has been published in September 2014. The PDF file is inserted from the next page. The second article³¹ (paper 3), which is presented after the paper 2 in this Chapter, reports the results of the IPVA analysis in this study. This article was submitted to a peer-reviewed music therapy journal and is under review.

Paper 2

Lee, J., & McFerran, K. (2014). Applying interpretative phenomenological analysis to video data in music therapy. *Qualitative Research in Psychology*.

³¹ The original word file, which is the published version, is inserted.

Applying Interpretative Phenomenological Analysis to Video Data in Music Therapy

In the field of music therapy, a video microanalysis is considered “the most comprehensive and powerful tool” (Wigram and Wosch, 2007, p.312) among the three types of analysis: text, audio, and video. It is because video data captures complicated non-verbal and musical interactions and enables researchers to watch a particular moment repeatedly. By controlling the play speed of video footage, researchers can observe every detail of particular behaviours and interactions. Accordingly, music therapists working with clients who have developmental disabilities and limited communication abilities have often utilised video microanalysis¹ in various ways. For example, non-verbal and/or musical interactions between music therapists and children with autism, Rett syndrome, developmental disabilities as well as adults with Profound Intellectual and Multiple Disabilities (PIMD) have been video-analysed (Elefant, 2002, Gilboa and Roginsky, 2010, Lee and McFerran, 2012, Plahl, 2007, Scholtz, Voigt and Wosch, 2007). Video microanalysis was also used as an observation instrument to assess a quality of relationship between a therapist and a client (Schumacher and Calvet, 2007).

The study presented here involves a participant in music therapy who has PIMD, thus she is non-verbal and her communicative behaviours are subtle and idiosyncratic. As clinicians, we experienced great difficulties in understanding the non-verbal behaviours of people with PIMD at the initial stages of music therapy and sharing meaningful interactions and relationships required lengthy time over several years. Therefore, we believe that developing a particular way of describing and

¹ “Microanalysis is a detailed method investigating microprocesses. Microprocesses are processes and changes/progressions within one session of music therapy.” (Wosch and Wigram, 2007, p. 22)

interpreting the non-verbal interactions with people with PIMD in a meaningful moment using a video microanalysis seems essential and important for our ongoing clinical and research work with this group of people. Particularly, adopting an interpretative approach to give meaning to the interactions appears useful. However, with the exception of one study by the authors, video microanalysis has not often been conducted with this population in the field of music therapy. Consequently, the current study presents a unique way of microanalysing a video data following key principles of Interpretative Phenomenological Analysis (IPA) (Smith, 2007, Smith, Flowers and Larkin, 2009).

Application of Phenomenology in Music Analysis

Lawrence Ferrara was the first to apply phenomenology to musical analysis within the field of musicology. Ferrara (1984) analysed a piece of post-modern music and described the five steps used as follows:

- Step 1: Open listening
- Step 2: Syntactical meanings (fundamental level)
- Step 3: Semantic meanings (referential level)
- Step 4: Ontological meanings (composer's intention)
- Step 5: Open listening

When conducting each step, Ferrara listened to the piece of music with different intentions and foci. For example, after listening to the whole piece openly, Ferrara focused on the structure of music in the second step. The third step involved an

interpretative stage where Ferrara reflected on the sounds of various instruments and their implicit meanings. In step four, composer's intention was considered while listening to the music. Each step generated a thick description, and integrating the five descriptions into the final essence resulted in rich layers of explicit and implicit meanings.

This reflective and procedural model of analysis has inspired many music therapists and has been adapted in music therapy studies (Arnason, 2002, Forinash and Gonzalez, 1989, Grocke, 1999, McFerran and Wigram, 2005, Trondalen, 2005). In particular, Grocke (1999) and Trondalen (2005) analysed musical data that was used to facilitate powerful moments in music therapy. Grocke (1999) explored pivotal moments in Guided Imagery and Music (GIM) by interviewing both music therapists and clients to identify perceived moments of importance and then analysing the classical pieces of music played and imagery, which appeared during the moment. A seven step, structural model of music analysis (Grocke, 2007) was developed and the study resulted in the comprehensive understanding of the pivotal moments in GIM.

Similarly, Trondalen (2005, 2007) analysed improvised music that facilitated significant moments for two young people struggling with anorexia nervosa. She utilised both phenomenology and also a hermeneutic approach for the analysis and nine steps were suggested (Trondalen, 2005, pp. 402-404).

Step 1. Contextual step

Step 2. Open listening

Step 3. Structural step

Step 4. Semantic step

Step 5. Pragmatic step

Step 6. Phenomenological horizontalisation

Step 7. Open listening

Step 8. Phenomenological matrix

Step 9. Meta-discussion

Trondalen (2005) analysed various aspects of the improvised music as well as the clients' bodily responses and comments during the improvised music. Clients' personal, social, musical, and clinical history were considered and potential effects of the improvisation on the clients' lives were also contemplated. The multiple layers of musical analysis produced comprehensive and extensive understanding of the significant moments that occurred with the young people in music therapy. Grocke and Trondalen's holistic approaches to various data sources, such as music, imagery, and interpersonal dialogue with the clients, influenced the analytic strategy of the current study. Particularly, Trondalen's study involved both principles of phenomenology and hermeneutics, which is central to Interpretative IPA. The following section describes our influences in understanding IPA and developing a new method.

Interpretive Phenomenological Analysis

IPA has been described as “a specific hermeneutic version of phenomenology” (Finlay, 2011, p.139) and has become one of the most popular qualitative approaches in the field of psychology in the past ten years (Smith, 2011). Three theoretical perspectives are central in IPA: *phenomenology*, *hermeneutics*, and *idiography* (Smith

and Eatough, 2007, Smith et al., 2009). *Phenomenology* is about studying lived experiences; *hermeneutics* involves multiple interpretative processes; and *idiography* concerns with individuals' detailed and unique experiences. Consequently, studies using this approach to IPA describe how individuals make sense of the lived world and interpret implicit meanings of the lived experiences.

The philosophical roots of IPA lie in the ideas of phenomenological philosopher, Martine Heidegger (1962). Heidegger refutes the use of the epoche, which is an important process for identifying and bracketing one's fore-understandings and pre-conceptions in Edmund Husserl's (2002) pure phenomenology. Heidegger claims that researchers need to actively use their fore-understandings when interpreting the appearance of phenomenon so that they can deeply understand the non-appearing parts of the phenomenon (Smith, 2007). Through the active interactions between the fore-understandings and emerging appearance of the phenomenon, Heidegger believes that the researchers can have richer and deeper understanding of the phenomenon.

Two critical hermeneutic principles, *the double hermeneutic* and *the hermeneutic circle* are important in IPA. The double hermeneutics occur when a researcher tries to make sense of the lived experience of a participant who tries to make sense of his/her experience. *The hermeneutic circle* refers to an interpretative process that is dynamic, non-linear, and mysterious (Finlay, 2011, Smith, 2007). Smith (2007) describes it as facilitating "the dynamic relationship between the part and the whole, at a whole series of levels. To understand the part, you look to the whole; to understand the whole, you look to the part." (p.5).

Smith (2007) further explains the types and levels of interpretations, advocating Schleiermacher's (1998) hermeneutic theory of *grammatical* and

psychological interpretations. For Schleiermacher, the purpose of the interpretative process is to understand “the writer” through *psychological interpretation*, as well as “the text” through *grammatical interpretation* (Smith, 2007). Based on Smith’s adaption of Schleiermacher’s hermeneutic theory, our use of IPA involves both *grammatical* and *psychological interpretations*, which we believe deepens the descriptions and interpretations of the phenomenon.

Development of Interpretative Phenomenological Video Analysis (IPVA)

In the current study, a naturalistic investigation was conducted to collect interview and video data. Five pairs of music therapists and clients who have been practising music therapy over several years were recruited. A single session of each pair was video recorded², and within two weeks in-depth face-to-face interviews were conducted with each music therapist. The music therapists provided descriptions of their experiences in building interpersonal relationships with the participating client. In the last part of the interview, the five music therapists were then asked to identify a meaningful moment in the video-recorded session and describe the moment.

According to the developmental psychologist, Daniel Stern (2004), a present moment such as a meaningful moment is understood as *implicit knowledge* which “is in awareness but remains outside the verbal explicit domain” (Stern, 2002, p.12). Because the music therapists understood the moments implicitly, verbalizing the processes of the interacting moments in detail seemed to be challenging and the descriptions they offered were brief. Consequently, based on the information

² Consent from the adults with Profound Intellectual and Multiple Disabilities was provided by their parents, as approved by the Human Ethics Committee (# 1136760) at The University of Melbourne

provided by the music therapists in the interviews, the rigorous video analysis was used to explicitly describe and interpret the implicit meanings of the moments.

In addition, the video data contained complicated exchanges of non-verbal and musical behaviours of two or more people, requiring both detailed descriptions and critical interpretations. Particularly, the adults with PIMD often displayed idiosyncratic behaviours that were personally unique. Therefore, interpreting these behaviours required pre-understandings of the person and appropriate theoretical perspectives. Information obtained from the interviews and some theoretical concepts were contemplated when data required them. Stern's (2010) *forms of vitality* and the theoretical framework about parent infant encounters labelled as *communicative musicality* (Malloch and Trevarthen, 2009) informed the interpretation of the idiosyncratic non-verbal behaviours as well as the music therapists' behaviours.

Interpretative Phenomenological Video Analysis (IPVA)

There are some patterns in the ways that IPA has been applied by diverse researchers, however conducting IPA is not a prescribed process. Researchers are encouraged to be creative and flexible with regards to types of data to collect and the way they utilise the hermeneutic principles (Smith, 2004). Being informed by the applications of phenomenology and hermeneutic approaches in two music therapy studies (Grocke, 1999, Trondalen, 2005) and considering crucial hermeneutic principles as discussed previously such as the *double hermeneutic*, the *hermeneutic circle*, as well as *grammatical and psychological interpretations*, the systematic process of IPVA that was developed in this study involved six stages.

Six stages in IPVA:

- Stage 1. Understanding the moment
- Stage 2. Understanding the whole
- Stage 3. Deciding a scope of analysis
- Stage 4. Describing what and interpreting how
- Stage 5. Looking at other parts
- Stage 6. Integrating parts and whole

The following section explains how each stage was conducted in the current study.

Stage 1. Understanding the moment

The first stage involved developing a narrative that represented the moment as it was described in the interview with the music therapist. The transcription was read verbatim and then reduced into essential elements and summarised into a single paragraph.

Stage 2. Understanding the whole

After focusing on describing the moment, the second stage involved looking at the whole to understand the context of the moment. The context was deemed to be represented in the video of the whole music therapy session within which the meaningful moment was occurred. The music therapist's description of the session was considered in light of the whole session and an attempt was made to understand

each in relation to the other. The overall structure and details of interactions between the music therapist and the client were contemplated and a general description was created. The tenets of *the double hermeneutic* informed the analysis in this stage.

Stage 3. Deciding the scope of analysis

According to Stern (2002), there are *interpersonal process units* in human interactions and each unit has a beginning, middle, and end. This concept was used to recognise the boundaries of a complete unit of the interaction process of the meaningful moment. After identifying the beginning and the end of the complete moment, the video of the whole session was edited into a small clip.

Stage 4. Describing what and interpreting how

This stage involved describing the bodily behaviours, facial expressions, and vocalisations of the participants in micro-detail. *Grammatical interpretation* was utilised by indexing each moment in an Excel spread sheet. The use of Excel in describing the interpersonal interactions inter-connectively was inspired by Olsson (2004) (see Appendix 2). The clip was viewed repeatedly to complete the indexing and psychological interpretations of the intentions and implicit meanings of particular behaviours were included. The psychological interpretation involved contemplating the theoretical concepts such as *forms of vitality* and *communicative musicality* in understanding and interpreting the participants' intentions of the non-verbal behaviours. The music therapists' tacit knowledge on the clients' preferences and styles of interactions and my experiences as a clinical music therapist and researcher

were also helpful in this process. New and different meanings were perceived with each viewing so that the descriptions or interpretations were updated each time. This was an iterative and cyclic process that was repeated until some consistent interpretations persisted and no new description or interpretation was required. This process was conceptualised as *the hermeneutic circle*.

Stage 5. Looking at other parts

In this fifth stage, I contemplated impacts of music on the meaningful moment. A musical structure of a song and its influence on the music therapist's musical and communicative behaviour were considered. As I have experienced similar moments with my own clients, I tried to reflect those similar situations in my experiences and capture exact emotions, thoughts, and sensations. Theories such as *forms of vitality* and *communicative musicality* were contemplated when data invited me in the interpretative process. By observing the ways in which bodies move, facial expressions are displayed, and vocalisations are expressed and sounded, I tried to interpret the intentions and meanings of the participants. These processes again required multiple and iterative observations and interpretations facilitated by the process of the *hermeneutic circle*.

Stage 6. Integrating parts and whole

Each of the previous five stages generated rich narrative descriptions. In this final stage, some of these five thick descriptions that were repeated or overlapped were eliminated in order to integrate them into one complete description.

In summary, the rich descriptions were generated as one way of understanding the meaningful moment that was identified by each therapist. Cycling iteratively between part and whole, and also looking at different elements that dynamically influenced the moment, contributed to developing this understanding. The active movement between levels was continued until a point of personal saturation was achieved. Whilst moving through the different stages of analysis, new layers of visible/invisible as well as explicit/implicit elements and meanings emerged again and again. Both insider perspectives as a clinical music therapist and outsider perspectives as a researcher were utilised on this journey. The narratives that were generated were intentionally vivid, so that a reader could visualise the scene and at the same time understand the rich and deep dynamics in the description.

An Example of a Case Study

The following section demonstrates how each step was actually conducted, using one of the pairs, Steve and Eva, to illustrate the process. The first author collected the data by video recording a music therapy session and interviewing the music therapist and also analysed the data. Therefore as it is often presented in qualitative studies, a first person approach was used in describing the case study using the word, “I” referring to the first author.

Information about Steve and Eva

Steve is a male music therapist who was in his 30s at the time of the data collection. After being qualified and registered with Australian Music Therapy Association, he has been working in a not-for-profit disability organisation for people with multiple disabilities. Steve met Eva in a group session in an adult day-care centre. They have been working for the last two years and Steve chose Eva to participate in the current study because Eva is an expressive person who shows good responses in music therapy sessions. Eva is female in her early 20s. She was diagnosed with Moya moya brain disease, cerebral palsy, and epilepsy. Her favourite songs are big diva songs such as Kylie Minogue's songs and Abba's songs. To video record a single session, I visited Steve and Eva's music therapy session and video recorded a single session. A semi-structured face-to-face interview was conducted with Steve. Steve provided his knowledge and perspective on the interpersonal relationship with Eva. Then Steve and I watched the whole session together and I asked him to choose a meaningful moment.

Stage 1. Understanding the moment

Steve chose a moment where Eva said "Ieeyah" for the first time (see Appendix 1 for the interview transcription) and described it as a significant moment. His description was reduced and neatly summarised such as:

A significant moment with Eva in the session is where she says "Ieeyah" for the first time because it's different from the routine. We've got a familiar kind

of relationship going, I knew that the songs work quiet well with her. To hear her vocalise something a little bit different was significant in itself because it's kind of like a developmental occasion. So she vocalises now she's vocalising with the sound "Ieeyah". And also the level of excitement on that day was quite a lot and for longer period of time more frequency kind of observable behaviours occurring so you can tell she was definitely happy.

In this description, Steve talks about his meaningful moment with Eva so he uses first person language from his perspective. During the analysis, this moment was observed by me and re-described. Therefore at this second stage of the analysis, I changed the first person approach to a third person approach by changing the terms such as "Steve" for "I" and "She" for "Eva" and "we" for "Steve and Eva" or "they". Tense issues are addressed as well. I changed the present tense into past tense as Steve was reflecting a moment that has happened in the past. This process demonstrates that *double hermeneutics* were occurred.

Stage 2. Understanding the whole

By watching the whole session many times, I described the context and session as follows:

Steve usually has a group session, which includes Eva in a day-care centre. Eva has some individual time for greetings and vocal interactions while listening to her favourite songs. This particular individual session was conducted after a big group session. Because the group session produced

many people's vocal and musical sounds, video recording the interactions of Steve and Eva only in a quiet environment was important. The day was special because the centre was having a Christmas party, and therefore Eva was in a very excited mood.

In the individual session, Steve started singing Kylie Minogue's "Can't get you out of my head" (Dennis and Davis, 2001) because Eva likes big diva songs. Eva was very excited, shivering all the body, smiling, looking at the camera, and vocalising regularly. Emphasising "la la la" was essential to facilitate the vocal exchanges. Then Steve sang several diva songs, such as "Big girls don't cry" (Ferguson and Gad, 2007), but Eva did not seem to recognise the songs and did not respond but just looked at Steve without any affective facial expressions and bodily responses (typical shivering of her whole body and hand movements).

Then, Steve sang "Mamma Mia" (Andersson, Anderson and Ulvaeus, 1973) and the meaningful moment was occurred. Eva was very excited and reacted to Steve's musical and communicative behaviours. Eva also seemed to display intentional behaviours, such as looking at the camera and vocalising. After this song, Eva was really in the mood for musicking so Steve sang one more Abba song "Dancing Queen" (Andersson, Ulvaeus and Anderson, 1976).

Stage 3. Deciding a scope of analysis

The meaningful moment was occurred while Steve sang "Mamma Mia". Steve started the song by asking Eva her choice of songs between two songs and the

meaningful moment was occurred just at the end of the first verse. Therefore, I decided to analyse from the beginning of the song to the end of the first verse. The video footage was edited into its essential length. The total length of the video footage was 1:31 minutes, and the meaningful moment was developed during the last 10 seconds as presented in appendix 2.

Stage 4. Describing what and interpreting how

I described the details of Steve and Eva's non-verbal behaviours into the Excel spread form (see Appendix 2). Following description was generated by integrating the interactions appropriately:

Steve was vocalising the famous intro melody of the song "Mamma Mia". His upper body was still and closely leaning towards Eva. Steve made a nice and firm eye contact with Eva. Steve's behaviour seemed very intentional as he was giving this gestural cue for Eva, indicating, "It's the time to make music together!" As soon as meeting Steve's eyes and receiving the melody "Loo Loo Loo ", Eva vocalised "ah~" with a mild excitement. At the same time, she looked at the camera as if she was making sure the video recording was still going. Upon receiving Eva's vocal sound, "Ah~", Steve adapted that sound into the same melody "Ah~Ah~Ah~Ah~" and produced "Ah!!" at the end of the phrase, imitating Eva's typical vocal sound that is high pitched excited tone. Eva happily watched and listened (waiting for her turn) to Steve's vocalisations. Straight after, Steve continues "La~La~La~La~" and "Ah!!" Eva said "Ieeyah~~"(as if she was waiting for this moment), instead of

vocalising "Ah!!" as Steve might have expected. Then, she quickly shook her right hand up and down twice. Steve copied "Ieeyah?" with his eye brows going up and down fast (with a bit of surprise), then he shouted "Ieeyah!!!" again in a confirming way - eye brows were going up and down a little slowly this time. Soon, Steve moved on, singing the verse 2.

Stage 5. Looking at other parts

The more I watched the scene, I became conscious of the famous song. Then I became aware of the song structure and thought that the unique and dynamic song-structure influenced Steve's way of presenting the song, which affected Eva's emotional and expressive behaviours. Therefore, I analysed the structure and musical characteristics of the song, "Mamma Mia" and recorded in the excel form. The structure of the song provided a particular musical space and time, creating dynamic, fun, and motivating atmosphere for Steve and Eva. The song influenced Steve to play certain parts in a unique style. By controlling tempo, volume, and tone of sounds, Steve seemed to control the situation and at the same time provided Eva opportunities to respond in these musically communicative situations. The analysis produced the following description:

Steve was singing "Mamma Mia" with a guitar accompaniment. His voice sounded tired (because of the prior big group session) but the guitar accompaniment was very dynamic, creating an atmosphere. The musical structure of the song provided Steve and Eva the musical time and space. From the start, Steve played upbeat rhythms on his guitar with a fast tempo,

which seemed to excite Eva naturally. With the visual presentation of his guitar playing, Steve also used facial expressions, bodily postures/movements such as leaning towards Eva/standing tall, and making an eye contact with Eva to indicate her when to vocalise with him.

After singing the verse 1 and chorus, in the refrain, Steve played only two chords, shifting between one and the other in a regular pulse. He softly strummed the chords and his singing voice was louder than the guitar sound. He intentionally modelled vocalising to facilitate Eva to vocalise. On top of this stable musical container, Steve started humming the famous melodic introduction, using the sound "Loo". Then the "Loo" sound was changed into "Ah" and then "La" by adopting Eva's vocal sounds. Then this interaction finished with a surprise from Eva's brand new sound "Ieeyah".

Stage 6. Integrating parts and whole

By integrating the descriptions from stages 1 to 5, I developed the following description:

For Steve, a meaningful moment with Eva occurred when she said "Ieeyah" for the first time. Steve was singing "Mamma Mia" with a guitar accompaniment. His voice sounded tired because of the previous big group session, but Steve's rhythmic and lively guitar accompaniment excited Eva very much. To encourage her to vocalise with him, Steve displayed various animated facial expressions and bodily movements. Steve and Eva seemed contained in their own music time and space for the creative

interactions. For Steve, Eva's sudden new sound was felt like a developmental occasion (*sic*). The following describes the ten-second moment.

After singing the first verse, Steve plays the famous refrain. Shifting between two guitar chords, Steve plays soft but fast rhythms and now sings the song loudly to encourage Eva to vocalise with him. Leaning closely towards Eva and making friendly inviting eye contact with her, his eyes seem to say, "Eva, It's the time for us to make music together!" As soon as meeting Steve's eyes and receiving the melody, "Loo~Loo~Loo~Loo~", Eva vocalises "ah~~" with a mild excitement. She then looks at the camera as if to check that the video camera is still recording them. Steve adapts Eva's "ah~~" sound into the intro melody, singing "Ah~Ah~Ah~Ah~", and then he excitedly shouts a short "Ah!" at the end of the phrase, which imitates Eva's typical high pitched vocal sound. Eva happily watches and listens to Steve's vocalisations. After Steve sings "La~La~La~La~, Ah!", out of sudden Eva quickly vocalises to Steve, "Teeyah~~," and quickly shakes her right hand up and down twice with much excitement. It seems like she has been waiting for this moment. Steve seems to be taken aback by Eva's unexpected vocalisation as his eyebrows go up and down, but soon he copies the sound by shouting back "Teeyah!" His eyebrows move up and down slowly this time.

Reflection of Using IPVA Method

As described and demonstrated in this paper, IPVA was developed and used in a music therapy research project to micro-analyse the interactions occurring between pairs of music therapists and adults with PIMD in a meaningful moment. Several

limitations of the method are found. First, conducting IPVA might be a labour intensive and time-consuming process. In order to analyse the ten-second moment, an extensive interview that lasted about one and a half hour was conducted and a single session of 30 minutes was video recorded in the current study. As part of a bigger study, conducting the lengthy interviews was necessary and useful, however it might appear too demanding for some readers. The need of interviews and the amount of time spent for data collection should be adjusted for the need of a study in the future. Second, the iterative, cyclic processes of analysis that involved movement between the different stages are intensely complex and mysterious. Understanding the important concepts of hermeneutics and applying them to the multiply layered processes of interpretations may require immense time and effort for novice clinicians and researchers. Therefore, it may not be an easy tool to use initially.

However, the strength of IPVA lies in its complexity and depth of descriptions and interpretations, which also differentiate this method from other existing video microanalyses that often use category systems (Plahl, 2007; Scholtz et al., 2007; Schumacher and Calver, 2007). In the current study, applying hermeneutic principles was crucial in reflecting and articulating the invaluable moment and generating a fresh and rich description with critical interpretations. Using the information provided by the music therapist as fore-understanding was also important because *psychological interpretations* could be facilitated in an individualised and idiographic way.

This new method seems to provide a distinctive perspective and tool for music therapy clinicians and researchers as well as allied health professionals working with people with PIMD. The clinicians can use this tool to understand a meaningful moment that facilitates therapeutic change and progress in their clinical sessions. By

comparing the descriptions over time, they may be able to document the progress of their clients in music therapy in a long term. Researchers can use this tool to generate deep and powerful description of lived experiences and find implicit meanings beyond the description. Van Manen (1999) argues that these kinds of thick and rich descriptions are unique and irreplaceable because they facilitate fuller understandings of the phenomenon under investigation. He states:

rich descriptions, that explore the meaning structures beyond what is immediately experienced, gain a dimension of depth [...] depth is what gives the phenomenon lived experience to which we orient ourselves its meaning and its resistance to our fuller understanding (van Manen, 1999, p.152).

In conclusion, it is particularly important to seek understanding of the voices of the adults with PIMD as they are often ignored in a society dependent on verbal forms of communication. Regardless of their abilities and level of function, adults with PIMD have equal rights to be heard and understood as human beings like other people without disabilities. As illustrated by the case study in this article, the adult client with PIMD was able to meaningfully relate and interact with the music therapist using her own unique strategies. By documenting each person's unique form of expression, our understanding of the individualised and personal communications of non-verbal adults can be deepened. We hope this IPVA method facilitates further powerful interpretations of such non-verbal, symbolic, and implicit human experiences that deepen our understanding of the diverse world.

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Appendix 1

Steve's Interview Transcription

J: So would you pick some moments you think meaningful?

S: It's the song Kylie Minogue song and Abba song in the end. It's definitely more engagement and interaction. The vocalisation's happening more frequently and there is "Ieeyah" sound which is, it's a new thing.

J: Ieeyah sound was at the end of Mamma Mia was it?

S: Yes, a couple of times she did it, it will be during those songs.

Watching that part

J: Would you pick?

S: So yeah, the vocalisation of Ieeyah, it's a moment. Because during all three, she's making eye-contact, she's vocalising, she's trembling as well. Definitely more engaged more interactions, interacting more.

J: Do you think you can be able to pick some point?

S: Um, you wanna a definite time. Well, yeah, just where she says "Ieeyah".

J: Ieeyah? Where is it?

S: Yeah, go back to the Kylie Minogue song. Cause she was really excited in that. And also after the music finishes she seems to be really excitable. Once the music was finished. So it's like she wanted more. She's happy.

J: Is it this bit?

S: Um~~!

J: I think this is quite good isn't it?

S: Yes, that's quite a bit of vocalisation.

J: La La ...you guys sort of vocalised together.

S: Yes yeah yeah it's the repetitive part of the song as well. Yeah so the la la la bit definitely.

J: Does she say "Ieeyah" here?

S: Ieeyah, yeah, not sure actually.

J: I try to find the second where she says "Ieeyah".

S: Yeah, la la la's in the more repetitive bit maybe. There's quite a lot of cause she will breathe and then vocalise, breathe and then vocalise. And it's like keeps going there's more frequency.

J: So this bit?

S: Yes, so the la la la in Kylie Minogue yeah

J: Ok

S: Wherever she says "Ieeyah" for the first time

J: I feel like you already explained but can you just repeat why you choose these two moments meaningful?

S: Yes because it's different from the routine. We've got a familiar kind of relationship going, I know the songs work quiet well with her. And to hear her vocalise something a little bit different was significant in itself because it's kind of like a developmental occasion. So she vocalises now she's vocalising with the sound "Ieeyah". And also the level of excitement on that day was quiet a lot and for longer period of time more frequency kind of observable behaviours occurring so you can tell she was definitely happy.

Appendix 2

Indexing Form for Musical and Non-Verbal Interactions

Time	Music	Steve	Eva
1:21	Refrain: in this section, Steve uses only two chords, shifting between them in a regular pulse. He softly strums the chords and his voice is louder now because he intentionally facilitates Eva to vocalise.	Steve sings the famous intro guitar melody, "Loo~ Loo~ Loo~ Loo~", leaning closely towards Eva and being still and making eye contact. (Steve seems very intentional here. He is giving this gestural indication for Eva saying, "it's the time to shine!")	As soon as meeting Steve's eyes and receiving the melody, "Loo~ Loo~ Loo~ Loo~", Eva vocalises "ah~~" with mild excitement. At the same time she looks at the camera.
1:24	Based on the stable musical container, Steve starts humming a short melody using "Loo". Then the sound is changed into "Ah" and "La" by adopting Eva's sounds and then this interaction finishes with Eva's new sound "Ieeyah!"	Upon receiving Eva's vocal sound, "Ah~", Steve adopts that sound into the same melody, singing "Ah~Ah~Ah~Ah~" and produces "Ah! (imitating Eva's usual vocal sound "Ah~h~"- high pitched excited tone).	Eva happily watches and listens (waiting for her turn?) to Steve.
1:28		Straight after Steve continues "La~La~La~La~" and "Ah!"	Eva says "Ieeyah~~" (as if she was waiting for this moment), and she shakes her right hand twice up and down.
1:31		Steve copies "Ieeyah?" with his eyebrows going up and down fast. Then he shouts "Ieeyah!" again with a confirming way: eyebrows are going up and down a little slowly this time. Soon Steve continues singing the verse 2.	

Paper 3

Lee, J., Kim, J., & McFerran, K. (Under Review). Meaningful moments with adults with profound intellectual and multiple disabilities in music therapy: An interpretative phenomenological video analysis.

Meaningful Moments with Adults with Profound Intellectual and Multiple Disabilities in Music Therapy: An Interpretative Phenomenological Video Analysis

Abstract

Sharing meaningful moments with adults with Profound Intellectual and Multiple Disabilities (PIMD) is generally believed to be challenging due to their communication difficulties. In music therapy, however, music therapists often experience meaningful moments with them by using a non-verbal medium of music. The aim of the current study was to describe meaningful moments with adults with PIMD in music therapy and interpret the implicit meanings of the moments. Five pairs who have been practicing music therapy for over several years were invited, and single music therapy sessions of the pairs were video-recorded. In in-depth face-to-face interviews, the music therapists were asked to identify a meaningful moment. Interpretative Phenomenological Video Analysis (IPVA), a new method of applying IPA into video analyses developed in the current study, was used in analysing the meaningful moments. Amir's (1992) classification of meaningful moments was used in the interpretative analysis. As a result, five descriptions of the meaningful moments were generated, and the interpretative analysis indicated that the moments facilitated *physical closeness* and *musical intimacy* between the pairs. On the intrapersonal level, clients experienced moments of *joy and ecstasy*; *completion and accomplishment*, which seem to reflect psychosocial benefits of the meaningful moments on the adults with PIMD.

Keywords 3-6 words

Adults with profound intellectual and multiple disabilities, Meaningful moments in Music therapy, Video analysis, Interpretative Phenomenological Analysis (IPA)

“The life of people with profound multiple disabilities is imbedded in relations with other people that give meaning to their existence. They can have meaningful living and learning experiences only when there are other people who support them” (Petry & Maes, 2007, p. 137).

Introduction

People with Profound Intellectual and Multiple Disabilities (PIMD)³² or Profound Multiple Learning Disabilities (PLMD) are a group of people who have more than two profound impairments in physical, intellectual, medical, and sensory areas (Mednick, 2007). As the severe and complex conditions significantly limit their abilities to live independently, individuals with PIMD need life-long care and support from others. Moreover, as the above quote by Petry and Maes claims, the lives of people with PIMD can be meaningful only when they are *valued for beyond cared for* by others. However, some people have negative perspectives on their meaningful participation in the community. For example, a title of research study reflects this view by quoting a disability support worker’s statement: “it’s pretty hard with our ones, they can’t talk, the more able bodied can participate” (Bigby, Clement, Mansell, & Beadle-Brown, 2009).

However, a group of researchers in United Kingdom (Bellamy et al., 2010) suggest a new definition of PIMD that identifies not only disabilities but also abilities of people with PIMD. They compared ten different definitions and interviewed 23 people who support adults with PIMD, such as service managers, disability support workers, and health professionals. As a result, the researchers claim that although adults with PIMD “may have limited ability to engage verbally” (p. 233), they are able to respond to non-verbal cues within their familiar environments, and need constant support and an individualised relationship with a carer to achieve their optimum potential.

³² In 2008, an international group of researchers has identified that PIMD is the most accurate term to call this group of people (Carnaby & Pawlyn, 2009).

As one of therapeutic interventions provided for people with disabilities since the 1960's, music therapy supports a client with a non-verbal medium of music and individualised therapeutic relationship (Bruscia, 1998). As a result, music therapists have reported that they have shared meaningful interactions with people with PIMD (Agrotou, 1994, 1998; Elefant, 2001; Graham, 2004; Lee & McFerran, 2012; Oldfield & Adams, 1990, 1995; Ritchie, 1993; Watson, 2007). Particularly with adults with PIMD, who are reportedly *at risk of social isolation* (Forster, 2008), music therapy often has resulted in building a long-term relationship with the clients over several years. Agrotou (1994, 1998) reported both individual and group works in institutional settings and qualitatively analysed therapeutic changes of the clients over several years. Graham (2004) described how her vocal interactions with two clients with severe multiple disabilities validated the clients' feelings of sadness and anger and consequently resulted in clients' reduced challenging behaviours. Similarly, Watson (2007) described her group work with four females with PIMD and reported that they felt the profound connection with each other toward the end of eight months of therapy in spite the initial feelings of absence and rejection in the group.

Commonly, the music therapists used a psychodynamic theoretical approach and improvisational music therapy methods, which seems crucial in interpreting non-verbal sounds and behaviours meaningfully. Moreover, most clients have been extremely isolated in residential institutions in these studies. But in music therapy, maybe for the first time in their lives, most clients learnt to interact and build meaningful relationships with others such as music therapists, their peers, or disability support workers. Some of them even progressed to participating in community activities at the end of music therapy (Agrotou, 1994; Ritchie, 1993). Therefore, these studies have demonstrated the value of sharing meaningful interactions over time on the lives of adults with PIMD.

Although the previous studies have provided knowledge and insight on the long-term process of music therapy with adults with PIMD, no study has explored a moment that is meaningful in a micro-momentary level. Accordingly, music therapists lack knowledge on micro-processes³³ of meaningful interactions with adults with PIMD. In recent years, analyzing micro-processes in music therapy has become

³³ According to Wosch and Wigram (2007, p. 22), "*microprocesses* are processes and changes/progressions within one session of music therapy."

important in understanding therapeutic changes and development (Wosch & Wigram, 2007). Some music therapists have collected video data and analysed micro-processes of non-verbal interactions with clients with communication difficulties (Holck, 2007; Plahl, 2007; Ridder, 2007). Furthermore, Stern (2004) discuss the importance of looking at a present moment on a micro level with a phenomenological view in his book, “The Present Moment in Psychotherapy and Everyday Life.” Stern refers to a present moment as a *microscope* that “makes the process of psychotherapy look different and alters our conceptions of how therapeutic change comes about. How we conduct psychotherapy will shift because our view of what is happening will be different” (p.4). Consequently, the current study aims to describe meaningful moments with adults with PIMD by micro-analysing non-verbal interactions within one session of music therapy and interpret the implicit meanings of the moment in terms of therapeutic changes and development.

Meaningful moments in music therapy

Two research studies have examined meaningful moments in music therapy (Amir, 1992; Johns, 2013). Amir (1992) firstly investigated the lived experiences of meaningful moments by interviewing four music therapists and four clients who have various clinical experiences. A grounded theory was used for the text analysis, and a total of 15 meaningful moments were identified and classified into *intra* and *inter* personal levels. Recently, Johns (2013) micro-analysed improvised music created with six children with developmental disabilities during meaningful moments. The musical and non-verbal interactions were described and the role of music and therapist were further analysed. Interestingly, both studies used ethnographic approaches, which resulted in detailed descriptions of meaningful moments and further analysis of the implicit meanings of the moments.

Similarly, music therapists have explored different moments such as pivotal, significant, and spiritual. Most studies have explored the moments by examining the lived experiences of music therapists and/or clients and meanings of these moments on them in a similar way to Amir’s (1992) interview study. For example, Marom (2004) explored music therapists’ experiences of spiritual moments and Grocke (1999) investigated clients’ experiences of pivotal moments in Guided Imagery of

Music (GIM) by interviewing both clients and music therapists. Comeau (2004) and Muller (2008) also investigated the lived experiences of being effective and present as a music therapist.

On the other hand, other studies have explored the moments by microanalysing recorded or improvised music, images, and non-verbal interactions, which occurred during the moments as Johns (2013) investigated. Grocke (1999) analysed recorded classical music played during the pivotal moments in GIM. Trondalen (2005) analysed improvised music created with two young people with eating disorders during the significant moments. In a similar way, a group of interdisciplinary researchers (Ansdell, Davidson, Magee, Meehan, & Procter, 2010) have investigated a present moment with a female client experiencing a psychotic condition. They microanalysed four minutes of improvised music created during an acute moment where the client felt extreme negative emotion towards her life then felt better after four minutes of improvisation. By adopting theoretical perspectives of mother-infant interaction theories, the researchers preliminarily interpreted the process and outcome of the *musical present moment on the client*.

The reviewed studies have utilised two different methods, interviews and microanalysis of complex data depending on the foci of the study. However, all the studies have used qualitative approaches, which resulted in rich descriptions of individual moments and critical interpretations of implicit meanings of the moment. Methodologically, a phenomenological approach has been dominantly used (Ansdell et al., 2010; Comeau, 2004; Grocke, 1999; Marom, 2004; Muller, 2008; Trondalen, 2005), however an ethnographic approach has been applied (Amir, 1992; Johns, 2013). Aigen (2008) assumes that it is because a focus of phenomenology is on exploring inner experiences of people.

With regard to microanalysis methods informed by phenomenology, two researchers, Grocke (2007) and Trondalen (2007) have developed systematic and procedural methods, such as Structural Model of Music Analysis (SMMA) and nine steps of phenomenologically inspired procedure. Particularly, Trondalen (2005, 2007) utilised both phenomenology and hermeneutics, a theory of text interpretation, in analysing the audio (improvised music) and text (interpersonal dialogue) data. The hermeneutic approach facilitated her to contemplate the phenomenon from various levels moving along the multiple steps. Furthermore, in recent years, Interpretative Phenomenological Analysis (IPA) has been often used in microanalysis of improvised

music and shown the value of this method in describing and interpreting the complex data (Ansdell et al., 2010; Solli, 2014). Accordingly, adopting an interpretative approach was crucial in the current study as demonstrated in these studies.

Theoretical perspective for the interpretation

In the current study, the theory of *innate intersubjectivity* (Trevarthen, 1979) that originated from mother-infant interaction studies provided a vital theoretical lens in interpreting the non-verbal behaviours of the adults with PIMD. As this theory advocates the innate social abilities of every human being to relate to each other including people with severe disabilities, it provided a useful framework in viewing the non-verbal behaviours of adults with PIMD meaningfully. Furthermore, *communicative musicality* (Malloch & Trevarthen, 2009b) and *forms of vitality* (Stern, 2010) provided further theoretical guides in the actual analysis of interpretation. Communicative musicality enabled the researcher to analyse the musical qualities of the non-verbal interactions between therapists and clients. Forms of vitality (Stern, 2010) highlighted the way people perceive and understand different non-verbal forms of vitality. Stern (2010) claims:

We naturally experience people in terms of their vitality. We intuitively evaluate their emotions, states of mind, what they are thinking and what they really mean, their authenticity, what they are likely to do next, as well as their health and illness on the basis of the vitality expressed in their almost constant movement (p.3).

Consequently, the theories of communicative musicality and forms of vitality, which originated from innate intersubjectivity were crucial in developing descriptions of the non-verbal interactions.

In summary, music therapists have explored various types of moments to understand the therapeutic changes and developments in music therapy. Qualitative approaches produced detailed descriptions of the moments. Particularly, two studies that examined meaningful moments in music therapy provided useful knowledge on the sub-types of meaningful moments and role of music and therapists in these

moments. However, no study explored meaningful moments with non-verbal adult clients with PIMD, and video data has not been used to understand the micro-momentary levels of the interaction. Therefore, the current study aims to describe the meaningful moments and interpret implicit meanings of the moments shared between music therapists and non-verbal clients with PIMD, by collecting and analysing video clips of music therapy sessions. Furthermore, because the idiosyncratic non-verbal behaviours of adults with PIMD require critical interpretation to elicit implicit meanings, an interpretative approach in phenomenology was applied to the video analysis. Guiding research questions for the current study were: how can the meaningful moments with adults with PIMD be described? And, what are the implicit meanings of these moments for the adults with PIMD?

Method

Interpretative phenomenological analysis (IPA)

IPA (Smith et al., 2009) was developed by UK psychologist, Jonathan Smith, in 1990s to use in research and clinical studies in the field of psychology. As it stresses a researcher's active role in interpreting implicit meanings of the experience, despite its short history compared to the empirical descriptive approach (Giorgi, 1975), many researchers in the fields of health and social science soon have recognised the value of IPA. Three theoretical principals are central in IPA: *phenomenology*, *hermeneutics*, and *idiography* (Smith & Eatough, 2007; Smith et al., 2009). Phenomenology is a study of lived experiences; hermeneutics involves interpretations of the experiences; and idiograph focuses on individuals' unique stories. Based on the three principals, IPA seeks to understand how an individual makes sense of his/her lived experience. Particularly, the hermeneutic notions, such as *the double hermeneutic*, *the hermeneutic circle*, and the *grammatical/psychological interpretation* enable a researcher to explore the phenomenon repetitively from different levels and perspectives (Smith, 2007). *The double hermeneutic* happens when a researcher tries to understand a participant who is trying to understand his/her own experience. *The hermeneutic circle* occurs when a researcher analyses different parts and a whole of the experience moving around them. A grammatical interpretation occurs when a researcher interprets the experience as it is described, and a psychological

interpretation occurs when a researcher interprets the experience in relation to the principals of psychology.

Participants

Five pairs of music therapists and adult clients with PIMD in Australia participated in the current study. Ethical clearance was obtained from the Human Research Committee at the University of Melbourne (# 1136760). The inclusion criteria for the music therapists: a person who was qualified or registered as a music therapist with the Australian Music Therapy Association, and had a work experience of more than a year with the participating client. The inclusion criteria for the adults with PIMD: a person who was aged between 19 and 60; diagnosed with profound levels of two or more major impairments in physical, intellectual, sensory, and medical areas. Information of the five pairs are summarised in the table 1.

Table 1.

Participants Information

Music Therapist	Gender/ Age	Client	Gender/ Age	Diagnosis	Years of practice together	Settings
Frances	F/ 40's	Amy	F/19	Rett Syndrome, Epilepsy	4	Client's home
Steve	M/30's	Eva	F/22	Moya Moya Brain Disease, Cerebral Palsy (Spastic Quadriplegia), and Epilepsy	2	Daycare Centre
Erica	F/50's	Mark	M/22	Cerebral Palsy (Spastic Quadriplegia) and blinded right eye due to renal failure	6	Therapist's studio
Darren	M/30's	Mia	F/29	Mitochondrial Cytopathy, Movement Disorder, Epilepsy, and Metabolic Disorder	2	Client's home
Owen	M/30's	Nelson	M/46	Cerebral Palsy, Severe Developmental Delay, Epilepsy, Arthritis, Oesophageal dysphagia	4	Institution

The participants' names are all pseudonyms, and mothers of the five clients provided demographic information and written consents for their adult children to participate in the study. The adult clients with PIMD attended a single recorded music therapy session with their own music therapist in their usual settings.

Data collection

To video record music therapy sessions, a naturalistic investigation (Lincoln & Guba, 1985) was employed as the researcher, who is the first author of this article, visited various places where the pairs have their sessions. Only a single session was recorded for each pair and it was believed to reflect a typical music therapy session. However, if any music therapist reported that it did not reflect their typical sessions for any reason, then recording more sessions was anticipated. Sony digital video camera recorder and wide conversion lens were used for recording. After one or two weeks, the music therapists individually participated in in-depth face-to-face phenomenological interviews (Englander, 2012) with the researcher at their convenient time and place.

Interviews were divided into three sections, and in the first and second parts of the interviews, the music therapists were asked to describe their interpersonal relationships with the participating clients. In the last part, each music therapist watched his or her recorded music therapy session and asked to choose a meaningful moment of the session. They were also asked to describe it in detail and explain why they choose that moment as meaningful. The information obtained from the first and second parts of the interviews later assisted the researcher when interpreting the non-verbal and idiosyncratic behaviours of the clients. The average time of the five interviews was 82 minutes, and most music therapy sessions lasted for approximately 30 minutes.

Data analysis

In the current study, IPA was applied to the video analyses, and as a result a new analysis method named Interpretative Phenomenological Video Analysis (IPVA) was developed. The purpose of each analysis was to create a description that contains a description of what happened and interpretation of implicit meanings of the experience. Six stages were used:

- Stage 1. Understanding the moment
- Stage 2. Understanding the whole
- Stage 3. Deciding a scope of analysis
- Stage 4. Describing what and interpreting how
- Stage 5. Looking at other parts
- Stage 6. Integrating parts and whole

At the first stage, the researcher repetitively read the last part of the interview transcription to understand the meaningful moment identified by the music therapist. A short summary of this transcription was created. At the second stage, the researcher watched the video clip in order to understand the whole context. At the third stage, after repetitively watching the whole session and the meaningful moment, the researcher decided a scope of analysis. At the stage four, the researcher described second by second behaviours of the client and music therapist in an excel spread sheet and interpreted implicit meanings behind the behaviours actively utilising the information about the client obtained from the first and second parts of the interview, and also considering theoretical ideas of *communicative musicality* (Malloch & Trevarthen, 2009b) and *forms of vitality* (Stern, 2010). At the stage five, the researcher explored the impact of music on the participants' behaviours. Each stage generated short descriptions, and by integrating parts of these descriptions, the researcher created a whole description at the last sixth stage. Throughout the six stages, *the double hermeneutic*, *the hermeneutic circle*, and *the grammatical/psychological interpretations* (Smith, 2007) occurred.

Results

Individual descriptions of the meaningful moments

Frances' meaningful moment with Amy

For Frances, a meaningful moment with Amy happened when Amy responded with a big smile to a song-choice offer. One of the songs offered to Amy was “One Thing” (Falk, Kotecha, & Yacoub, 2012) sung by the popular English-Irish boy band “One Direction”. Considering Amy’s age 19, and the fact that she has a pre-teenage sister influencing Amy’s musical taste, she seemed to like this boy band very much. Initially, Amy took a while to process what was being asked and also she appeared very tired and weary due to a big seizure, which had occurred just before this session. Then, when Amy’s carer, Judy, commented on the photo on the song-card, Amy seemed to recognise the boy band. She became very excited, which indicated to Frances and Judy that she would like to listen to the song. Frances felt good because she originally had provided Amy a different song, and Amy enjoyed this song immensely while sharing the song later. The following section describes the 50 seconds moment.

Frances encourages Amy to use her eyes to make a choice by saying, “You show us with your eyes... ‘One thing’? Or... ‘Dancing Queen’?” As soon as Frances says to use her eyes, Amy beams her bright smile across her face and looks up at “One Thing” for about few seconds. Then, Amy briefly looks at “Dancing Queen” song-card, Frances, and then the video camera. Frances is not sure whether Amy is making a clear choice because she looks at both cards. Now Frances swaps the two song-cards and asks Amy to choose again. Amy looks at the right side, where the song-card of “One Thing” was previously placed, but it is now replaced with “Dancing Queen.” Frances says, “Dancing queen? You are looking at that way?” with a little bit of wonder. Amy continues looking at “Dancing Queen.” Then Judy says, “You like handsome boys, don’t you?” Straight after Frances asks, “Dancing Queen?” Amy shakes her head briefly and then looks at the song-card of “One thing.” Amy makes smiley eye contacts with Frances and then with Judy. It

seems clear that Amy is choosing the song, "One thing". Judy laughs at this, saying "Oh Amy~." Frances also excitedly shouts, "I thought so. 19 year old girl is a 19 year old girl!" Amy keeps smiling, looking at Judy. Frances starts singing and Judy helps Amy to play bells and maracas by supporting Amy's arms and hands. Amy laughs audibly twice while listening to the song. When the song has finished, Judy excitedly says, "Oh, Amy~, just because it's a boy band!" and then repeated it again. This made Amy even more excited and Amy hits the tambourine with her maracas.

Darren's meaningful moment with Mia

For Darren, a meaningful moment with Mia occurred when he offered Mia an instrument choice. He presented two types of bells at the same time and kept swapping the locations of the two bells, asking Mia to look at the bell she liked. Darren repeated this process again and again, however, Mia did not show consistent responses. Darren knew how Mia would usually respond and she might have been experiencing a challenge sitting in a new wheelchair. So he offered Mia a second chance by presenting the bells one at a time. Darren noticed that Mia was trying very hard to communicate her choice with him. He also believed that if they had no therapeutic relationship formed from the previous history, Mia might have just looked away, not trying to communicate her choice and looking up in a way she felt comfortable. The following describes the 14 seconds moment.

"Alright." Darren decides to present only one bell at a time after spending about one minute, presenting two bells together. Darren presents the metal bell, hiding the wooden bell under his arm. He says to Mia, "You need to look down. That's the metal one. Can you look down for the metal one?" and he moves the metal bell down. Mia looks at the metal one and then looks down, following the moving metal bell. "Thank you." Darren says. Now Darren shows the wooden one. "This is the wooden one." Mia keeps looking up even when Darren puts the wooden bell down, which means, "No, I don't like to choose this one." Darren says, "So you don't want the wooden one." It is a clear response from Mia. However, Darren wants to confirm Mia's choice once more so Darren shows Mia the metal bell again. "How about the metal one? Look at down if you want it." Mia looks up and then down at the metal

bell, meaning ‘Yes, I would like to choose this one.’ Darren says, “Thank you.” Then he repeats the process once more, placing the metal bell up in the air and then down. “Can you look at down?” Mia quickly looks up and down at the metal bell. Darren says, “Thanks.” with a clear and firm voice. After the long choice-making trials, Darren and Mia are relieved to achieve this nice ending. Darren helps Mia to wear the metal bell in her left hand. Mia enjoys her red metal bell ever after in the session.

Steve’s meaningful moment with Eva

For Steve, a meaningful moment with Eva occurred when she said “*Ieeyah*” for the first time. Steve was singing “Mamma Mia” (Andersson, Anderson, & Ulvaeus, 1973) with a guitar accompaniment. His voice sounded tired because of the previous big group session, but Steve’s rhythmic and lively guitar accompaniment excited Eva very much. To encourage her to vocalise with him, Steve displayed various animated facial expressions and bodily movements. Steve and Eva seemed contained in their own music time and space for the creative interactions. For Steve, Eva’s sudden new sound was felt like a developmental occasion (*sic*). The following describes the ten seconds moment.

After singing the first verse, Steve plays the famous refrain. Shifting between two guitar chords, Steve plays soft but fast rhythms and now sings the song loudly to encourage Eva to vocalise with him. Leaning closely towards Eva and making friendly inviting eye contact with her, his eyes seem to say, “Eva, It’s the time for us to make music together!” As soon as meeting Steve’s eyes and receiving the melody, “Loo~Loo~Loo~Loo~,” Eva vocalises “ah~~” with a mild excitement. She then looks at the camera as if to check that the video camera is still recording them. Steve adapts Eva’s “ah~~” sound into the intro melody by singing “Ah~Ah~Ah~Ah~.” Then he excitedly shouts a short “Ah!” at the end of the phrase, which imitates Eva’s typical high pitched vocal sound. Eva happily watches and listens to Steve’s vocalisations. After Steve sings “La~La~La~La~, Ah!,” out of sudden Eva quickly vocalises to Steve “Ieeyah~~,” and quickly shakes her right hand up and down twice with much excitement. It seems like she has been waiting for this moment. Steve seems

to be taken aback by Eva's unexpected vocalisation as his eyebrows go up and down, but soon, he copies the sound by shouting back "leeyah!" His eyebrows move up and down slowly this time.

Owen's meaningful moment with Nelson

For Owen, a meaningful moment with Nelson occurred when Owen was improvising music on his guitar and Nelson suddenly vocalised. Nelson was very quiet, not playing any instrument and just putting his head down. So Owen tapped the musical instruments in front of Nelson to remind him to play them. But at that time, Nelson was preparing to vocalize. Owen reflected that they were not connected at that point, then they were clicked back in (*sic*) when Nelson vocalised. The following describes the 40 seconds moment.

Owen takes a capo out of his back pocket and puts that on the guitar that is placed on his lap. Nelson puts his maracas down on the table and looks at Owen. Owen softly strums the key of E major and starts improvising. In this session, Owen has played 9th and 13th chords with fast bossa nova rhythms, but this time, Owen plays open triads with slow and soft melodies. Nelson appears to be listening to Owen's music. Suddenly a female's high-pitched scream-like-sound is heard from a distance. Nelson appears very surprised at this sound as his pupils become larger with a frozen look on his face. Then he seems to take a deep breath by leaning back, stretching his upper body, and opening his chest. Nelson holds his breath. At the same time, Owen rhythmically taps two maracas and a tambourine to remind Nelson that he has musical instruments in front of him. As soon as Owen finishes tapping, Nelson loudly bursts the first vocalisation, "Ah~~~" for three seconds and looks at Owen. Nelson appears to be making a huge effort to produce this sound because his face displays a painful look and his voice sounds like it is coming from deep in his belly. Owen is taken aback by the Nelson's vocalisation but he does not overtly express his surprise. Owen softly vocalises back and continues playing the guitar louder with more complicated melodies on his guitar, supporting and encouraging Nelson to explore more vocalisations. At this moment it feels like as if Nelson stirs up Owen's music and peaceful

atmosphere in the room. Because of the perfect timing, it feels like it is the real start of this improvised music. Nelson continues vocalising with Owen.

Erica's meaningful moment with Mark

For Erica, a meaningful moment with Mark happened when he vocalised in the chorus of the song, "Daniel" (John & Taupin, 1973). Mark vocalised a high pitched sounds in this and it demonstrated how Mark would respond when he understands the structure of the song and knows those particular points where he really gets a lot out of that (*sic*) and becomes excited. Mark vocalised loudly when Erica asks if he wanted to listen to the song "Daniel" again. Erica was not sure whether he was saying "yes" but because Mark kept vocalising, she started playing from the middle section of the song. Erica knew Mark likes the chorus where the lyric goes "Daniel my brother~, you are older than me" so she sang the chorus straight away this time. The following describes the 30 seconds moment.

As Mark does not vocalise as much as he usually does, Erica decides to sing the chorus once more to provide him another opportunity to vocalise. This time, she sings it slowly with much more articulation and elaboration with each note and lyric. In the part, "Daniel, you are a star~,," she gradually slows the tempo down and reduces her piano volume as well. She sings softly, looking at Mark as if giving him a gestural cue to vocalise. Because of his visual impairment, Mark is not able to look at Erica, but he seems able to detect Erica's body movement by feeling the sound source and movement in the air and know whether she is facing the piano or him. Upon listening to this, Mark takes a deep breath and then holds it for a second, firmly grabbing his face. Then he stretches his two arms open wide in the air, and loudly vocalises "Ah~hh~Ah~" for about five seconds. Then, he actively moves his upper body side to side, and then shakes his head very quickly side to side many times with much excitement. His mom says, "That's it Mark, Don't stop it!" with bursting laughter. Erica smiles at this and plays the piano faster than the previous section as if she wants to move along with a good tempo. With the Erica's musical support on the piano, Mark continues his vocal

exploration for the rest of the song, which was a great fun for everyone in the room.

Interpretative analysis of the results

To explore the implicit meanings of each moment, a further interpretative analysis was conducted. Amir's (1992) classification of meaningful moments was used as it empirically examined extensive experiences of meaningful moments in music therapy. Amir interviewed both music therapists and clients with a variety of clinical backgrounds, including a music therapist working with children with PIMD. Therefore, the classification seems highly relevant to studies of meaningful moments in music therapy in general.

Moreover, the classification provides definitions of the 15 meaningful moments, which indicates characteristics and meanings of the moments. For example, the 12 intra-personal³⁴ meaningful moments are moments of: *awareness and insight; acceptance; freedom; wholeness and integration; completion and accomplishment; beauty and inspiration; spirituality; intimacy with self; joy and ecstasy; anger, fear, and pain; surprise; and inner transformation*. The name of each moment reflects unique characteristics of the moments. Similarly, the three inter-personal³⁵ moments of *physical closeness; musical intimacy; and close contact between client and a significant person* also indicate the nature of the interpersonal moments. Accordingly, categorising the five meaningful moments into the classification seems useful in understanding the characteristics and meanings of the moments.

To identify the most relevant moments on intra and inter personal levels, the researcher examined each case in the following way. First, the researcher read the description of meaningful moment and definitions of the 13 intra-personal meaningful moments. Then, by comparing the person's affective responses or behaviours before, during, and after the meaningful moments with Amir's definitions, the most appropriate moment was identified for the therapist and client.

³⁴ According to Amir (1992), intra-personal moments were experienced within a person

³⁵ Inter-personal moments were experienced between therapists and clients.

For example, in the case of Steve and Eva's meaningful moment, the researcher noticed that Steve was surprised by Eva's new vocal sound, which was also expressed by Steve in the interview. According to Amir (1992, p. 580), the moment of *surprise* is defined as "moment in which clients and therapists were surprised by the quality and the intensity of their own experience or their client's experiences". Therefore, Steve's intra-personal experience was classified as a moment of *surprise*. Similarly, Eva showed high levels of excitement and joy over the course of the moment, hence Eva's intra-personal moment was classified as a moment of *joy and ecstasy*. On the inter-personal level, it was obvious in the video footage that Steve and Eva became physically close for the intense exchanges of facial expression and vocalisation occurred during the meaningful moment. Therefore, it was classified as a moment of *physical closeness*. In this way, each moment was analysed and the results are presented in table 2.

Table 2.

Meaningful Moments on Intra and Inter Personal Levels

Music therapist's intrapersonal moment	Music therapist	Interpersonal moment for the pair	Client	Client's intrapersonal moment
Completion and accomplishment	Darren	Physical closeness	Mia	Completion and accomplishment
Completion and accomplishment	Erica	Musical intimacy	Mark	Joy and ecstasy
Completion and accomplishment	Frances	Physical closeness	Amy	Completion and accomplishment
Surprise	Owen	Musical intimacy	Nelson	Joy and ecstasy
Surprise	Steve	Physical closeness	Eva	Joy and ecstasy

Music therapists' interpersonal moments

The five music therapists have experienced moments of *surprise*, and *complication and accomplishment* during the meaningful moments. Owen experienced moments of surprise similarly to Steve. On the contrast three music therapists, Erica, Frances, and Darren experienced moments of *completion and accomplishment*. Amir (1992) refers these moments as “where the music therapists felt that their efforts and explorations bore fruit and the clients felt proud and had a sense of achievement in their music making” (p.57). Erica was encouraging Mark to vocalise with her, Darren and Frances were encouraging Mia and Amy to use their eye-gaze to make their choices. As the clients finally displayed the expected behaviours after a long period of time, the music therapists appeared content and pleased by the clients’ responses. Accordingly, it seems appropriate to classify the three music therapists’ moments as of *completion and accomplishment*.

Clients' interpersonal moments

Clients seemed to experience moments of *joy and ecstasy*, and *completion and accomplishment*. The clients who participated in active musicking with their music therapists seemed to experience the moments of *joy and ecstasy* when considering their affective responses after the moments. The moment of *joy and ecstasy* is defined as a moment of “excitement, delight, joy, and exhilaration” (Amir, 1992, p.57). Eva, Mark, and Nelson were musically interacting with their therapists and their sudden and creative contribution made them very excited and delighted. Eva showed typical body responses with big smiles; Mark displayed big smiles and shook his upper body and head many times with excitement and exhilaration. Similarly, Nelson displayed smiles after a while. On the other hand, Amy and Mia who participated in choice-making processes seemed to experience moments of *completion and accomplishment* in a similar way to their music therapists experienced.

Interpersonal levels

On the interpersonal levels, the moments of *musical intimacy* and *physical closeness* were experienced. Two pairs, Erica and Mark; Owen and Nelson seemed to experience a moment of *musical intimacy* as Mark and Nelson's vocal explorations lasted for a period of time and created beautiful musical moments. The music therapists also stressed Mark and Nelson's musical capacities to vocalise in the key that the music therapists were playing in the interviews. In the case of Steve and Eva, although Eva vocalised during the song-sharing, she only made a short single phrase which was not musical. Rather, their interpersonal moment seems to represent the moment of *physical closeness* as they became physically close for intense interactions to each other. It was also illustrated in the description as "leaning closely towards Eva". In a similar way, the choice making processes created moments of *physical closeness* for Darren and Mia; Frances and Amy on the interpersonal level.

Discussion and conclusion

The current study has generated five descriptions of meaningful moments shared by five pairs of therapists-clients with PIMD. A further interpretative analysis of each moment has identified implicit meanings of the moments. The process of developing the individual descriptions has revealed a novel way to imply meanings about the micro-momentary moments that are usually perceived as *implicit knowledge*³⁶. Using interpretative theoretical and methodological perspectives, the researcher explicated subtle idiosyncratic behaviours of the non-verbal clients. Although the descriptions may appear basically descriptive to some readers, "such description inevitably contains interpretive statements concerning intention and subjective states" (Ansdell et al., 2010, p. 10). Consequently, the moments have become *explicit knowledge*³⁷, offering meanings to the clients' subtle and idiosyncratic behaviours.

³⁶ "Most simply, implicit knowledge is non-symbolic, nonverbal, procedural, and unconscious in the sense of not being reflectively conscious" (Stern, 2004, p. 113).

³⁷ "Explicit knowledge is symbolic, verbalizable, declarative, capable of being narrated, and reflectively conscious" (Stern, 2004, p. 113).

The newly perceived explicit knowledge that was garnered has opened up “new areas of possible theoretical formulation” (Ansdell et al., 2010, pp. 6-7) and indicated psychosocial benefits of the moments for the clients with PIMD. For example, the moments of *completion and accomplishment* were likely to be empowering for the clients. The moments of *joy and ecstasy* appeared to improve clients’ mood and energy levels, which was also observable after the moments in the sessions. Moreover, two clients showed their capacity to exert some control over the interactions during the meaningful moments, which surprised their music therapists. This altered the music therapists’ perspectives about the clients with whom they were in long-term relationship.

The outcomes that Ansdell and colleagues (2010) theorise as resulting from participation in *musical present moments* add a further layer of understanding about the significance of this new knowledge. Based on Stern’s (2004) description of *present moments*, they argue that experiencing the present moment may potentially result in three helpful consequences: “musical companionship, enhancement of the intersubjective field between the therapist and client, or the creation of positive shifts towards affect regulation” (Ansdell et al., 2010, pp. 8-9). In the study reported here, the moments of *physical closeness* could be related to enhancement of the intersubjective field and the moments of *joy and ecstasy* as well as *completion and accomplishment* seem related to the creation of positive shifts towards affect regulation. Similarly, the moments of *musical intimacy* seem to refer to the musical companionship. Although their relevance to each other seems reasonable, more research is needed to confirm and clarify these theoretical concepts and terms in the future.

Similarly, the individual descriptions of the meaningful moments seem to illustrate “the development of a temporal sequence within the client-therapist dyad” summarized by Ansdell et al. (2010) as:

- (i) moving along without event, then
- (ii) reaching a sudden crisis (or Kairos) point defined as a "special present moment" or now moment, which then
- (iii) finds resolution in a moment of meeting between the pair (pp. 6-7).

Each description in the current study demonstrates this three stage processes. However, it is evident that the descriptions mostly focus on the second stage, and the first and third stages are described only briefly. The first stage provides important context in order to understand how the special present moment has been built up, and the third stage provides important descriptions of the impact of these moments. Microanalysing these different stages in sequence will be important in the future studies.

Ansdell et al., (2010) also raise an important question about the duration of the special present moment. They claim that the musical present moment lasts for about 8-35 seconds, whereas Stern suggests that a present moment usually lasts for about 3-4 seconds. The duration of moments in the study reported here had an average duration of 28.8 seconds. Ansdell et al. (2010) tentatively suggest that musical present moments may last much longer than Stern's (2004) present moments. Therefore, further research on comparing characteristics of Stern's present moments and musical present moments will be useful in the future. Moreover, key theories and concepts such as present moment, forms of vitality, and implicit/explicit knowledge by Stern (2004, 2010) were found to be significant over the course of the entire study. Accordingly, applying his theoretical perspective of present moment is recommended for future studies in exploring different types of moments in music therapy.

The application of Interpretive Phenomenological Analysis to video data and the development of IPVA is a final outcome from the study reported here. The efficacy of using IPA in microanalysis of music has been demonstrated previously (Ansdell et al., 2010; Solli, 2014), however, no study has applied IPA to video data before. Therefore, the current study suggests a new way of analysing video data and also strengthens the value of IPA in microanalysis of musical present moments for the future studies.

In conclusion, the results and findings of the current study provide a solid rationale for appropriating the non-verbal and affective medium of music to promote meaningful moments with adults who have profound intellectual disabilities. Music therapists appear to create appropriate and useful conditions for discovering and developing the social capacity of adults with PIMD. Although the clients in this study took a long time to share a meaningful moment with their music therapists, the descriptions showed that they did socially and emotionally relate with the therapists

and shared meaningful moments using their non-verbal responses when appropriate environment and support was provided. Consequently, it may also imply that more adults with PIMD should be provided with these opportunities to discover their hidden social ability and have more meaningful moments in their lives.

Notes on contributors

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CHAPTER 7

META-DISCUSSION AND CONCLUSION

This chapter is divided into three parts. The first part provides a summary of the results and discusses the significant findings of the interview and video analyses. The second part evaluates the study design and methods used in the current study. Then, implications and limitations of the current study are identified, and recommendations for the future study are suggested. Finally, a conclusion for the study is provided at the end of this chapter.

Summary of the Results

The aim of the current study was to understand essence and meanings of the lived experiences of the music therapists who had been building interpersonal relationships with adults with PIMD. A qualitative naturalistic investigation was conducted. Single music therapy sessions of the five therapist-client pairs were video-recorded, and the music therapists were interviewed. Descriptive phenomenological analysis method was used to analyse the interview data, and Interpretative Phenomenological Analysis (IPA) was applied to video analysis, resulting in the development of a new video analysis method, “Interpretative Phenomenological Video Analysis (IPVA).” The following section summarises the results of the interview and video analyses, as recommended by Edwards (2012) to “provides outcomes of the analysis of the research in detail and *in summary* [emphasis added]” (p.390).

Results of the interview analysis.

Individual analyses were conducted, and five individual distilled essences were generated (Chapter Five). Group analyses across the music therapists' experiences resulted in nine collective themes, three global meaning units, and one final distilled essence. The summary of these group analyses is presented in two tables below. First, table 12 presents the collective themes that are common, significant, and individual described by five music therapists.

Table 12.

Collective Themes

Common Themes
1. The context in which music therapy happens impacts the quality of interpersonal relationship for all the music therapists. 2. All the music therapists are heartened by the clients' commitments in music therapy.
Significant Themes
1. Four participants believe that music therapists have unique roles in meeting the psychosocial needs of their clients. 2. Three music therapists experience emotional bonds and attachments with the clients. 3. Two music therapists consider the inter-subjective interactions meaningful in their relationships. 4. Two music therapists have struggled before developing confidence in the relationships. 5. Two music therapists believe that the degree of profound disability will always impact the quality of interpersonal relationship. 6. Two music therapists think that adults with PIMD are more capable than they appear.
Individual Theme
1. One music therapist wishes the interpersonal relationship with her client to keep growing further in the future.

Note. The number of music therapists shared each theme is articulated to show the transparency of the result.

Table 13 reports the three global meaning units.

Table 13.

Global Meaning Units

Global Meaning Unit 1
The conditions such as contexts and severity of disability exert significant influence on the quality of interpersonal relationships.
Global Meaning Unit 2
The process of building an interpersonal relationship requires mutual efforts over time.
Global Meaning Unit 3
Inter-subjective interpersonal relationships foster the psychosocial wellbeing for clients, and music therapists play a significant role in promoting these benefits.

The final distilled essence resulted in the group analysis of the interviews are presented below.

Final distilled essence.

For the five music therapists, the experience of interpersonal relationship with adult clients who have profound intellectual and multiple disabilities is a process that requires mutual efforts over time. The interpersonal relationships foster psychosocial wellbeing for the clients, and the music therapists play a significant role in promoting these benefits. Conditions such as context and the severity of disabilities also exert significant influence on the quality of interpersonal relationships.

Results of the video analysis.

From the individual analyses of video clips, five descriptions of meaningful moments were generated (Chapter Six). Further interpretative analyses across the five meaningful moments found that:

- the meaningful moments reflected the final distilled essence discovered from the interview analysis.
- the moments were co-created shared moments.
- three adults with PIMD were seen and perceived by the music therapists to experience moments of *joy and ecstasy*, and two adults with PIMD appeared to experience moments of *completion and accomplishment*.
- three music therapists experienced moments of *completion and accomplishment*, and two music therapists experienced moments of *surprise*.
- On interpersonal levels, three pairs experienced moments of *physical closeness*, and two pairs experienced moments of *musical intimacy*.

The results of the current study were written as three academic articles, and each article provides a discussion for each result. Accordingly, in the following section, I aim to provide a comprehensive meta³⁸-discussion integrating all the results of the articles. As the main findings of the current study are the tacit knowledge and insights of the five experienced music therapists on the processes and benefits of music therapy with adults with PIMD, these are discussed in the following section. Then, the second section discusses characteristics of the contemporary music therapy practice identified in the current study, by comparing them with the conventional practice as described in the previous studies.

³⁸ “Combining form” (Oxford University Press, 2010, 2012).

Discussion of the Results

Process and benefits of music therapy with adults with PIMD.

In the current study, the findings of the interview and video analyses enable me to reflect on the processes and outcomes of music therapy with adults with PIMD from multiple perspectives. The focus of the interview analysis was on the interpersonal relationship built in a long-term process of music therapy; whereas the focus of the video analysis was on the meaningful moment identified by the music therapist in a single session. As the interviews were concerned with experiences over several years, the findings reflect on a macro process, referring to a process over a long period. In contrast, the moments investigated in the video analysis were concerned with a few minutes, represents a micro process. Consequently, the outcomes of these two macro and micro processes were identified as improving the psychosocial well-being of the clients in a long term process and creating the moments of joy and ecstasy or completions and accomplishment in a single session. Table 14 summarises these different aspects of the processes found from the interview and video results.

Table 14.

Multiple Perspectives on Process and Benefits of Music Therapy with Adults with PIMD

	Interview analysis	Video analysis
Focus	Interpersonal relationship built in a long-term process	A meaningful moment occurred in a single session
Scope	Reflection of the past moments	Awareness of the present moment
Perception in time	Macro ³⁹ process	Micro ⁴⁰ process
Benefit	Psychosocial well-being based on meaningful relationships	Moments of joy and ecstasy & completion and accomplishment

Looking at the two processes from multiple perspectives deepens our understanding of the interpersonal relationships with the five adults with PIMD in this study as a whole. Moreover, the relationship between the micro and macro processes provides significant insights as the little micro processes form the macro process in a long term. Accordingly, in this perspective, it might be appropriate to claim that experiencing the moments of joy and ecstasy; completion and accomplishment in music therapy contributes to the clients' psychosocial wellbeing in a long term and vice versa.

Although the comparison from two perspectives appears that the two processes have only differences, in fact, the processes seem to have similarities as well. For example, the macro and micro processes of music therapy with adults with PIMD are a gradual journey that takes different stages. The following section discusses it in detail.

³⁹ Macro has meanings such as *large; large-scale; long; over a long period* (Oxford University Press, 2010, 2012).

⁴⁰ Micro has meanings such as *extremely small; small-scale* (Oxford University Press, 2010, 2012).

The gradual journey.

From the analysis of the interviews, four stages of the macro process were discovered. Similarly, the micro process of meaningful moments could be also explained as having three stages as suggested by Ansdell et al. (2010), who analysed a present moment in music therapy. As most music therapists working with adults with PIMD find the progress of clinical work confusing and challenging due to its gradual process over several years, understanding both micro and macro processes might help them to find confidence in their work. Because of the different scope in time, a direct comparison of these two approaches might not be possible, however, the graduating elements of the progress seems like a common characteristic when communicating with adults with PIMD. Table 15 shows the macro and micro processes.

Table 15.

Macro and Micro Processes

Macro-process	Micro-process
Stage 1: Struggling to understand each other at the initial stage	Stage 1: moving along without event ⁴¹
Stage 2: Getting to know each other more, then realizing that the clients are more capable than they appear	
Stage 3: Recognizing the clients' commitments and feeling heartened	Stage 2: reaching a sudden crisis (or Kairos) point defined as a "special present moment" or now moment
Stage 4: Getting pleasure from the relationship and wishing to grow the relationship further	Stage 3: finds resolution in a moment of meeting between the pair

Overall, as the adult clients with PIMD take a long time to understand, process, and respond to any communication attempt, both macro and micro processes

⁴¹ In this context, "without event" means there is no special affective moment.

take much longer than typical communication processes between verbal adults. In fact, the macro processes progressed over several years and the micro processes in single sessions took about a minute or more, which is much longer than typical processes between verbal adults without disabilities. For example, typical infants take about one and a half years to establish interpersonal relationships with their mothers. Similarly, Stern (2004) argues that a typical present moment between verbal adults lasts only three to four seconds. Therefore, communication partners who interact with people with PIMD need to be patient, understanding these gradual processes both in micro and macro perspectives.

Moreover, these two processes show close relevance to Stern's theories on the interpersonal world of infants (1985) and present moments (2004). The theory of the four senses of self in infants' developments (Stern, 1985) seems highly relevant to the process of macro music therapy process:

Stage 1: The sense of an emergent self

Stage 2: The sense of a core self: I. self versus other

Stage 3: The sense of a core self: II self with other

Stage 4: The sense of a subjective self: intersubjectivity

In particular, the last stage, the sense of a subjective self, is where a client develops the psychosocial ability of intersubjectivity with others. This seems like the most important stage where a meaningful relationship is formed. From a transactional perspective, Stige (2002) values this theory and explains it as a process of *enculturation* where both therapist and client are adjusting and changing, or learning in relationship.

Notably, recent studies with children with SIMD focused on the facilitation of social and relational skills of the clients and developed specific programs and evaluation tools based on Stern's theory (Gilboa & Roginsky, 2010; Raglio et al., 2011; Schumacher & Calvet, 2007). Consequently, given that most adults with PIMD have a psychosocial ability between primary and secondary intersubjectivity developmental levels (of two to nine month infant), understanding these therapeutic processes based on mother-infant interaction studies continues to be crucial in understanding the process and outcome of the intersubjective interactions and relationships in music therapy.

Similarly, the three stages of the interaction process, identified from the video analysis, are congruent with Stern's (2004) theory of *shared feeling voyage* as found by Ansdell et al. (2010). By conducting microanalysis of present moments of four minutes in music therapy, Ansdell et al. (2010) found that:

These episodes, which Stern also calls shared feeling voyages, and which take place in spans of at most one minute, are seen as where the vital work of therapy happens, as they often enable the creative emergence of an enhanced intersubjective field between therapist and client. In short, they change the relationship, and this helps the client to change his or her state or thought (p. 7).

In this perspective, the current study suggests that the macro music therapy process is in fact gradually progressed by many micro-processes that have various meanings. One of the music therapists, Steve claims, "*meaningful moments are those familiar moments in every session. Significant moment is when something new, unexpected, and pivotal happens.*" In short, most familiar moments with adults with PIMD are meaningful in themselves, because having meaningful interactions with adults with PIMD is generally believed to be rare. By practicing and experiencing these familiar and meaningful moments, the clients seem to develop a sense of self⁴². Then, when the client displays new or different behaviours, a significant moment happens. This seems to facilitate a movement for the pair to the next stage of their interpersonal relationship. Accordingly, it further suggests music therapists' be mindful of the present moment, "since actual sessions proceed and continue by these experiences" (Ikuno, 2013).

As a way of analysing the micro-momentary process, the current study stresses the value of thick and rich descriptions, suggesting a new innovative video microanalysis method, IPVA. The value of microanalysis is supported by many

⁴² Graham (2004, p. 27) explains this process such as: "as infants begin to experience themselves within the context of an interactive relationship with their parents, it appeared as though they were beginning to see themselves as emotional and communicating beings".

music therapists who believe in the power of present small moments that facilitate therapeutic changes and development (Wigram & Wosch, 2007). They often conduct microanalysis of text, audio, and video data, however video data is considered the most powerful tool among them.

Consequently, to understand the music therapy process with adults with PIMD, understanding both macro and micro processes and the relationship between them are important. In addition, understanding the various types of moments such as *challenging, meaningful, significant, pivotal, familiar, unfamiliar, and spiritual* in everyday sessions in music therapy, seems crucial in deepening our understanding of the therapeutic progress fully and holistically.

The emotional journey.

In this study, the macro and micro processes were an emotional journey for both the clients and the music therapists. Two music therapists described their experiences in the initial stages such as *confused, feeling lost, getting no response, challenging, hit and miss, very difficult, unfamiliar, and not having a lot to work with*. These descriptions are similar to the descriptions provided by the music therapists in the previous studies. Feelings of *fear and despair* (Agrotou, 1994); *sadness and distress* (Graham, 2004); *absence and rejection* (Watson, 2007) were described. Accordingly, it is plausible to claim that these described emotions are common and natural experiences regardless of time and context. Whether in institutional settings or community-based settings, the music therapists seem to experience similar feelings at the initial stages. Accordingly, this information is valuable for any novice music therapist who is beginning to work with this group of people in the future.

Furthermore, the experiences of five music therapists working with children with coma seem closely related to the music therapists interviewed in this study. Using descriptive phenomenological analysis method, Beth Dun (1999) found 13 common themes. Among them, three themes describing the emotional experiences are similar to the music therapists working with adults with PIMD:

- (a) the music therapists have doubts about the child's responsiveness;
- (b) feelings of inadequacy may be experienced by the music therapist;

(c) music therapists may experience joy and gratification in working with children in coma.

Because of these emotional challenges, the other theme, “debriefing and supervision are important to the music therapists” seems very important and also has implications for the music therapists working with adults with PIMD.

On the other hand, while describing the macro process of building interpersonal relationships, some music therapists expressed their emotional bond and attachment to their clients. Interestingly, at the same time, they did not want to overtly stress this fact because they believe that feeling the attachment and bond is not professional. However, recently, in the field of disability, some researchers claim that having attachment and emotional bonds to the clients is an indicator of good interpersonal relationships (Schuengel, Kef, Damen, & Worm, 2010) and good quality of services (Reinders, 2010). For example, Reinders (2010) claims that “a high quality relationship between professionals and their clients is crucial for quality of care. This relationship generates the positive interaction that enables professionals to gain adequate insight in the needs of their clients” (p.28). Therefore, these recent findings encourage music therapists to value and feel comfortable with their emotional bond and attachments with clients with PIMD.

Another important emotion to contemplate in the work with adults with PIMD is feeling pleasure and joy. After experiencing the difficult emotions in the early stages of relationships, all the music therapists reported that they experience feelings of joy and happiness. They were heartened by the clients’ progresses and commitments, and they experienced confidence in their relationships. Wheeler (1999a) reported similar phenomenon of “experiencing pleasure in working with severely disabled children” and analysed the characteristics of this pleasure by closely examining exciting spots in video recorded sessions. Wheeler highlighted the concept of intersubjectivity and concluding that the feelings experienced by the music therapist could be a reflection on the client’s feelings. Remarkably, experiencing these positive emotions after negative emotions seems to amplify the positive feelings and lead to psychosocial well-being in long term music therapy.

Phenomenological statements, like philosophical statements, state the obvious and the necessary. They tell us what we already know. They are not new information, but even if not new, they can still be important in illuminating, because we often are very confused about just such trivialities and necessities (Sokolowski, 2000, pp. 57 as cited in Starks & Trinidad, 2007).

As the current study was informed by phenomenology, the above quotation provides a critical insight in understanding the findings of the study. It is obvious that some results are somewhat *not new information* as Sokolowski states. The lived experiences of building interpersonal relationships with adults with PIMD seem similar with the descriptions from the previous studies. The benefits of these interpersonal relationships and meaningful moments in music therapy on adults with PIMD are similar to the benefits of the previous studies and somehow anticipated.

However, as it is stressed in the above quotation, through the current study, we now see the process from multiple perspectives and we are able to articulate the relationships between the macro and micro levels of experiences and the impacts on the clients. Furthermore, the findings of the current study show some differences from the conventional practices described in the previous studies. For example, music therapy settings, music therapy methods, and interaction styles described by the music therapists in the current study were generally different from the conventional music therapy. The next section discusses the characteristics of contemporary practice with adults with PIMD by comparing them with conventional practice. By doing so, the current study further *illuminates the trivialities and necessities* of the contemporary practice.

New knowledge on the contemporary practice.

The findings of the current study show how five Australian music therapists worked with their adult clients with PIMD in 2013 in Australia. In comparison, I have chosen six studies that provided detailed information on music therapy processes and benefits with adults with SIMD and PIMD. Three case studies (Agrotou, 1994; Ritchie, 1993; Watson, 2007) and three qualitative research studies (Agrotou, 1998; Graham, 2004; Watson, 2007) are highly relevant to this comparison. The differences between the conventional⁴³ and contemporary⁴⁴ practices are found in five aspects:

- 1) characteristics of the clients
- 2) therapy settings
- 3) theoretical approaches
- 4) music therapy methods
- 5) music therapists' interaction strategies

Table 16 summaries the differences across these five aspects.

⁴³ "In accordance with what is generally done or believed" (Oxford University Press, 2010, 2012).

⁴⁴ "Occurring at the same time" (Oxford University Press, 2010, 2012).

Table 16.

Comparison of the Conventional and Contemporary Practices

	Conventional practice	Contemporary practice
Characteristics of the clients	Passive	Active
Therapy settings	Institutions	Home & community based settings
Theoretical approaches	Psychodynamic	Humanistic
Music therapy methods	Improvisation	Musicking ⁴⁵ /various song based activities
Therapists' interaction strategies	Parallel interaction	Intensive interaction

Characteristics of the clients: Active and committed clients.

One of the most impressive findings of the current study is the discovery of the clients' passion and commitment to music therapy, which is contrasting to the participation of adults with PIMD in the past. Previously, the characteristics of institutionalised adults with SIMD and PIMD have been extreme in nature (Agrotou, 1994; Ritchie, 1993). In institutionalized settings, the adults were deprived of human interactions and lived in extreme isolation. Most adult clients with PIMD showed extreme passivity, fear, and a condition of learned helplessness in meeting and interacting with people, as well as displaying autistic behaviours. (Agrotou, 1994, 1998). Similarly, most adult clients with SIMD in these environments displayed self-

⁴⁵ Stige and Aarø (2012, p. 29) acknowledge that this term "Musicking" was first introduced by Small (1998) and different from the other term "Musicing" used by Elliott (1995). Musicking refers to "music-making as the performance of relationships in a social situation" (Stige & Aarø, 2012, p. 29)

harming/challenging behaviours (Graham, 2004; Ritchie, 1993; Warner, 2005). Whereas, in the current study, the music therapists articulated the clients' dedications, commitments, and achievements in music therapy, and this also was observed and documented in single music therapy sessions in the video clips.

It is possible that the active participation of the clients reflects the fact that Australian music therapists are now working with a new generation of young clients who have been living in better environments than past generations. In the current study, Nelson was the only one who was living in an institution for over forty years. When he was born in 1967, placement in an institution was typical for most children with disabilities in Australia and many other countries, in particular, those who were severely and profoundly disabled. Accordingly, Nelson was institutionalized when he was four years old and has lived there since. His life has been similar to those clients who were described in previous music therapy literature (Agrotou, 1994, 1998; Ritchie, 1993).

In contrast, all the other clients, Eva, Amy, Lyn, Mia, and Mark were born in 1990, 1993, 1983, 1984, 1991, and were aged in their early 20's at the time of data collection. They had been living with their parents, attending special schools, and were still living with their parents and siblings in their family homes. During my visit to their houses, I observed how their mothers provide care and love to their adult children as most typical mothers do. Consequently, this suggests that contemporary music therapists now work with clients who are more ready and eager for building meaningful interactions and relationships in music therapy and furthermore, this seems to impact on the overall process of music therapy as well as theoretical approaches and music therapy methods appropriate for them.

Therapy settings: Emergent of home settings.

In the current study, the results of both interview and video analyses show the emergence of new therapy settings including clients' homes based in the community. Frances and Darren were working at the clients' homes; Erica was working at her music therapy studio that was part of her home; and Steve was working at an adult daycare centre. Owen was the only music therapist working at an institution. An interesting thing to note here is that most studies reported in the 1990s were

conducted in institutions (Agrotou, 1994, 1998) and the studies conducted in the 2000s reported music therapy work in adult daycare centres (Watson, 2007) or adult group homes (Graham, 2004; Warner, 2005). This indicates that the deinstitutionalization process has already been completed in some countries such as the UK. As a result, some clients who are similar to, or slightly younger than Nelson now spend their days in daycare centres and go back to their group homes. Studies reported after 2010, including the study by Lee and McFerran (2012) and the current study show some younger generations who spend their daytime at the daycare centre and then return to their family homes. In some cases, the young adults with disabilities have professional services during the day at their home. This indicates that contemporary music therapists are now working in a variety of settings in community.

As the experiences of music therapists working in clients' private homes has never have been reported previously in music therapy literature, this finding makes the current study the first study exploring this new phenomenon. The music therapy work by Darren, Frances, and Erica reflected the home-based practice in the interviews and video clips. The characteristics of the home setting is that the music therapists are working closely with the parents and family members in their homes, and they all reported positive feelings about going to the clients' homes and also building personal and close relationships with the parents and support workers of the clients. Although music therapists working in community based settings in Melbourne all expressed their happiness working in these environment, the satisfaction of music therapists in private home environments appear greater than any other settings. This was in contrast to Owen's experience working in an institution. Owen strongly expressed negative thoughts and feelings towards the institutional setting and towards the nursing staff who did not understand the value of human interaction and socialisation for adults with various disabilities.

Theoretical approaches: The humanistic approaches.

Although the five music therapists were not asked to explain their theoretical approaches to the work, their belief and general approaches to working with clients with PIMD were described in the interviews. Erica stated,

“I always try to assume that the person, especially someone like Mark who’s got cerebral palsy, has got the ability too. I try to remember that how that person presents isn’t potentially what they’re fully capable of for whatever reason.”

This statement shows how a music therapist with a humanistic theoretical approach conceives of “unconditional positive regard for the client, where the therapist respects and accepts from the client whatever they wish to explore” (Choi, 2008, p. 95). Most music therapists in the interviews express similar beliefs towards their clients in the current study.

On the other hand, in the previous studies, most British music therapists adopted psychodynamic orientations. McFerran (2010) explains that “psychodynamic therapists maintain a calm stance in order to provide a blank slate for the client to project upon” (p. 53). Choi (2008) explains further:

the aim of classical psychoanalysis was and is for the patient to ‘discover’ himself or herself. Therapy presumably consists largely of bringing unconscious material to consciousness. One way in which unconscious material is brought to consciousness is through the patient's relationship with the therapist through musical experiences (p.95).

McFerran (2010) and Choi (2008) consider this difference between music therapists on their theoretical approaches is generally decided on the institution in which they were trained. McFerran (2010) explains:

Training has an impact on the beliefs that we develop about how music therapy works. So does our prior education, our familial beliefs and our experiences, all of which occur within a cultural context. In fact, it is simplistic, but possible, to make an educated guess about what orientation a music therapist is most likely informed by based on the nation he or she trained in. But of course, there are many exceptions to these kinds of broad cultural generalizations (pp.55-56).

She goes on to explain that her humanistic approach is originated from her training “under Denise Grocke at the University of Melbourne during the early 1990s, who previously trained under Professor Bob Unkefer at Michigan State University in the late 1960s and whom she describes as humanistic in orientation” (p.55). Accordingly, this can explain how this humanistic approach has influenced the music therapists trained in the University of Melbourne as seen in the current study.

With regard to the impact of these different approaches, Choi (2008) conducted an interesting survey study that investigated the theoretical orientations of American music therapists and concluded that:

Having various theoretical orientations showed no significant difference in perceived image of their value, importance, amount of use of music, satisfaction from work, previous education, and desire to expand theoretical approaches. The results suggest that comparing the value or levels of particular approaches may be less important than effectively expanding theories applicable for a therapist’ clinical setting, creating suitable models, and developing a variety of techniques (p. 108).

As Choi critically argues, the differences between the music therapists in the current study was apparent in their interaction techniques and music therapy methods, rather than in the theoretical orientations. Although Owen was trained in a university in Sydney where Creative Music Therapy was important, his theoretical approach or attitude was not apparently different from other music therapists in Melbourne. Rather his music therapy methods, based on improvisations were the big difference between Owen and Melbourne music therapists. Interestingly Frances was trained in Sydney, however she was trained in a university that is different from Owen’s and upon completing her training, Frances started practicing music therapy in Melbourne. Therefore her theoretical approach and music therapy method were similar to those in Melbourne. Consequently, comparing the music therapy methods and interaction styles might be more important.

Music therapy methods: Musicking based on various songs.

Another interesting finding of the current study is that the music therapists who worked in community based settings in Melbourne were utilising various musicking methods that are based on clients' preferred songs and choice-making interventions. As mentioned previously, Owen was the only music therapist who mainly used an improvisational method. Table 17 summarises how each music therapist facilitated various methods.

Table 17.

Music Therapy Methods used

Pair	Music therapy method	Music therapist's contribution	Client's contribution
Steve & Eva	Song-sharing	Song-singing with a guitar accompaniment	Vocalisation
Erica & Mark	Song-sharing	Song-singing with a piano accompaniment	Vocalisation
Owen & Nelson	Improvisation	Improvisation on a guitar	Vocalisation/ Instrument playing
Frances & Amy	Choice-making	Speech/Use of two song-cards	Use of eye-gaze
Darren & Mia	Choice-making	Speech/Use of two instruments	Use of eye-gaze

Two music therapists used the clients' familiar and preferred songs for musical interactions. Steve sang Eva's preferred song, "Mamma Mia" (Andersson et al., 1973) by Abba, and Erica sang Mark's old-time favourite, "Daniel" (John & Taupin, 1973) by Elton John. The clients responded with active vocalisations.

Another two music therapists offered their clients choice-making opportunities, using their preferred songs or musical instruments. Frances provided Amy two song-cards including one of her favourite songs and encouraged her to choose a song using her eyes. Darren offered Mia two wrist bells including her favourite metal bell and facilitated Mia to use her eye-gaze to choose her choice. The use of choice-making intervention was also reported by Lee and McFerran (2012) who worked in an adult day-care centre in Melbourne.

On the other hand, Owen sang hello song and then improvised on his guitar. Although Owen based his improvisation in a jazz style and played a famous song, “From little things, big things grow” (Carmody & Kelly, 1991) at one time, mainly he was improvising according to Nelson’s mood, behaviour, and atmosphere. Like Owen, in conventional practices, music therapists often explained their music therapy methods as improvisation. For example, Agrotou (2000) produced a DVD using the video footage recorded for her doctoral study, and the improvisational method she used for group sessions was clearly seen. Agrotou improvised on a piano to provide musical space for the clients to join in and reflect on their moods and behaviours. The clients were provided with various instruments to freely participate when they are ready. Similarly, Watson (2007) explains how she would position the clients in a circle and place various musical instruments in the middle. Her role is providing safe musical container for the clients to join in at their own time. Graham (2004) also describes how she imitates the vocal sounds of the clients to understand their emotions and help them to express and communicate them with her.

MacDonald (2013) identifies this difference between the music therapists in conventional and contemporary practice and explains it such as:

a psychodynamic dynamic music therapist will practice in very different ways from a community-based music therapist. There are now different models of health musicing and these different models all have different types of interventions associated with them (p.11).

Evidently, this new tendency using various musical activities and clients’ preferred songs has been also reported by music therapists working in community-based settings in UK, Ireland, and Canada. Jeff Hooper (2001, 2002) in UK reported using various music activities such as singing along and passing musical instruments to

each other, while he was providing live singing for two clients with severe learning disabilities. Hooper explains that these activities are appropriate because some clients are not able to “develop the musical content through improvisation”. In Ireland, applying humanistic approach and Person Centered Plan (PCP), Jason Noone (2008) described how he utilizes various music therapy methods. For group sessions, he uses singing and discussion of songs to develop the clients’ identities and relationships with each other. For individual sessions, he utilizes the following activities:

- Lyric analysis
- Song-writing and performance
- Instrument playing
- Music instruction
- Musicians in the community
- Music technology (making CD/in-house radio station)
- A Christmas concert

Particularly, using technology is a new method in contemporary music therapy practice. In the current study, a female client, Lyn was using an I-Pad to participate in musicking activity, producing various musical sounds.

Similarly, from Canada, Curtis and Mercado (2004) reported their community music therapy program for adults with various ranges of disabilities, and described how they facilitated Community-based Performing Ensembles for instrumental/vocal groups and American Sign Language (ASL) music interpretation groups. Importantly, Curtis and Mercado theoretically framed their approach in relation to community engagement. This approach is similar to the action research study conducted by McFerran (2008) in Australia that explored Community Music Therapy and Community Music for adults with various disabilities. McFerran’s basic approach to this study was also based on the belief that music can facilitate community engagement of adults with disabilities.

These examples again confirm that since many adults with disabilities now live in community-based-settings, music therapists are using more varied musical activities to support the different needs of individuals and groups. Furthermore, given that group music therapy sessions in adult daycare centres often include disability

support workers, these musical activities based on songs and musicking seem like a natural phenomenon to support and embrace everyone's needs in these community-based settings.

Therapists' interaction strategies: Intensive interactions.

During the interview, the music therapist, Owen from Sydney explained his interaction strategies as Parallel Interactions. As a music therapist who was trained and practiced in Melbourne, I had never heard of the term. Instead, I was recently taught that Intensive Interactions are the most appropriate ways to communicate with adults with PIMD. Therefore Owen's explanation of Parallel Interactions was interesting and important to pay attention in the interview. I asked him to explain it further, and he provided me a long, detailed description:

"It's a term I actually got from the speech pathologist that I work with here. So I'm not sure whether its speech term. And he actually used Parallel Play. [...] Whereas other people who aren't perhaps that capable physically or they might not have the level of initiative, they might just totally ignore me, then I will pick up the guitar they like or trombone they like and all of a sudden, they're fully alert and into it, responding whether it be with facial expressions, vocalizations, or body movements, and sometimes actually playing instruments depending... [...] For example, with Nelson I will never come in and grab his hand and start to burst the drum. I will always lay it in front of him and there's usual, I use to bring drums, tambourines and sorts of things, now I just bring a tambourine that has a skin on it. And there is a maraca and there is a drumstick with a large grip so they help him hold it. And I lay them on his lap or on the table if he has a table and um...he will get them when he's ready."

The interaction styles of parallel play seem to be closely related to his general approach as a psychodynamic music therapist.

In contrast, Intensive Interaction is "an approach to teaching the fundamentals of communication to children and adults who have severe learning difficulties or

autism, and who are still at an early stage of communication development” (Hewett, 2012). Similarly, but from the perspective of a music therapist, McFerran (2008) explains it such as:

Intensive Interaction is a way of communicating individually with people who have a severe disability that utilises similar strategies to those found in traditional music therapy practice – close listening, and interpreting and valuing of non-verbal communication attempts that are responded to in a mother-infant interaction style using mirroring and extending (p.40).

Similar to Owen’s case, the Intensive Interaction styles seemed to be used by the humanistic music therapists as their approach. This is explained as facilitating active interactions and “go with it” (McFerran, 2010, p. 53). Whereas the psychodynamic music therapist like Owen utilises the principals of Parallel Play as their approach are described as “stay calm” and provide “a plate for a client to project on” (McFerran, 2010, p. 53). Again like theoretical approaches, these two contrasting approaches do not seem to yield different outcomes in the long term, but understanding clients’ preferred interaction styles and using appropriate styles seems important.

Reflection on the discussion.

By comparing the major findings of the current study with conventional practices identified in the previous studies, it is apparent that the disability paradigm shifts, from a medical model to social model, and the following disability policies such as deinstitutionalization have had a huge impact on contemporary music therapy practice. As society keeps changing, our practice is also changing. In order to improve our practice accordingly and to be proactive in the future, we need to have more active roles in the community and society where we belong. In this context, the role of music therapists working in community-based-settings seems to be getting larger. In conventional music therapy, the therapists only focused on the clients in clinical settings. Now it is apparent that contemporary music therapists naturally work with clients in context, which is the basis of Community Music Therapy. Accordingly, it seems inevitable that principals and key concepts of Community

Music Therapy will influence our thoughts and practice in the future. One of the early definitions of Community Music Therapy was provided by Bruscia (1998) such as:

In Community Music Therapy, the therapist works with clients in traditional individual or group music therapy settings, while also working with the community. The purpose is twofold: to prepare the client to participate in community functions and become a valued member of the community; and to prepare the community to accept and embrace the clients by helping its members understand and interact with the clients (p. 237).

Stige and Aarø (2012) point out that this definition is “less extended than several of the definitions of Community Music Therapy that have been developed after 2000 (p.15)”. Then they suggest the definition of Community Music therapy at three levels:

Community Music Therapy as an area of professional practice is situated health musicking in a community, as a planned process of collaboration between client and therapist with a specific focus upon promotion of sociocultural and communal change through a participatory approach where music as ecology of performed relationships is used in non-clinical and inclusive settings.

Community Music Therapy as emerging sub-discipline is the study and learning of relationships between music and health as these develop through interactions between people and the communities they belong to.

Community Music Therapy as emerging professional specialty is a community of scholar-practitioners with a training and competence qualifying them for taking an active musical and social role in a community, with specific focus upon the promotion of justice, equitable distribution of resources, and inclusive conditions for health-promoting sociocultural participation (Stige, 2003, pp. 454 as cited in Stige & Aarø, 2012).

Bruscia's definition seems to reflect on the current situation of music therapy with adults with PIMD, reported in the current study. In short, music therapists are still working traditionally, but focusing on the client in community-based-settings. This individual based approach seems crucial for adults with PIMD. However, at the same time, they also need to have an opportunity to be included and engaged in the community. McFerran (2008) calls it Musical Justice and explains it such as:

The unique strength of the music therapy program is this responsiveness, and it was particularly valued for those adults with the most profound disabilities, who flourished with the individualized attention, exceeding carers' expectations of participation. [...] therefore a useful entry point for musical access. [...] Further, the excitement and pleasure of community music making is also an important opportunity for those adults with severe disabilities in wheelchairs (p.9-10).

In this perspective, the definition by Stige (2003) seems to suggest the way we need to work in the future to actualize the true meaning of social inclusion, community engagement, and social justice for adults with PIMD.

Discussion of the Research Design

This section discusses the study design and research methods used in the current study. According to Stige, Malterud, and Midtgarden (2009), providing self-critique on engagement, processing is important in reporting qualitative studies. Major issues are discussed as in the order they were presented in Chapter Three.

The study design and application of phenomenology.

Kenny asserted “one’s philosophical stance or burning question should precede the actual research method” (Kenny, 1989 as cited in Forinash & Grocke, 2005). By taking a phenomenological philosophical stance, I was able to approach and explore the phenomenon of interpersonal relationship and meaningful moment, which are abstract and symbolic in concept. The philosophical stance further guided me to utilise appropriate methods to explore the topic while valuing the music therapists’ lived experiences and their voices. Therefore, following the principles of phenomenological philosophy was the most appropriate choice in this study.

Furthermore, although I was not aware of an approach called Pluralistic Qualitative Research (PQR) while designing and conducting the study, it is plausible to claim that the current study employed a method of PQR. According to Frost and Nolas (2011), PQR is defined as “the employment of more than one qualitative approach to accessing meanings within the same piece of research” (p. 115). Frost (2011) explains that PQR researchers “seek to access as much meaning as possible from data” (p. 4), but depends on the research aim and questions, they use different ways such as Pragmatism, Bricolage, and Multiperspectival Analysis. For example, researchers using Pragmatism “are less concerned with the epistemological debates underlying method, and instead set out to use whichever techniques will answer or address the research question” (Frost, 2011, p. 5). Researchers using Bricolage seek an interdisciplinary approach “to avoid the limitations imposed by employing a single method” (Frost, 2011, p. 5). Multiperspectival analysis allows “the researcher to see the phenomenon in more dimensions than if they employed a single-method approach” (Frost, 2011, p. 6).

Particularly, in this study, Multiperspectival Analysis seemed to be used “to enhance dimensional insight and illuminate the complexity of the phenomenon under study” (Frost, 2011, p. 6). As a result, I was able to see the music therapy process in two levels: macro and micro, deepening my understanding. In the field of music therapy, Amir (1992) seems to have conducted a kind of PQR by using phenomenology as a philosophical guide and grounded theory as a methodological guide. However, combining two different phenomenological approaches has never been applied, and therefore this seems innovative in the field of music therapy as well as in the field of phenomenology.

In conducting both methods, the order of analysis played an important role. As the descriptive approach, which values the concept of Epoch, was conducted first, I was able to start data collection and interview analysis without being influenced by my biases and pre-assumptions. After completing both individual and group analysis of the interview data, I gained rich information and knowledge about each pair and the phenomenon of interpersonal relationships across the five pairs. At this stage, bracketing these valuable results again for video analysis was not considered effective at all. By following the IPA approach, I was able to use this newly gained knowledge as my fore-understandings. In this way, thick and rich descriptions were developed during the video analysis, and a new video analysis method inspired by IPA was developed. Consequently, I recommend anyone who may use both methods in one study to follow the same order used in the current study.

The recruitment process.

The purposeful sampling strategy (Patton, 2001) used in the current study was effective. In general, recruiting people, who have particular experiences, is believed to be challenging in conducting phenomenological interviews (Englander, 2012). However, because I purposefully recruited a group of music therapists from one organization, the recruitment process was conducted efficiently in this study. It could be conceived as a limitation of the study, however in the real world, it was the only place where a group of music therapists working with adults with PIMD gathered and finally two of the five pairs did come from different clinical places. Consequently, it was an appropriate and useful strategy.

Another possible factor for the successful recruitment was the fact that I knew the music therapists in person for various reasons. The rapport and trust that we had been building before conducting this study was essential and critical for producing knowledge on the personal and intimate therapeutic relationship. Some other music therapists, who were invited to this study, provided appropriate reasons of not being able to participate in the current study. For example, some were not working at the time or some people were busy because the data collection was conducted during the busy months of December and January in 2012. These were explicit reasons but perhaps, the fact that they did not know me in person could be seen as an implicit reason that they did not participate in the study. This highlights for me that the fact that the participation of the five music therapists in this study is invaluable.

In a similar way, the participation of the clients was also indispensable. Coincidentally, except for the withdrawn pair, all the clients' consents were provided by their mothers, and they willingly accepted the invitations of their children to participate in the study. I met three of them in person and they showed warm and welcoming attitudes to me. For example, when I visited Lyn's home for data collection, Mia and Lyn's mothers welcomed me and provided me with useful information. Mark's mother stayed in the studio during the video recorded music therapy session and later participated in the session. Erica later said that the mother was excited for Mark to participate in this research study. I met Eva's mother after recording the session as she was attending the Christmas Party of the daycare centre. She was happy about Eva's participation in music therapy and willing to share that with me. I could not meet other two mothers because Amy's mother was working when I visited Amy to record the session. Nelson's mother visited him in other day. However, like other mothers, these two mothers positively responded to me and provided their consent without hesitation. The mothers' trust and positive relationships with the music therapists, which were built over several years, seemed positively influenced the recruitment process in this study.

On the other hand, unfortunately, there was one withdrawn pair. The music therapist was recruited from the community music therapy organisation. Recruiting the client, who was living in a small group home, had several problems. First, the client was over 70 years old, which did not meet the inclusion criteria. Second, because her parents were all deceased, she had a legal guardian, who was her niece

living in another state in Australia. The house manager of this client became a *gatekeeper*⁴⁶ in this case, and she did not allow me to contact the legal guardian.

With very much patience and waiting, the very first session of this pair was finally recorded, however, the music therapist reported that it did not reflect their typical session. Therefore, I planned to record another session. Then the house manager cancelled the sessions in consecutive three weeks because the client was unwell. The manager did not give any notice to the music therapist and me, so we went there but could not conduct the session. When I had a second opportunity, the staff took a long time to get the client ready for the session. As a result, the music therapist only had 20 minutes of the session and that was not satisfying for her. Therefore, another session was arranged for the pair. I visited them several times more but the client was actually very sick and slept whenever the music therapist and I were visiting her. In the end, the pair had to withdraw from the current study.

Although the client was actually ill and was not able to actively participate in the session, I felt that the house manager might have not been happy for the client to participate in the current study. Accordingly, identifying any concerning issues of the house managers in group home settings regarding being involved in a research project will be helpful when conducting a real-world research in the community settings in the future. It is also closely related to ethical considerations of the research with the people with intellectual disabilities, therefore more study on this issue seems necessary in the future.

The data collection.

The data collection involved two stages. First, I visited five different places, where each pair was practicing their music therapy sessions, to record a single music therapy session. Then within a week or two, I conducted phenomenological interviews with each music therapist. Video recording of the single music therapy sessions first and

⁴⁶ “The person who controls research access. For example, the top manager or senior executive in an organization, or the person within a group or community who makes the final decision as to whether to allow the researcher access to undertake the research” (Saunders, 2006).

watching them with the music therapists at the end of the interviews was time-efficient. As a result, collecting the five sets of video footage and interviews took only two months. Discussion on the methods of data collection follows.

Video-recording of the sessions.

After participating in the session, Erica provided me feedback about the method of video collection:

“Regarding the video, I actually think that setting up the video and then the session runs without your presence would be the answer. I don’t know if that conflict with anything for you, but you could check that it wasn’t doctored or come set up leave and return after the session. In my place you could hear the session through the door if needed! Some of my concerns regarding the ‘authenticity’ of the session weren’t related all to your presence per se but also the mother’s involvement, which impacted on it. I think a few more sessions of recording would be a good idea too as we know that there are many variables with this population.”

Obviously, Erica raised critical issues on the data collection method. The first issue she solicited is that the video recording might have been conducted without my presence because it affected the pairs in the session. Three clients, who have good vision, kept looking at the camera and me when I was approaching to them to record closely. Similarly, because of their vision impairments, the other two clients could not look toward me but they also seemed aware of my presence and therefore did not actively participate in the session. For example, Mia struggled to clearly express her choice of metal bell over the wooden bell, and Mark did not vocalise as much as usual. Finally his mother sat close and encouraged him to vocalize towards the end of the session. Therefore, this issue is reasonably raised and needs to be seriously considered in the future research in similar situations.

The second issue Erica raised with the video recording is related to the fact that only a single session was video recorded. This decision was made because the aim of recording a single session was to identify one single meaningful moment of a

session and to analyse the moment on a micro-momentary level. To fulfil this aim, recording one typical session seemed useful and effective, which resulted in rich descriptions of the five meaningful moments. Another reason, which was more practical, was that I had to visit all the different places across Australia. I flew to Sydney, and even within Melbourne, I had to visit various places. Recording several sessions in these five different locations was considered neither practical nor efficient. It was clearly explained to the music therapists that if they thought the recorded single session did not reflect the typical session then one more session could be recorded. Actually the withdrawn pair had few more chances to record their sessions according to this rule. Nevertheless, the methods of video recording of music therapy sessions in natural settings seems to need a more careful approach and improvement in the future, particularly, in relation to the impact of the researcher's presence.

Interviewing the music therapists.

Before conducting actual interviews with the music therapists, preparing an interview guide was helpful for me to understand specific approaches and questions that required in phenomenological interviews (Englander, 2012). Using the interview guide also facilitated consistent styles in the interviews. By doing this, credibility and transparency of the data collection process were maintained. In addition, the order of the questions was effective in facilitating the conversations. The music therapists started describing their general experiences as music therapists working with adults with PIMD and then the conversation moved onto their specific experiences with their clients. They then reflected upon a meaningful moment or session in their relationships and finally they looked at the video footage. The flow of the interview sessions was excellent as it naturally lead to the following subsequent questions. Therefore, a similar interview structure is recommended for future studies.

In contrast, an important issue was recognised after the interviews with regard to the questions about “meaningful moments,” which were asked twice during the interviews. The second question was appropriate and yielded powerful results in the video analysis. As this question was asking for a specific scene in the video recorded single session, music therapists appeared interested and enthusiastic for this process. However, the first question about identifying a meaningful moment over several years

did not seem effectively presented. It is because two female music therapists, Frances and Erica did not seem to expect this kind of question, and therefore became flustered. With regard to this issue, Englander (2012) suggests having a pre-meeting with participants, a week before the scheduled interview, to prevent their surprise. However, other phenomenologists disagree with revealing the interview questions. Therefore, researchers who ask this type of phenomenological question in the future studies need to contemplate this issue before conducting interviews.

Note-taking.

During the interviews, I tried to take notes, however it was often ineffective because I preferred to look at the interviewees, to listen carefully and also observe their body gestures and facial expressions. At times, I felt some key words or significant phrases were important and asked for further explanations or clarifications. Therefore, in these occasions, I took some notes and asked subsequent questions to the music therapists when they had finished their speech. Most music therapists provided in-depth and detailed information, and therefore my role was asking the pre-planned questions and then subsequent questions. Obviously, in this context, the phenomenological interviews required only several key questions that were well tailored and thought provoking.

Audio-recording of the interviews while watching the video footage.

In the last part of the interviews, while I was watching the video footage with the music therapists, I kept recording the interview conversations. Later while transcribing the interviews, I found that some of the sounds from the video footage were loud and that it was difficult to understand some conversations with the music therapists. Given that the conversations in the last part were equally important as the conversations exchanged during the first and second parts, using headphones or earphones to hear the sounds from the video footage might be helpful in the future. In this way, the interviewer and interviewee can listen to the video clips and engage in conversations at the same time. Taking clear notes on the scenes of the video footage discussed during the interviews will become important in this case.

The data analysis.

Transcribing and using a computer software.

Transcribing the five interviews took a lot of time for me as a sole novice researcher. All interviews lasted for about between 1:30 and 2 hours, and the average interview time was 82 minutes. In total, two months were spent to dictate them. Using the software Express Scribe (NCH Software, 2013) was helpful in the process, which was found and downloaded for free from an internet website. This software did not dictate the conversations, however it enabled me to save the audio files and play them in the computer program, controlling the speed of speech. All the five music therapists had their own speeds and unique styles of talking, therefore by slowing down the speed some words or phrases were easily understood. The software also has an empty space under the recordings where I can type each sentence. Rather than mechanically typing several interviews at the same time, I transcribed one interview at a time to become familiarized with each music therapist' experience. This was helpful for me in the actual analysis.

The interview analysis.

Although some guidelines are available, there is no one right way to analyse interview data. Phenomenological methods have many unique philosophical concepts to understand before applying them to actual analysis. Therefore, at the initial stage of analysis, I felt challenged. Although the phenomenological microanalysis (McFerran & Grocke, 2007) guided the interview analysis, some of the elements were not clear in understanding and implementing them. Therefore I read the important textbooks and articles written by key academics in the field of descriptive phenomenology. The introductory text books (Finlay, 2011; Giorgi, 2009a; Lewis & Staehler, 2010; Moustakas, 1994; Sokolowski, 2000) were useful and particularly Linda Finlay's recent textbook "Phenomenology for therapists" was important. The text book reviews and introduces various types of phenomenological approaches and methods.

As the title indicate, the main audience for the book is therapists, therefore most chapters were useful for me in understanding the basic and important concepts of phenomenology.

The second book that I found important was Clark Moustakas' (1994) book "Phenomenological Research Method". Moustakas uses easy and plain language thus it was easy for me to understand crucial concepts such as *epoch*, *noema-noesis*, *imaginative variation*, and *synthesis*. Moreover, the fact that he was a humanistic psychologist and therapist may have explained the reason why I found his book useful. The third academic, who I often learnt from was Amedeo Giorgi. His recent textbook, was useful, however it was not as simple or clear as Moustakas or Finlay. Giorgi has very strict rules for his version of the descriptive analyses method, which has been expressed in a series of his articles (Giorgi, 2006, 2008) and this seems to limit this method's application to various topics.

The video analysis.

Developing a distinct video analysis method informed by IPA (Smith et al., 2009) is another contribution of the current study to the fields of music therapy, intellectual disability, and phenomenology. Although this was not planned at the start of the research project, as the study design was explorative and flexible, I was able to notice that the meaningful moments required an interpretative approach. This new methodology was regarded a "methodological innovation" by the reviewers when I submitted a paper to an academic journal, Qualitative Research in Psychology. Two reviewers stated:

Reviewer 1: *"I review many IPA-based papers but this one is distinctive. It aims to develop or apply IPA to visual/video data as well as text, which constitutes an innovation. The paper is well written and engaging, displaying the authors' passion and commitment to the methodology. All steps in the process are outlined clearly, and the case study is interesting."*

Reviewer 2: *"IPVA is a new development or modification (IPA video microanalysis) in the field of video microanalyses in music therapy"*

research. The field of video microanalyses has to be enlarged. IPVA does it. Moreover, we had only 1,5 qualitative video microanalyses (Holck, parts of Ridder) so far. IPVA enlarges this subfield too. In a really comprehensive way IPVA investigates meanings and patient's 'own unique strategies', which is a special strength beside category systems in this field (Scholtz e.al., Plahl, Schumacher e.al.)."

In the field of music therapy, it can be used as an effective method in explicating the implicit non-verbal behaviours of clients who have developmental delays. It could be also used with clients with autistic spectrum disorders as well as verbal clients who have various clinical backgrounds and diagnoses. For example, as non-verbal communications are often exchanged during instrumental/vocal improvisations and music making, the bodily movements, facial expressions, and sounds could be described and the implicit meanings could be articulated and reflected in depth. The collection of these descriptions and interpretations over time could also show a progress of therapy. Furthermore, the founder of IPA, Jonathan Smith (2007) adopted relevant principals of hermeneutics to the interpretative phenomenological analysis and understanding these was crucial during the iterative and cyclic analytic processes. Although the concepts such as double hermeneutics and hermeneutic circles are philosophical in nature, these played a powerful role in actual analysis.

Credibility of the study.

The current study utilised three methods to ensure the credibility of the data. Using procedural systems of step-by-step methods in both interview and video analysis was effective in ensuring the transparency. Particularly, Keith (2014) who edited the academic journal: *Qualitative Inquiries in Music Therapy* Volume 9⁴⁷, comments on the transparency of the interview analysis of the current study, including the other study published together, in Editor's Introduction:

⁴⁷ The first article of the current study was published in this journal in July, 2014.

In addition to a welcome set of topics, these studies are characterized by particularly clear descriptions of the method, including the often complex steps involved in analyzing qualitative data. The authors are to be commended for this accomplishment, because communicating about the qualitative research process is rarely easy. I predict that readers will appreciate the transparency these authors have modeled, and that future researchers and students will reap concrete benefits.

Therefore, the transparency of the analysis process was validated in this way. The member-checking method was vital as well in this study. Using the participant music therapists as members was an efficient way to validate and verify the results of the interview analysis. As I used the descriptive empirical approach, the descriptions should have reflected their authentic experiences and the music therapists' validation and verification of the results were very effective. Lastly, consulting with peers and experts in the field of music therapy was crucial in both interview and video analysis. Most importantly, as a novice researcher, this process was critical for me to gain confidence in my skills on different types of phenomenological analysis.

Implications of the Findings

For music therapists.

“This is a valuable contribution to the literature on a topic that is hard to study, because of the challenges that typical verbal communication presents these individuals” (Keith, 2014). This reviewer’s comment on the interview study validates the usefulness and relevance of the current study to the field of music therapy. First, the findings of the current study provide a new body of knowledge and insight about contemporary practice in Australia for both inexperienced and experienced music therapists. The tacit knowledge on the macro and micro processes of music therapy is rich and in-depth and it will be a useful guide to inexperienced music therapists in the early stages of their practice. Moreover, the exploration of meaningful moments in this study reminds music therapists of the importance of microanalysis of present moments, which facilitate therapeutic changes and development in music therapy. The IPVA microanalysis method developed in the current study also suggests a new perspective and tool to describe and create meaning of these valuable moments in long-term music therapy.

Second, the current study provides music therapists an opportunity to reflect on past and current practice, and to contemplate a future direction of music therapy in community-based settings. As reported in the current study, a music therapist in Sydney was still working in an institutional setting. However it was planned to be closed near future. Therefore, more Australian music therapists in 21st century are working and will be working in new work environments including adult day-care centres, neighbourhood houses, and clients’ private homes or group homes. This study showed that these new work environments provide a better environment for clients to have music therapy than previous settings. However, we now face different questions:

- a) what is our role in the new community based settings?
- b) how can we control environmental impacts such as the types of settings and locations?
- c) how can we effectively work with staff and family members in community based and home settings?
- d) how can we move progressively from community-based music therapy to community music therapy?

Most of all, the biggest challenge we face is that the new environments have some negative impacts on music therapists' work conditions in general. Three music therapists, Frances, Steve, Darren, and I have been working in a not-for-profit organisation that supports people with disabilities over several years. Several issues caused dissatisfaction for music therapists over a long time, such as travelling issues and under payment. Community work requires extensive travelling, which is physically demanding, however the under payment does not seem to reflect this challenge of community work. This is a big issue in the field of music therapy for adults with disability at the moment and because of this, many music therapists have left the organisation. The negative impacts of this high turn over are experienced by clients after all. Personally, I was greatly saddened by the music therapists' situations while visiting their work environments. Although they were feeling pleasure and joy in the relationships with their clients and their carers, at the same time the real world problems bothered them. In fact, Steve left the organisation soon after participating in this study, and now works as a private practitioner. I believe in the powerful benefits of community work, however we have to find some solutions for these issues to provide better services in community based settings in the future.

For parents and professionals in the field of intellectual disabilities.

This study has implications for those who take care of adults with PIMD, such as parents, health professionals, disability support workers, and disability policy makers. First, the findings of the current study provide useful information and insight about music therapists' work and perspectives on working with adults with PIMD. For example, the types of meaningful moments identified may increase their understandings about the psychosocial benefits of music therapy, particularly in relation to one of the SSMR needs, *participation, interaction, and social roles* (Petty & Maes, 2007).

Second, the findings of the current study suggest a new way of describing and interpreting the intersubjective communications with children and adults with PIMD using rich visual descriptions. Furthermore, this may alter views and perspectives on the clients' abilities to meaningfully communicate with others using non-verbal and musical medium. Recently, in July 2014, the International Association of Scientific Studies of Intellectual and Development Disabilities (IASSIDD) organised their annual regional conference, titled "the 4th IASSIDD Europe Congress" in Vienna at the University of Vienna, followed by the 2013 Asia Pacific conference in Japan. The theme of the 2014 conference was "Pathways to Inclusion" and the Convention on the rights of persons with disability (CRPD) (United Nations, 2006) was the main focus of the congress. In this conference, I provided a demonstration session titled, "meaningful participation and inclusion of adults with PIMD in music therapy." The abstract of the paper follows:

Purpose: This video presentation session aims to demonstrate that music therapy fosters full, effective participation and inclusion of people with Profound Intellectual and Multiple Disabilities (PIMD). By showing meaningful interactions created between five pairs of music therapists and their clients with PIMD in natural music therapy sessions, it also aims to increase public awareness of music therapy as a beneficial therapeutic intervention that improves psychosocial wellbeing for people with PIMD.

Rationale: One of the general principles of *the UN Convention on the Rights of People with Disabilities (CRPD)* is "full and effective participation and

inclusion in society.” As people with PIMD have limited abilities and communication difficulties, only a few activities guarantee their full, effective participation and inclusion. Music therapists use a non-verbal medium of music to interact, communicate, and build interpersonal relationships and report the successful participations of people with PIMD in music therapy. Interpretative Phenomenological Analysis (IPA) was conducted to understand and interpret the five meaningful moments. Common characteristics and benefits of these moments will be discussed as well. Summary: This demonstration session is expected to inform and inspire and as a result promote the use of music therapy with people with PIMD in the future.

I showed them the video clips of meaningful moment explored in the current study. This presentation received great interest from the audience from diverse backgrounds. The academics and researchers from all around the world responded as follow:

- A journalist from Netherland: *“I would like to write about your study in my magazine. Would you please send an image of the pair singing Mamma Mia?”*
- A speech therapist from UK: *“Everyone in the conference should have seen the videos.”*
- Two Japanese professors in special education & medicine: *“We would like to learn music therapists’ skills.”*
- Researchers from Italy and Netherland: *“Do you conduct group sessions as well?”*

I believe that the messages from these attentions are clear that: first, experts in special education and intellectual disabilities are interested in learning music therapists’ professional skills and tacit knowledge in facilitating the meaningful participation of adults with PIMD. Second, our job in the future, as music therapy clinicians and researchers, is joining in the dialogue with these experts. I felt that they were ready to welcome us, and that we never tried hard enough to join in their conversations. Consequently, from an interdisciplinary and partnership perspective, I

believe that music therapists have roles to contribute in the field of intellectual disability, and this is the time we need to move on for the future.

Limitation of the Study

Several minor limitations are identified in the current study. First, following the nature of phenomenological investigations, I interviewed only five music therapists practicing in Australia. Although this small sample size allowed a deep and rich exploration of the phenomenon, the results should be understood in the Australian context. Furthermore, as it was clearly seen, the music therapists in Melbourne and Sydney showed some differences in their theoretical approaches and music therapy methods. Therefore, considering the impact of the unique context on each individual is crucial in appreciating this type of phenomenological study.

Second, several issues were raised with regard to the data collection of the video footage. As discussed previously, the video recording techniques might have been different and therefore produced a better quality of data. Presenting video footage of the meaningful moments in music therapy is a powerful way of demonstrating music therapy practice, as it was reflected in the responses of the conference audiences. Accordingly, a more sensible approach to video recording of natural sessions should be studied, and practical guides and suggestions for appropriate video recording techniques, particularly with adults with PIMD will be useful for the future studies. Perhaps, as the adults with PIMD do not move during the sessions, setting up a fixed camera might be a possible solution for the pairs not to be disrupted by the presence of researcher.

Recommendations for Music Therapy Clinicians

Recommendation 1:

Developing suggestions and guidelines for novice music therapists will help them to feel confident when working with the clients with PIMD in the future. In this study, it was apparent that the tacit knowledge and skills of the experienced music therapists are invaluable, and the music therapists described the work with adults with PIMD as rewarding and pleasing experiences after all. However, they have been silenced, as they were not asked before. I believe that the experienced music therapists should speak out to inform others that this invisible, painstaking yet valuable and rewarding work is beneficial for our clients, as well as ourselves. This may motivate more music therapists to continue working with the clients with PIMD. Furthermore, this information and insight may also motivate disability support workers and other health professionals to continue working with these clients with pride and hope for a joyful future.

Recommendation 2:

Increased communications and collaborations between music therapists and other health professionals, such as disability support workers or speech therapists will increase each other's understanding of the complimentary benefits of different practices leading to benefits for individual clients. It is apparent that music therapists are usually working independently and privately in individual or small group sessions. These types of settings are crucial for adults with PIMD, who required individualised attention and intervention in the early stages of music therapy. However, it seems that working in this way sometimes does not facilitate any opportunity for the music therapists to meet and communicate with other health professionals. This also prevents opportunities for the clients to enjoy group music-making and develop peer relationships. Beside, these work settings sometimes cause boredom and burnouts to some music therapists (Igari, 2004). Perhaps, after working individually for several years and when the music therapists think that the clients are ready for more socialization, joining a big group session with the music therapist as a pair may be a possible solution. In order to communicate with other health professionals, conducting group sessions in collaboration with disability support workers and other health professionals might be effective. In this way, music therapists and the clients

can demonstrate their meaningful interactions, and often other staff can understand how music therapists work with different individuals in different ways.

Recommendations for Music Therapy Researchers

Recommendation 1:

Interviewing music therapists who are practicing in different countries or cultures may deepen our understanding of music therapy with adults with PIMD in various contexts. As it was shown in this study, the difference between the Melbourne music therapists and a Sydney music therapist was evident. Although the process and benefits of music therapy were similar across different contexts, the impacts of various conditions on the clients may be useful in deepening our understanding. Furthermore, this will enhance our understanding with each other and may facilitate more communication and collaboration.

Recommendation 2:

Interviewing parents and disability support workers who have been experiencing music therapy for a long time may provide us with valuable knowledge and different perspectives. The five mothers of the participants involved in the current study provided consents and information about their children's music therapy history. Interviewing these mothers will produce significant knowledge as much as the interviews with music therapists have produced in this study. In this way, music therapy service for adults with PIMD will be understood better, and its role in a broader context will be explored.

Recommendation 3:

Finally, it was apparent that building meaningful interactions and relationships with adults with PIMD takes a long time over several years. Therefore, conducting a longitudinal study tracing the process and benefits of individual as well as group sessions in naturalistic community based settings will provide knowledge and insights in the future.

Conclusion

The aim of the current study was to understand essence and meanings of the lived experiences of five music therapists who have been sharing meaningful interactions and relationships with adult clients with PIMD in music therapy. A qualitative flexible design informed by phenomenology facilitated a naturalistic investigation. Each pair's single music therapy session was video recorded, and the music therapists were interviewed. They were asked to describe their experiences of building meaningful relationships and identify a meaningful moment in the video recorded session. Given that the adults with PIMD receive little meaningful interventions and activities, the identified benefits such as psychosocial well-being and the moments of *joy and ecstasy; completion and accomplishment* provide useful insights for everyone who takes care of adults with PIMD.

Finlay (2011) explains what phenomenology offers, which is not offered by any other methodologies:

Phenomenological research is potentially transformative for both researcher and participant. It offers individuals the opportunity to be witnessed in their experience and allows them to 'give voice' to what they are going through. It also opens new possibilities for both researcher and researched to make sense of the experience in focus (p.10).

The current study began with an initial idea of exploring music therapists' lived experiences working with adults with PIMD in 2012 in Australia. This initial question led me to investigate the process and benefit of music therapy, and then I recognised the difference between conventional and contemporary music therapy. This then suggested I consider new possible theoretical approaches for future music therapy. Furthermore, appreciating the important principals of the Conventions of Persons with Disabilities (United Nations, 2006) and the World Report on Disability (World Health Organization, 2011) leads me to value the concepts of Social Inclusion, Community Engagement, and Social Justice. By "attending to unheard

voices” (Stige & Aarø, 2012, p. 3), I now see the needs of adults with PIMD and the music therapists in the future.

However, before moving fast, we need to remember that there are still many people with PIMD, living in institutional settings without meaningful interventions. Many Asian countries do not seem to provide music therapy to adult clients with disabilities. Accordingly, many people may still be suffering from extreme isolation and lack of human contacts. The current study shows how music therapists can offer a humanistic intervention in these environments. More adults with PIMD should be provided with music therapy. For this, experienced music therapists who are witnessing these miraculous and touching moments everyday, should speak out loudly and gather their voices into a bigger one. We should advocate for our clients and our practice in a way that people understand in these contexts.

On the other hand, the findings of the current study show that now more children with PIMD survive into adulthood, and these children born after 1980s are experiencing different lives from past generations who were institutionalised for all their lives. We now need a new approach in supporting them. In 1994, two Australian music therapists, Ely and Scott claimed “one way in which integration can be more fully and holistically achieved is if we, the general public, accept people with disabilities for the persons they are and not for their disability” (p.18). More critical questions were asked in relation to “integrating clients with an intellectual disability to the community through music therapy” (Ely & Scott, 1994):

- Will this mean physical and social integration with members of the general public or access only to a community facility?
- Will members of the general public access or participate in a programme with people with an intellectual disability?
- What role will the general public have in an integrated group? and what are the educative strategies, if any, that need to be put into place for the public, so that an understanding, supportive relationship is there for people with disabilities and not necessarily a sympathetic one? (p. 18).

I believe that they asked fundamental questions about the true meaning of Community Inclusion. After 20 years, their questions still remained unanswered.

However, we now have advanced knowledge and theory that can help us to actualise our dreams and hopes. In 2009, McFerran explored Musical Justice in Australia by exploring the processes and benefits of both Music Therapy and Community Music. Through the powerful action research, McFerran concluded that adults with PIMD benefited from the individual attention in music therapy sessions. However, experiencing joy and excitement in group sessions is also important for them. She suggested a Practical Model of Musical Participation in community, advocating the co-existence and complimentary benefits of music therapy and community music on adults with a wide range of disabilities.

Furthermore, throughout the world, many music therapists now suggest a new way of actualizing Community Engagement and Social Justice through music therapy. Norwegian music therapists have paved the rough road with the concepts of Community Music Therapy (Kenny & Stige, 2002; Stige, 2003; Stige & Aarø, 2012; Stige, Ansdell, Elefant, & Pavlicevic, 2010). Some Canadian music therapists suggest their vision of using music therapy as an anti-oppressive practice (Baines, 2013) and social justice (Curtis, 2012; Vaillancourt, 2012). The current study shows how working with adults with PIMD in the long term brings people joy and pleasure. Community Music Therapy may naturally inform the public of the value of caring for the weak and fragile in our society as well as a way to share our genuine humanity with each other, resulting in meaningful experiences and an enrichment of one's life.

In conclusion, I believe that the time has come. There are many possibilities, hopes, and meanings to discover in the future. The current study suggests a new perspective and tool for constructing the meanings of provision of music therapy for adults with PIMD. This thesis has reflected on our past, contemplated the present, and now suggests a hope for Tomorrow. Let's be hopeful for Tomorrow⁴⁸ (Strouse, 2009).

The sun will come out Tomorrow.
Bet your bottom dollar that Tomorrow, there'll be sun!
Just thinking about Tomorrow,
Clears away the cobwebs and the sorrow, till there's none!

⁴⁸ "Tomorrow" is a name of song from a musical Annie, and a favourite song of one of my clients.

When I'm stuck with a day,
That's grey, and lonely,
I just stick out my chin and grin, and say,

Oh! The sun'll come out Tomorrow
So you got to hang on till Tomorrow
Come what may!

Tomorrow, Tomorrow, I love you Tomorrow
You're always a day away.

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APPENDICES

Appendix A. Letter of Ethics Approval

22 October 2012

Dr K.S. McFerran
SCHOOL OF MUSIC
The University of Melbourne

Dear Dr McFerran

I am pleased to advise that the Humanities and Applied Sciences Human Ethics Sub-Committee approved the following Project:

Project title: **A phenomenological investigation of the interpersonal relationships between six music therapists and adults with profound intellectual and multiple disabilities**

Researchers: **Dr K S McFerran, J Lee**

Ethics ID: **1136760**

The Project has been approved for the period: **19-Oct-2012 to 31-Dec-2013.**

It is your responsibility to ensure that all people associated with the Project are made aware of what has actually been approved.

Research projects are normally approved to 31 December of the year of approval. Projects may be renewed yearly for up to a total of five years upon receipt of a satisfactory annual report. If a project is to continue beyond five years a new application will normally need to be submitted.

Please note that the following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

(a) **Limit of Approval:** Approval is limited strictly to the research as submitted in your Project application.

(b) **Variation to Project:** Any subsequent variations or modifications you might wish to make to the Project must be notified formally to the Human Ethics Sub-Committee for further consideration and approval. If the Sub-Committee considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised Project.

(c) **Incidents or adverse affects:** Researchers must report immediately to the Sub-Committee anything which might affect the ethical acceptance of the protocol including adverse effects on participants or unforeseen events that might affect continued ethical acceptability of the Project. Failure to do so may result in suspension or cancellation of approval.

(d) **Monitoring:** All projects are subject to monitoring at any time by the Human Research Ethics Committee.

(e) **Annual Report:** Please be aware that the Human Research Ethics Committee requires that researchers submit an annual report on each of their projects at the end of the year, or at the conclusion of a project if it continues for less than this time. Failure to submit an annual report will mean that ethics approval will lapse.

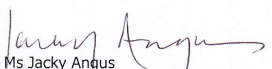
(f) **Auditing:** All projects may be subject to audit by members of the Sub-Committee.

If you have any queries on these matters, or require additional information, please contact me using the details below.

Please quote the ethics registration number and the title of the Project in any future correspondence.

On behalf of the Sub-Committee I wish you well in your research.

Yours sincerely


Ms Jacky Angus
Humanities and Applied Sciences HESC
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cc: HEAG Chair – Music
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Appendix B.

Plain Language Statement for Music Therapists – Page 1



THE UNIVERSITY OF
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Information Sheet for Music Therapists

Dr Katrina Skewes McFerran (Supervisor)
Faculty of the VCA & MCM
Ph: 0407 350 251

Miss Ju-Young Lee (PhD student)
Faculty of the VCA & MCM
Ph. 0403 266 471

Project: "A Phenomenological Investigation of the Interpersonal Relationships between Six Music Therapists and Adults with Profound Intellectual and Multiple Disabilities"

Introduction

Forming meaningful relationships with close others is important to maintain a good quality of life. The aim of the study is to better understand the nature of interpersonal relationships between music therapists and adults with Profound Intellectual and Multiple Disabilities (PIMD) in music therapy. We would like to invite you to participate in our research project as you are an experienced music therapist working with adults with PIMD. This project has been approved by the Human Research Ethics Committee at the University of Melbourne and the reference number is HREC 1136760.1.

What will I be asked to do?

Should you agree to participate, you would be asked to contribute in two ways. First, we would ask you to select a client who you feel connected and have established an interpersonal relationship. Then, we would ask you to conduct a typical music therapy session with the client at a time convenient to you and the researcher will observe and video-record the session. After the session, we would ask you to select any moments that reflect your interpersonal relationship with the client to further analyse the moments descriptively. Second, we would ask you to participate in a face to face interview of about 45 minutes to 1 hour, so that we can get a detailed description of your experience of working with adults with PIMD in general as well as the experience of an interpersonal relationship with an adult client who has PIMD. With your permission, the interview would be recorded so that we can ensure that we make an accurate record of what you say. When the interview has been transcribed, you would be provided with a copy of the transcript, so that you can verify that the information is correct and/or request deletions.

HREC 1136760.1 (Version 3/OCT 2012) 1

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Plain Language Statement for Music Therapists – Page 2

How will my confidentiality be protected?

We intend to protect your anonymity and the confidentiality of your responses to the fullest possible extent, within the limits of the law. Your name and contact details will be kept in a separate, password-protected computer file from any data that you supply. This will only be able to be linked to your responses by the researchers, for example, in order to know where we should send your interview transcript for checking. In the final report, you will be referred to by a pseudonym. We will remove any references to personal information that might allow someone to guess your identity, however, you should note that as the number of people we seek to interview is very small, it is possible that someone may still be able to identify you. The data will be kept securely in the Faculty of the VCA & MCM for five years from the date of publication, before being destroyed.

How will I receive feedback?

Once the thesis arising from this research has been completed, a brief summary of the findings will be available to you on application at the Faculty of the VCA & MCM. This can be also sent to you. Please indicate whether you want to receive a copy of a summary of the findings in the consent form. It is also possible that the results will be published at academic journals and the video footage might be presented at academic conferences.

Will participation prejudice me in any way?

Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so without prejudice. The researchers are not involved in the ethics application process. Your decision to participate or not, or to withdraw, will be completely independent of your dealings with the ethics committee.

Where can I get further information?

Should you require any further information, or have any concerns, please do not hesitate to contact either of the researchers on the numbers given above. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 8344 2073, or fax: 9347 6739.

How do I agree to participate?

If you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided. The researchers will then contact you to arrange a mutually convenient time for you to conduct a music therapy session and complete interview.

Appendix C.

Consent Form for Music Therapists



THE UNIVERSITY OF
MELBOURNE

Faculty of the VCA & MCM

Consent form for music therapists participating in a research project

PROJECT TITLE: A Phenomenological Investigation of the Interpersonal Relationships between Six Music Therapists and Adults with Profound Intellectual and Multiple Disabilities

Name of participant: _____

Name of investigator(s): _____

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written information sheet to keep.
2. I understand that after I sign and return this consent form it will be retained by the researchers.
3. I understand that my participation will involve an observation of my music therapy session and interview and I agree that the researcher may use the results and video footage as described in the information sheet.
4. I acknowledge that:
 - (a) the possible effects of participating in the interview and observation of my music therapy session have been explained to my satisfaction;
 - (b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;
 - (c) the project is for the purpose of research;
 - (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
 - (e) I have been informed that with my consent the interview will be audio-taped, and the music therapy session will be video-recorded. I understand that audio and video tapes will be stored at University of Melbourne and will be destroyed after five years;
 - (f) my name will be referred to by a pseudonym in any publications arising from the research;
 - (g) I have been informed that a copy of the research findings will be forwarded to me, should I agree to this.

I consent to the interview being audio-taped

yes no
(please circle)

I consent to the music therapy session being video-recorded
and agreed that the video footage may be presented at conferences

yes no

I wish to receive a copy of the summary project report on research findings

yes no

Participant signature: _____

Date: _____

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Appendix D.

Plain Language Statement for Parents and Legal Guardians

– Page 1



THE UNIVERSITY OF
MELBOURNE

Information Sheet for Parents or Legal Guardians

Dr Katrina Skewes McFerran (Supervisor)
Faculty of the VCA & MCM
Ph: 0407 350 251

Miss Ju-Young Lee (PhD student)
Faculty of the VCA & MCM
Ph. 0403 266 471

Project: "A Phenomenological Investigation of the Interpersonal Relationships between Six Music Therapists and Adults with Profound Intellectual and Multiple Disabilities"

Introduction

Forming meaningful relationships with close others is important to maintain a good quality of life. As it has been reported that your son/daughter/client (referred as a client only from here) has developed an interpersonal relationship with his/her music therapist, we would like to invite your client to participate in our research project. The aim of the study is to better understand the nature of interpersonal relationships between music therapists and adults with Profound Intellectual and Multiple Disabilities (PIMD) in music therapy in order to improve the quality of music therapy service. This project has been approved by the Human Research Ethics Committee at the University of Melbourne and the reference number is HREC 1136760.1.

What will my client be asked to do?

Should you agree for your client to participate, your client would be asked to simply attend an individual/group music therapy session that he/she has been attending with his/her music therapist regularly. The session will be conducted as natural as possible, and a researcher will observe and video-record the session. As your client and his/her music therapist will perform their usual music therapy session, no risk is anticipated. Music therapy participation is generally a pleasant experience because the client listens to his/her favourite songs and interacts meaningfully with the music therapist. However, if the client indicates signs of distress due to the presence of the researcher, this will be respected and the researcher will stay out of the sight of the client or leave the room leaving a fixed video-camera. After the session, the music therapist would be asked to select any moments that reflect the interpersonal relationship with your client. The music therapist will be also interviewed about his/her experience of working with adults with PIMD in general and the interpersonal relationship with your client.

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e:

Plain Language Statement for Parents and Legal Guardians

– Page 2

How will my client's confidentiality be protected?

We intend to protect your client's anonymity and the confidentiality of your client's response to the fullest possible extent, within the limits of the law. Your client's name and contact details will be kept in a separate, password-protected computer file. In the final report, your client will be referred to by a pseudonym. We will remove any references to personal information that might allow someone to guess your client's identity; however, you should note that as the number of people we seek to include is very small, it is possible that someone may still be able to identify your client. The data will be kept securely in the Faculty of the VCA & MCM for five years from the date of publication, before being destroyed.

How will I receive feedback?

Once the thesis arising from this research has been completed, a brief summary of the findings will be available to you on application at the Faculty of the VCA & MCM. This can be also sent to you. Please indicate whether you want to receive a copy of a summary of the findings in the consent form. It is also possible that the results will be published at academic journals and the video footage might be presented at academic conferences.

Will participation prejudice me and my client in any way?

Please be advised that your client's participation in this study is completely voluntary. Should you wish for your client to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so without prejudice. The researchers are not involved in the ethics application process. Your decision for your client to participate or not, or to withdraw, will be completely independent of your dealings with the ethics committee, and we would like to assure you that it will have no effect on your client's music therapy.

Where can I get further information?

Should you require any further information, or have any concerns, please do not hesitate to contact either of the researchers on the numbers given above. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 8344 2073, or fax: 9347 6739.

How do I agree to participate?

If you would like your client to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided. The researchers will then contact your client's music therapist to arrange a visit to the regular music therapy session of your client.

Appendix E.

Consent Form for Parents and Legal Guardians



THE UNIVERSITY OF
MELBOURNE

Faculty of the VCA & MCM

Consent form for parents or legal guardians of clients participating in a research project

PROJECT TITLE: A Phenomenological Investigation of the Interpersonal Relationships between Six Music Therapists and Adults with Profound Intellectual and Multiple Disabilities

Name of client: _____

Name of parent/legal guardian: _____

Name of investigator(s): _____

1. I consent for my client to participate in this project, the details of which have been explained to me, and I have been provided with a written information sheet to keep.
2. I understand that after I sign and return this consent form it will be retained by the researcher.
3. I understand that my client will attend a music therapy session and this will be video-recorded. I agree that the researcher may use the results and the video footage as described in the information sheet.
4. I acknowledge that:
 - (a) the possible effects of my client's participation in this study has been explained to my satisfaction;
 - (b) I have been informed that I am free to withdraw my client from the project at any time without explanation or prejudice;
 - (c) the project is for the purpose of research;
 - (d) I have been informed that the confidentiality of the information of my client will be safeguarded subject to any legal requirements;
 - (e) I have been informed that the music therapists will be interviewed about the interpersonal relationship with my client and with my consent my client's participation in a music therapy session will be video-recorded. I understand that video tapes will be stored at University of Melbourne and will be destroyed after five years;
 - (f) my client's name will be referred to by a pseudonym in any publications arising from the research;
 - (g) I have been informed that a copy of the research findings will be forwarded to me, should I agree to this.

I consent to the music therapy session being video-recorded

yes no
(please circle)

I agree that the video footage may be presented at conferences

yes no

I wish to receive a copy of the summary project report on research findings

yes no

Parent/Legal Guardian signature: _____

Date: _____

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Appendix F.

Demographic Survey Form for Clients

Demographic Survey for Clients

Full Name	
Age & Date of Birth	
Gender (Please circle)	M F
Diagnosis (Please write as much as possible)	1. 2. 3. 4.
Music Therapy (MT)	
Experience in General	
(Where and how long?)	
MT experience with the participating music therapist (in years?)	
Communication (Which statement best describes the person's way of communicating? – <u>Please circle one of the numbers</u>	1. Communicates through body language and facial expression only 2. Communicates through looking at or reaching to things 3. Communicates through gestures (e.g. pointing 1 metre away) 4. Communicates through single words or pictures or basic signs (e.g. toilet) 5. Communicates through short sentences or picture sequences

Appendix G.

SMUs and EMUs of Steve's Experience

Structural Meaning Units

1. Working with adults with PIMD is always challenging.
2. I'm looking for any reactions as an engagement when working with adults with PIMD.
3. It takes different stages over time to build relationships with adults with PIMD.
4. Familiarity is the core of the relationship and it's built in the middle of the relationship.
5. Meaningful moments with Eva are those familiar moments in every session.
6. Significant moment is when something new, unexpected, and pivotal happens.
7. I believe that our relationship is definitely obvious, positive, and meaningful to both of us.

Experienced Meaning Units

1. Steve believes that initial stage is the most challenging time because of the low functioning levels when working with adults with PIMD.
2. Steve notices that no matter how much they are disabled, adults with PIMD receive music well and display reactions that we can observe.
3. Steve looks for any reaction in the initial stage of the relationship, but as he understands the client more, Steve can identify certain reactions as key behaviours.
4. Steve believes that meaningful relationships with adults with PIMD can be established while finding a way to understand the person better.
5. Steve thinks the relationship with Eva is in middle stage because they have created a familiar routine.
6. Steve believes that familiar vocal interactions with Eva are the core of their relationship.
7. Steve identifies that meaningful moments and significant moments are different; meaningful moments are when interactions are familiar and significant moments are when interactions are unexpected.
8. Steve believes that Eva enjoys his different attention that is not feeding or toileting.
9. Steve finds staff's support helpful in establishing meaningful relationships with clients with PIMD.
10. Steve felt that his work with Eva was validated by her mother when she explained how Eva positively reacted to attending music therapy.

Appendix H.

SMUs and EMUs of Frances' Experience

Structural Meaning Units

1. Working with adults with PIMD can be challenging at times due to the lack and subtlety of responses and feedbacks.
2. It's more rewarding when I do get a response such as an eye contact and smile, and its like "oh yeah, I'm getting somewhere...something".
3. Building interpersonal relationships with adults with PIMD takes a long time and the progress is gradual.
4. Building an interpersonal relationship with Amy is a positive experience for me.
5. I cannot pinpoint one particular moment when I felt meaningful.
6. The flip side of the relationship with Amy is that one day it will have to end, either because she gets sick or I leave the organization.

Experienced Meaning Units

1. Frances at times feels confused and lost, not knowing where to go, however, when she finally gets small responses, such as eye-contact and smiles, she feels relieved and it feels like she is getting somewhere.
2. Building interpersonal relationships with adults with PIMD is rewarding as much as challenging.
3. Frances finds working with Amy easier than other clients with PIMD because Amy gives so many recognizable responses back.
4. Once when Amy was sick, Frances realized that her condition is progressing more. Although Amy is her favourite client, Frances tries not to get attached too much.
5. Meaningful moments with Amy are the small interacting moments in every music therapy sessions when Frances gets lots of eye contacts and smiles.
6. Amy's progress has been gradual over the years. Frances never expected that she would experience this unrealistic journey with Amy.
7. Frances feels grateful for Julia's support because she believes it is important in Amy's progress.

Appendix I.

SMUs and EMUs of Darren's Experience

Structural Meaning Units

1. When a client's physical condition is good, we have interactions ongoing and I feel very rewarded. When a client's physical condition is not good, however, the clients and I can be frustrated because we cannot control these things.
2. Music therapy is all about how they feel with the things they choose and my job is to maximise their potential to benefit and improve the quality of life.
3. The family support is one of the very import factors in building relationships with Lyn and Mia.
4. Meaningful moments with Lyn and Mia have similarities. They both actively participated in music therapy session after being sick for a while.
5. I'm learning their language and they also learning my language definitely.
6. Lyn, Mia, and their family are one of the most understanding people due to their previous experience with music therapy.
7. The way, they communicate with me, makes me feel like I'm part of this little family.

Experienced Meaning Units

1. As adults with PIMD have uncontrollable physical conditions and limited abilities, Darren believes maximising opportunities to communicate choices and control over the environment through two-way interactions is important.
2. Comparing to his previous experience in hospital and aged care settings, Darren's experience of interpersonal relationship with Lyn, Mia, and their family in a home setting is different and positive.
3. Darren believes that the good thing about the family setting is that the parents really assist you in different ways anytime whenever there are difficulties.
4. When Darren first meets the clients who have PIMD, the most challenging thing is reading the non-verbal behaviours correctly, so the family's introduction to Lyn and Mia's behaviours and meanings was really helpful for Darren to reduce the time to understand them.

5. Darren has learnt to read Mia's emotional expressions. Darren feels great to know the clients in person.
6. When walking into the house for sessions, Darren feels welcomed and he feels like he is their brother rather than a therapist and this makes him feel happy.
7. Once when Lyn and Mia were sick, Darren felt worried and realised that he was emotionally attached to them. However, their active participation relieved him from the worries.
8. For Lyn and Mia, music therapy now has become a part of their life. Darren feels lucky to have this valuable experience with them.

Appendix J.

SMUs and EMUs of Owen's Experience

Structural Meaning Units

1. When working with adults with PIMD, things tend to move slowly over a long time.
2. In the institutional setting, there isn't that experience of developing and learning new skills and doing things in new ways.
3. Working with adults with PIMD who have non-verbal communication skills and no insight is really trying different things over time to get to know each client and his/her preference and interest better.
4. I think that each client needs different interactive approach depends on their personality and mood.
5. Nelson has continued to develop his musical expression even after he was actually got sick.
6. I have empathy for Nelson's isolation, and that's why I prioritise him among other clients.
7. Meaningful moments with Nelson are each time when I return after being away overseas for my holiday. He shows me his particular cheeky facial expressions.
8. As a music therapist, sometimes it's difficult to keep motivated to work because it is not musically rewarding but at the same time I feel proud of my professional skills when I see the progress of the clients.

Experienced Meaning Units

1. Owen believes that the rigid institutional environment and negative staff attitude are not ideal for adults with PIMD.
2. Owen thinks that people with PIMD need not only personal cares but also human interactions and socializations.
3. According to Owen, it is the "profound level" of physical disability that really limits what adults with PIMD can do; however, he believes that they can be more socially independent in interactions.
4. Owen believes he is working differently from other staff in the institution because they do not seem to consider each individual's interests and personality.
5. Owen finds it interesting when some nursing staff and parents are very surprised about the progress that adults with PIMD achieve in music therapy.
6. Owen has been impressed by Nelson, because he has tried hard and has achieved successfully as a drummer, challenging his physical limitation.
7. Owen finds it hard to explain, but certainly he has a special connection with Nelson and there were some meaningful and significant moments that Owen

felt they have this special relationship.

8. Owen believes his role, as a music therapist is different from musician who plays in a pub. He thinks that music therapists should be conscious of how to play music and adapt therapeutic interaction techniques to meet the client in the therapeutic relationship.
9. Owen has to interpret the responses and behaviors of the clients with PIMD because they cannot communicate verbally and sometimes he finds it difficult to judge how much is his own subjective imagination.

Appendix K.

SMUs and EMUs of Erica's Experience

Structured Meaning Units

1. Music therapists should be patient, and allow time and space for adults with PIMD to reveal who they are.
2. I have more time to accommodate the client's needs in individual sessions than group sessions.
3. Getting to know Mark, it's been a matter of working out and trying different things with him.
4. I observe Mark's behaviors and responses to understand his communication.
5. I had a meaningful session on his birthday by providing his favourite songs.
6. I think that my role as a music therapist is different from entertainers.
7. There are still things I would like to do within the relationship with Mark.

Experienced Meaning Units

1. Erica prefers individual settings to group settings because it allows time and space for the person to reveal who they are and finds the individual works enjoyable and fascinating.
2. Erica believes that getting to know Mark in depth was possible because of the individual setting.
3. As an experienced music therapist, Erica is now much more patient, relaxed, and confident about building interpersonal relationships with adults with PIMD. Erica has learnt that music therapists should be quick, alert, and patient when documenting the small changes and build the fluid relationship upon those.
4. Erica didn't underestimate Mark and discovered that Mark has abilities to vocalize in the tonality of music and anticipate certain points in songs.
5. Erica believes her role as a music therapist is to find those preferred songs that has particular parts that excites Mark to vocally interact with her.
6. Now, Erica knows Mark's various behaviors and the meanings in different situations and she feels achieved and excited about this progress.
7. Erica thinks that although Mark's birthday session was positive and meaningful, she didn't meet him in intellectual or cognitive level like an entertainer.
8. Erica thinks that Mark's behavior keeping her in his arms length is a clear negative behavior it is because he doesn't trust her enough. So Erica wants to help him overcome it but thinks it is unrealistic.
9. Erica wishes the interpersonal relationship with Mark to be developed into more fluid and equal relationship in the future.

Appendix L.

Letter for Member-Checking

Dear Co-researchers,

I have finally completed analysing your interviews.

The purpose of my interview analysis was to find meanings and essence of your described lived experience of interpersonal relationships with adults who have PIMD in music therapy.

I adopted three different phenomenological analysis methods (Giorgi, 2009b; McFerran & Grocke, 2007; Moustakas, 1994) for this study. Particularly, the phenomenological microanalysis method developed by McFerran and Grocke (2007, pp.277-282) provides a practical 7 steps (see below) to conduct.

The process of seven-steps microanalysis

1. Transcribing the interview word for word
2. Identifying key statements
3. Creating structural meaning units
4. Creating experienced meaning units
5. Developing the individual distilled essence
6. Identifying collective themes
7. Creating global meaning units and the final distilled essence

I basically followed the first 5 steps in order to create “individual distilled essence”. Before moving into the next steps for group analysis, I wish you to read the individual distilled essence for your experience (See appendix 1) and let me know your opinion with regard to this particular question.

“How do my descriptive results compare with your experience?”

You are welcome to suggest different words for certain emotional expressions. I also would love to hear any comments on your experience of participating in my study as well (your experience in interviews, video-recording session and etc.). I wish you well and looking forward to hearing back from you soon.

Sincerely regards,
Juyoung

PhD Candidate, The University of Melbourne
Registered Music Therapist