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Reflections and analysis to improve clinical practice:

A student music therapist's journey with a

preschool child with special needs

A dissertation presented in partial fulfilment of the requirements for the degree

of Master of Music Therapy

at the New Zealand School of Music, Wellington,

New Zealand.

Catherine Joy Wilkinson

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'The start of training is only the beginning of a lifelong process

of change, reflection and learning.'

Bunt and Hoskyns (2002a), p.25

Abstract

This qualitative study critically examines the researcher's music therapy clinical practice with a preschool child with global developmental delay. The researcher/student music therapist critically examined and refined her clinical practice using an action research model. Each cycle consisted of a plan, action, data collection, reflection, and analysis. The researcher was the main participant. The child, his mother and a speech-language therapist were co-participants with different roles. The child and his mother participated in the sessions. The speech-language therapist observed three sessions through a window. Feedback from the child's mother and the speech-language therapist contributed to the reflective data. Important issues that developed through the cycles related to early intervention techniques (having fun, being playful and spontaneous, and being in close proximity). Other important issues that developed were, the use of the voice and guitar; confidence; professionalism with parents and other health professionals; self-awareness; and the understanding of early childhood development (especially in the area of communication). Related literature on aspects of music therapy practice, music therapy in early intervention, music therapy and communication, and action research are described. These results cannot be generalised. However, they may firstly, illustrate relevant trends in early intervention, and secondly, enable the researcher to adapt skills learnt to use in future practice in early intervention.

17,400 words

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Contents

List of Figures and Tables

Figures

Tables

1   Introduction

This qualitative study investigated a single clinical music therapy case with a three-year, three-month-old boy with global developmental delay (see Glossary, p.114). The purpose, through action research, was to critically analyse my clinical practice in early intervention[1].

Throughout 2006 and early 2007, a collaborative music therapy and speech-language therapy programme were developed as part of the services provided by the child development team[2] (CDT) of a hospital facility. I worked with a speech-language therapist (SLT) as part of my clinical placement for the Master of Music Therapy programme. We worked with children under five years of age – a population group classified as early intervention.

The research had originally planned to conduct seven therapy sessions (described as cycles). This was to allow sufficient time to develop and improve my clinical practice. However, only six cycles were evaluated, as the child was unwell for the third cycle. Each weekly therapy session took place in a therapy room at the facility. Musical instruments, and objects/toys that related to music therapy, speech-language therapy, and early childhood development were used.

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[1] This paper is written in the first person (with the exception of the Literature review, which refers to other authors' works). It is appropriate to use this tense because of the nature of the action research model, which is 'self-reflective spirals'.

[2] The child development team caters for the needs of children from birth to 21 years of age. The multi-disciplinary team of health professionals includes paediatricians, physiotherapists, occupational therapists, speech-language therapists, visiting neurodevelopmental therapists, and social workers. Each team member works independently and sometimes jointly in sessions. Therapy sessions either take place at the child's home or in the specifically designed therapy rooms at the facility.

There were four people involved in the research. I was the main participant, and researcher. I was also the student music therapist who facilitated all six sessions. Co-participants were the child, the child's mother, and the SLT.

1.1 <u>Reasons for the research</u>

When I proposed the research, I had been working in early intervention for five months. As a new area of practice for me, I felt that there were several aspects about the work that I wanted to improve. Even though I enjoyed my clinical work, at times I lacked confidence and doubted my competence in the field of early intervention. I knew that I had the musical ability and I was able to 'be with' the child, but I lacked a confidence in myself when it came to the pragmatic features of relating to a child – i.e., having fun, playing, and exploring. I felt self-conscious and scared about taking risks in sessions in case the child did not respond, or they had a negative experience. I found myself 'stuck' using music that was 'safe' and this suppressed my creativity for fear of failure. In clinical supervision many of these issues were explored, and I decided to look at my clinical practice in detail through a research project.

I felt that undertaking action research would be a good opportunity to scrutinise my work in a detailed way. The action research model fitted in well with the aim of the project, which was to closely examine my clinical work with one child in order to develop and improve my practice accordingly. I hoped that through this research, it would lead to an increase in confidence, which would contribute to my ongoing professional development as a music therapist.

1.2 <u>Personal statement</u>

As the youngest child of three and the second youngest grandchild in my family, I have always grown up with older people. I tend to find it easier to relate to people older than myself. From my studies in psychology, I had been fascinated by human development – especially early childhood development. When my niece was born in 2004, I noticed that I initially found it difficult to relate to her. This was a new experience for me, as I had not had much contact with a young child. I wondered – how was I supposed to talk to her in a language she would understand, and how should I play with her?

When I began my music therapy studies, I knew that I wanted to work with younger children. At the 2005 World Music Therapy Congress in Brisbane, I was inspired by Helen Shoemark's presentation with babies in hospital. The infinite possibilities that one has with the human voice to connect with patients were amazing. So in 2006 when I was placed at a facility where I would be working with children under five years old, I was excited but nervous. Would I be able to relate to these children? Could I be playful, fun, spontaneous, and 'be with' the child? I would also need to be able to relate to their parents, and be confident in what I was doing and saying. This proposed research would be a good opportunity to look at these issues in a personally relevant and detailed way.

1.3 <u>Definitions</u>

The three key areas related to this research – music therapy, early intervention, and action research are defined here.

1.3.1   Music Therapy

Music therapy has many different definitions, depending on the theoretical foundations of the music therapy approach (Bruscia, 1998). The definition that seemed to be the most appropriate when relating to my clinical practice in early intervention was from *Music therapy: An art beyond words* (Bunt, 1994). He defined music therapy as the "…use of sounds and music within an evolving relationship between client and therapist to support and encourage physical, mental, social and emotional well-being" (p.8).

1.3.2   Early Intervention

Early intervention helps those children under five years of age, '…whose development is already delayed, through either biological, environmental, or unknown factors, or whose development may be at risk through these factors' (Archer, 1995, p.46). The goals typically associated in this field are, (1) to support families to maximise their child's development, (2) promote the child's development and coping skills, and (3) prevent future problems manifesting (Roffey, 2001; Wolfendale, 2000).

1.3.3   Action Research

In the 1930s, the social psychologist Kurt Lewin developed the concept of action research through his '…workplace studies comparing methods for training factory workers' (Hendricks, 2006, p.6).

The full definitions of McNiff, Lomax, and Whitehead (2003), and Koshy (2005) appear in the Glossary (p.114). They emphasised (1) understanding of responsibility for one's own practice (McNiff, et al.,) and (2) rigorous enquiry to consistently refine practice (Koshy).

The process of action research is described as 'self-reflective spirals'. It consists of 'planning a change, acting and observing the process and consequences of the change, reflecting on these processes and consequences and then replanning, acting and observing, reflecting, etc.' (Kemmis & McTaggart, 2000, as cited in Koshy, 2005, p.4).

2   Literature review

This section discusses the main areas of literature related to the research. These are: (1) aspects of music therapy practice, (2) early intervention in music therapy, (3) music therapy and communication (with a focus on joint attention[3] and turn-taking[4]), and (4) action research.

2.1   <u>Aspects of music therapy practice</u>

2.1.1   *What is good practice?*

'At the heart of music therapy is the person of the therapist' (Dileo, 2000, p.27). The quality of the therapist's skills and their personal approach are vitally important, not only to the profession of music therapy, but also for the clients whom the therapist helps. Dileo discussed these issues of good practice and what music therapy practitioners need, in relation to three models – (1) the trust-facilitating model, (2) the autonomy-facilitating model, and (3) the human welfare model (Cohen, 1994 as cited in Dileo). In summary, these models emphasise that (1) trust is paramount to the client–therapist relationship; (2) developing a client's independence and self-actualisation is important; and (3) caring for others (client and other parties involved) is a necessity and is derived from the first two models.

Further, Dileo (2000) discussed the core virtues of caring, empathy, courage and prudence. She stated that music therapists should endeavour to accomplish these values

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[3] This is related to the word *attention*. When infants start to engage with another person, they achieve *joint attention* when they become '…aware of another person's attentiveness to the world' (Hobson, 2005, p.186).

[4] 'To participate in rotation', (Schwarz (Ed.), The Chambers Dictionary, 1994, p.1868).

as they are, '…essential to (both) ethical thinking and (are) necessary components of an effective therapeutic process' (p.34).

Wheeler, Shultis and Polen's (2005) book emphasised the importance of continuous growth as a therapist. This growth starts with self-assessment. Key ideas included (1) the development of verbal therapy skills and music skills, and (2) the importance of supervision, self-reflection and personal therapy.

In an interview with an experienced music therapist, Coulson (2006) highlighted 12 points of reflection. 'First relate to the person; be close but don't intrude; give each person some personal time; follow their lead – build on what they can do; work with a speech and language therapist; educate by example; the same approach works with all population groups; address the whole person; singing; instruments (with an emphasis that the voice is the most useful); "the presence"; and follow your intuition' (pp.101-103).

Jonsdottir (2002) stated that the therapeutic skills of listening and empathy are important, not only for the child but for the parent as well, because families often turn to the therapist for support and encouragement[5].

2.1.2   *Working with children and families*

Rickson (1995) stated that, '…whenever possible, the music therapist should address the parents' priorities first' (p.33). Listening to parents' needs, their recommendations, and explaining the intervention are important issues. Parents'

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[5] The author refers the reader to the reference section for the full details of two music therapy textbooks that she found extremely helpful in this area of 'what is good practice' (Bunt & Hoskyns, 2002b; Wigram, Pederson, & Bonde, 2002).

involvement in the therapy process is then more likely to increase. Rickson also stated that, 'Good communication skills are considered to be the most critical component of positive family interactions…'(p.33). In summary, Rickson said, '…shared music-based experiences help families enjoy and become confident in their own roles, and better able to achieve their goals' (p.35). Kern (2005) in her interview with Humpal, stated that parents should be very involved in therapy sessions because they know their children best.

Oldfield (1999) argued that, 'For the music therapist, listening is the first step towards communication' (p.198). However when this skill is mastered, the process of establishing a therapeutic relationship with the child can begin. Bunt (2007) also discussed the importance of listening to both the music and the silence, in relation to making connections with children in music therapy. Aldridge (1996) described listening in a '…structured musical improvisational context, without the lexical demands of language, (as) a platform for communicational improvement' (p.268). Hoskyns (2002) also stated that, 'The awareness of the need for listening and observation skills is paramount in the early stages in any clinical or therapeutic training' (p.169).

2.1.3   *Professional development and supervision*

One part of a music therapist's professional learning is gaining confidence in one's abilities. Brown (1999) stated that, '…perhaps what most enables the therapy process is when we, as therapists, trust and are in tune with ourselves and what we have to offer' (p.195). Other music therapists have noted that reflecting on your own work is an important part of a being a therapist (Bunt & Hoskyns, 2002b; Wigram, et al., 2002).

Supervision is fundamental in the training of a music therapist. Dileo (2001) stated that supervision is important because, (1) it helps to gain skills in order to

practice competently, and (2) ethically, it is a primary way to enhance and improve skills, and essential in training in specialised music therapy methods.

2.2   **Early intervention in music therapy**

2.2.1   Early intervention

As the first few years of life are, '…critical to subsequent development' (Jonsdottir, 2002, p.3), early intervention is essential. Burrell (2005) said that, "Early intervention overlaps with early prevention, (which should) be promoted" (p.30). Descriptive music therapy studies in the field suggest that early intervention could be more effective than later invention (Archer, 1995, 2004; Croxson, 1999; Jonsdottir, 2002). It also seems to reduce the effects of the child's condition providing them with a better outlook for the future (Archer, 1995).

Working with families, especially the child's parents/caregivers is also a vital part of working in this field, as children rely heavily on their families for help, support and guidance (Archer, 1995; Croxson, 1999; Abad, 2002; Jonsdottir, 2002).

Participating in music therapy sessions, or playing music has been described as a core part of working in early childhood because, '…(they) both essentially operate in a non-verbal way' (Perret, 2005, p.96). Trevarthen and Malloch (2000) also discussed how music itself reaches further than the pre-verbal and non-verbal.

Hibben (1992) stated that, 'For children, play is the bridge between inner life and external reality' (p.33). She said that using music in association with play encourages and allows for expressive communication, and it can help social relationships – listening and sharing with others. In an interview conducted by Kern (2005), Humpal said that a child's world is filled and fuelled by play. Therefore, when

working with young children, we should make use of play techniques within music therapy[6].

2.2.2   Music therapy research in early intervention

The music therapist's role in early intervention is to help the child with their developmental needs by using music as the tool, and then giving their parents' ideas in which they can use music in the home environment, both between sessions and after closure (Abad, 2002; Archer, 1995; Kern, 2005; Skewes & Thompson, 1998).

Once the child is engaged in a specific musical activity, music therapy could have the potential to meet their non-musical goals. This is because music therapists adapt the musical activity so that they use the child's strengths to help them with their difficulties (Archer, 2004; Kern, 2005).

Peters (2000) noted that music could be a fun and positive way of learning language for children. It is also motivating and promotes interaction and sharing. Those children with speech difficulties can feel good about themselves and communicate in a meaningful and socially acceptable way through playing instruments and self-expressions.

Key links between music making and early development include imitation, turn-taking, vocalising, looking behaviour, attention, motor, and social skills; and other features of non-verbal communication (as discussed by Bunt, 1994). Those features

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[6] For more information, the reader is referred to – Marsh, K., and Young, S. (2006). Musical play. In G.E. McPherson (Ed.), *The child as musician: A handbook of musical development* (pp. 289-310). Oxford University Press.

include, '…proximity, posture, facial expressions, gestures, head-nods…' (Bunt, p.95).
He has referred to work with pre-schoolers as "playing with sounds" (Bunt, p.96).

Holck (2004) discussed her work on turn-taking with a two-and-a-half year old
boy with a communication disorder. She found that the boy was able to imitate and play
with sounds, but they had no communicative intent. Through the interplay of vocal
exchanges, which were often accompanied by the guitar and the child bouncing on the
Swiss ball, the child was able to develop turn-taking skills.

Bunt (1994) noted that both direct and indirect contact between a child and adult
can facilitate communication. He said that direct eye-to-eye contact is linked to smiling
which improves the attachment process especially with the mother-child relationship.
This position of 'en face' is often used in music therapy with this population, when
rapport within the child-therapist relationship is gained. Indirect contact via a musical
instrument can be a more natural way for the child and therapist to relate. It can also be
a common object for visual attention.

2.2.3   Research in other fields

When working in the field of early intervention, a music therapist will also meet
and may work with other therapists such as, speech-language therapists,
physiotherapists, and occupational therapists. Music therapy literature discusses the
widespread nature of collaboration and its importance for music therapy and other
disciplines, as mentioned above (Twyford, Parkhouse, & Murphy, 2005; Twyford,
2007; Twyford, 2008).

Kennelly, Hamilton, and Cross (2001), discussed the role of collaboration in
music therapy and speech-language therapy as an effective intervention for children

with communication difficulties. Peters (2000) highlighted the intimate connection between the two disciplines of music and speech, and argued that working with a SLT would be valuable for music therapists, in order to verify the specific needs of the client.

When learning language, visual stimuli (picture cards), paired with the aural stimuli of words can help children respond more correctly (Aldridge, 1996; Cassidy, 1992 as cited in Peters, 2000). Using language that matches the ability of the child and not displaying too many items at a time is also helpful (Michel & Jones, 1991 as cited in Peters). Dockrell and Messer (1999) also stated that many experimental studies confirm that, the '…link between speech and visual attention provides a basis for the development of vocabulary' (p.12).

2.2.4   Australasian studies of music therapy in early intervention

Music therapy is one intervention that can bring family members together and help them share, '…an intimate experience in a non-threatening environment' (Abad, 2002, p.38). Families bring particular strengths to the therapy process – commitment, awareness of their child's physiological and psychological patterns, and genuine concerns. Some matters also worry families, e.g. "What is music therapy? (and)…
I can't sing!" (Croxson, 1999, p.42).

Archer (1995) examined music therapy's impact on families in an early intervention programme (in New Zealand). Responses to the service from both families and staff members at the early intervention service were positive. One response from a parent was particularly significant – "We believe music therapy is a vital part of any early intervention programme, and has the potential to have a significant impact on any child's development" (p.52). Staff members described the sense of pleasure, fun and security while achieving non-musical goals (i.e. turn-taking, listening, interacting and

increased participation). She concluded that music therapy is a vital part of the early intervention service in promoting children's development and growth within the family.

Studies by Abad (2002) and Shoemark (1996) support the ideas discussed by Archer (1995, 2004). Abad's 'Sing and Grow' programme in Australia received positive responses from parents, and 93% of respondents wanted to attend another programme. Reports from Shoemark's family-centred early intervention music therapy programme indicate that both family members and the child had very positive experiences. Using songs and singing was a successful music therapy technique.

Coulson's (2004) paper examined different populations who have communication difficulties, including young children, in which music therapy intervention can be used. She concluded that singing in music therapy seemed to be a '…common factor in facilitating communication and in developing or maintaining speech/language. Musical instruments could also be used to encourage vocal response' (p.118).

Shaw (2006) examined ways in which to promote positive interactions between a four year old boy and his mother as well as developing the boy's communication skills through dyadic and triadic instrumental improvisations. She found that the music therapy sessions provided opportunities for positive interactions between the boy and his mother as well as promoting his pre-verbal communication skills.

Wallace (1996) described the use of toys in a music therapy programme. Toys proved effective in many situations, including establishing trust and rapport, providing comfort, and helping the child in a new environment. Wallace found that music '…offered a structure within which to use (the object)…' (p.25). She noted that, 'Music

therapists can use toys to model musical play and facilitate interaction between parent and child…' (p.27). She also noted that, '…positive interactions with their child, initiated by parent, child, or therapist, can reduce both their and their child's anxiety' (p.27). In music therapy, "…expressive instrument playing, movement, and manipulation of objects and puppets offer vehicles for expression" (Barrickman, 1989, p.14).

Wallace (1996) found that many songs could use toys as the subject and that using improvised songs gives no limits as to where the music will go. Burrell (2005) also found in her work with families and young children in the UK that not only do objects engage, focus, and lengthen a child's attention span, but they also provide an invitation to make music.

2.3   Music therapy and communication

2.3.1   Song and speech in music therapy

One of the earliest musical interactions experienced by a human being is singing (Oldfield, 1993, 1995; Shoemark, 1996). Usually this is shared between parents as a way of first communication with their child and is described as a '…millennia-old tradition…' (Abad, 2002, p.38).

Pioneering work by Nordoff and Robbins in the field of song and speech is emphasised and discussed by many modern music therapists throughout the literature. The idea is that there is a close relationship between song and speech and through the use of songs, one can encourage vocalisations, and therefore practise speech sounds (Nordoff & Robbins, 1983). Croxson and Rickson (2002) summed up this idea as follows,

A basic premise of music therapy is the belief that the child has an innate

musicality, which can be used to enhance other areas of development…

the baby is familiar with speech, songs and laughter and enters the world

as a communicating social being (p.2).

In music therapy, 'Singing activities can be effective in *stimulating the*

expressive use of speech in speech impaired children' (Miller, 1984, p.136). It is a

technique used to help developmental needs and enhance the parent-child relationship,

with particular focus on communication difficulties that can arise.

As song and speech have common elements of rhythm, melody/pitch, tempo,

dynamics, harmony and timbre, the relationship then between music and language is not

difficult to understand. Therefore singing songs can improve speech (Cohen, 1994;

Erkillä, 2004; Kennair, 2000; Loewy, 1995; Nordoff & Robbins, 1983; Stansell, 2001;

Wylie, 2000). Wylie (a New Zealand music educator) also noted that children find

learning words easier when the words are broken down into rhythmic syllabic patterns

and repeated. The three essential qualities of music – structure, modelling and repetition

also help develop these speech skills (Skewes & Thompson, 1998).

Live singing of children's nursery rhymes and play songs in music therapy can

encourage communication, because these songs have memorable melodies, simple

rhythms and harmonies, and lots of repetition. Through the musical structure of clear

beginnings and endings, children also feel satisfied when they have completed a song

(Mackenzie & Hamlett, 2005; Oldfield, 1995; Wylie, 2000). Lyric substitution can also

be used to encourage interaction and joint attention (Mackenzie & Hamlett). Dockrell

and Messer (1999) also wrote that interaction studies have suggested that vocal turn-

taking leads to turn-taking in speech.

Cohen's (1994) paper noted that singing might provide pleasure for children when practising their communication, compared to that of traditional speech therapy exercises. She also reported that in many previous studies, the technique of singing has helped those with speech difficulties, of all ages and disabilities. She concluded that, '…singing has been used successfully to expand the communication potential of persons with limited speech capacity' (p.12).

In Loewy's (2004) paper on *Integrating Music, Language and the Voice in Music Therapy*, she said that, '…the similarities involved in the mechanisms of the brain in both language and music acquisition, are of interest to the music therapist' (p.3). In conjunction with audio musical examples, she discussed the use of music therapy in helping language and communication in relation to four models – Music therapy in the: pre-linguistic stages, in a developmental context, in recovery, and the voice in psychotherapeutic function.

Loewy (1995) also discussed in depth the musical stages of speech and how music therapists use certain musical techniques to develop a child's language. In stage three, she discussed single and double-word utterances in relation to music therapy. The use of the child's name, for example, the greeting song, and using movement (such as waving) allowed the music therapist to connect with the child. Songs in relation to everyday objects are also to be encouraged in music therapy sessions because '…children begin language by using nouns to identify desired actions' (p.70).

Hoskins (1988) used improvised lyrics to describe the play behaviour of two to five year old developmentally delayed and non-developmentally delayed children. The aim was to bring the children closer in proximity and maintain interactions with each other. She found that using picture cards in conjunction with antiphonal singing could

be a beneficial technique when trying to improve communication. These practical ideas continue to be relevant to modern music therapy practice.

Sutton's (2001) PhD looked at the aspects of conversation/communication with regard to beginnings, endings, turn-taking and silence. In summary, she stated that turn-taking is '…essential because of the fundamental psychosocial need to communicate and receive a response to that communication…this would be impossible if everyone was to speak at once' (pp.206-207). However, in musical improvisations, this does not necessarily have to be the case. Through simultaneous play, one can still hear the different musical parts. Sutton discussed previous literature as noting that 'silence' is a meaningful element of conversation. In music, where it means 'an absence of sound', Sutton said that silence can help to keep the listener's attention and mark musical boundaries of beginnings and endings. She concluded that in relation to music therapy, every musical sound and silence has the potential for communication. The use of these aspects in musical improvisation is key to growing the client-therapist relationship.

Pavlicevic (1997) discussed the importance of music therapy improvisation in relation to speech. She said that it can create a relationship through sound forms that highlight energy and contour of speech, 'When music therapy improvisation is able to generate an inter-personal context between therapist and client, then the improvisation elicits and portrays the client's experience of himself-in-the-world, through sound' (pp.115-116).

Another pioneer in music therapy, Juliette Alvin (1975) said that not just singing, but playing instruments as well could enhance musical relationships. Wigram, et al., (2002) also discussed the appealing nature of making sounds and playing instruments with regard to relationships and extending concentration.

2.3.2   *Early communication aspects*

An infant's motivation to engage and have an intimate emotional relationship with another person, primarily their mother, has been written about by many modern music therapists (i.e. Aldridge, 1996; Bargiel, 2004; Bunt, 1994, 2006; Croxson, 1999; Croxson & Rickson, 2002; Holck, 2004; Jonsdottir, 2002; Kennair, 2000; Oldfield, 1993, 1995, 1999; Pavlicevic, 1997; Rickson, 1995; Schögler, 1998; Schwaiblmair, 2005; and Wigram, et al., 2002).

Communication with another person is fundamental for human interaction. It is an important part of childhood development. It allows the person, in this case the child, to learn about themselves and others. (Aldridge, 1996; Greenspan & Wieder, 1998). To help us communicate effectively, the voice, body language, and facial expressions are integrated (Corke, 2002; Welch, 2005).

The voice is an important part of human identity (Welch, 2005). It can be described as '…one of our most personal and direct means of spontaneous communication of expression and relationship…' (Brown, 1999, p.186). Our body language tells our communication partner how we are feeling without any words spoken (Corke, 2002). Facial expressions are one of the basic elements of communication. By using our facial expressions in face-to-face interactions, communication can be encouraged. Exaggerating the animation in our facial expressions, varying the pitch of our voice and vocalising different sounds increases and encourages communication from the child. Music therapy practice emphasises the importance of reciprocation, rather than 'performing' when encouraging communication (Burrell, 2005).

2.4 <u>Action research</u>

2.4.1 Action research and music therapy

Action research has been used extensively in the disciplines of education and nursing. An increasing number of action research and music therapy papers have been published worldwide (e.g. Hunt, 2005; Nicol, 1998; Stige, 2002; Warner, 2007; Williams, 2006; Zanini, 2006).

In particular, Nicol (1998) described action research as '…an approach to research which is rich with possibilities for music therapy' (p.53). In her paper, *Valuing the practice of music therapy: Possibilities with action research*, she stated that practice is the key element to action research because of the cyclic nature of practice/action. Nicol said that as active music therapy clinicians, whether we are students, educators, or qualified therapists we all have questions about our own practice. Through action research we can find some answers to these questions. Nicol concluded that action research provided a path to which music therapists could communicate meaningfully with others about their practice.

Reflection and collaboration are important aspects of action research. Schön (1983) discussed the importance of reflection. He said that if one does not reflect on their own inquiry, '…he keeps his intuitive understandings tacit and is inattentive to the limits of his scope of reflective attention' (p.282). Nicol (1998) said that through collaboration with other professionals, there is, '…dialogue and continued stimulation of ideas' (p.59). It may help improve practice and research, strengthen professional relationships and help with accommodating difference. However, Nicol noted that music therapists can also struggle with collaboration because it is hard work and can bring feelings of being uncomfortable with other professionals.

2.4.2   *Action research and music therapy in New Zealand*

At present, Potter's (2007) unpublished Master's dissertation is the only action research and music therapy paper in New Zealand. Potter examined how she could improve her clinical practice when facilitating verbal interaction in a music therapy group of mainstream high school students with developmental delay. She discovered specific techniques, which helped her to improve expressive language and communication skills with the group she worked with. She highlighted the importance of using music, which relaxed and instilled confidence in individual clients, which led to increased verbal communication.

2.4.3   *Action research and music therapy in early intervention*

While there have been a small number of studies in New Zealand, in the area of music therapy in early intervention, there are no published papers which relate to action research. This paper is assumed to be the first study that uses this model of action research in this field.

2.5   <u>Summary</u>

In summary, the literature indicates trends about the practice of music therapy in early intervention. These include three main areas, with features for the therapist to consider. Firstly, the playful technique of the therapist. Features were: to be playful, spontaneous, and have fun in clinical work; and to exaggerate the voice, body language, and facial expressions. Secondly, working closely with the parents and the team. Features were: that the therapist needs to listen to parents; and to work closely with other professionals (in this case, a speech-language therapist because of the communication goals). Thirdly, entering into the child's world. Features were: to work in close proximity with the child ('en face'); to use toys to help establish rapport and

provide comfort in a new environment; to sing songs, and play musical instruments; and to create songs around the child's play, by using familiar melodies.

2.5.1   Reflections and my research question

My research question was: *How can I improve my music therapy practice with a preschool child with special needs over a seven week period?*

With reference to the Code of ethics for the practice of music therapy in New Zealand, (NZSMT, 2006), the music therapist will always act in the best interest of the client. This requirement was at the forefront of the research. I wanted to improve my practice in order to provide my clients with the best music therapy practice possible. The action research model of 'self-reflective spirals' provided this opportunity to critically reflect and analyse my work.

Bunt and Hoskyns (2002b) stated, '…to benefit from the experience students will need to be open, brave, reflective and questioning' (p.164). This is what I will endeavour to do through the research process. I hope that by the end of this process, I will have learnt skills that I can use when working in this field. I also hope that through the personal development, growth, and improvement of my work, my clients in this field will be the ones that will ultimately benefit from the knowledge I have gained.

3   Methodology and Materials

3.1   Action research methodology and procedure

3.1.1   Participants and recruitment

There were four participants involved in the research – one main participant, and three co-participants. My role in the research was that of the main participant and researcher. I was also the student music therapist who facilitated all six sessions. Co-participants were the child, the child's mother, and the SLT.

The criteria for the child co-participant were: (1) the child will be receiving other therapies from the CDT and will have been referred to the SLT recently, (2) the child will be under five years of age, and (3) the child will not have received music therapy before. The SLTs in the CDT were approached; however, there was no child that met the criteria in their caseloads so the visiting neurodevelopmental therapist (VDNT) was approached.

The VDNT had a family on her caseload that was the first to meet the criteria. She approached the family and asked them whether they were interested in being part of a study and receive music therapy intervention. The information sheet and consent forms (Appendices 1-3) were sent to the family. The child's father then rang me and I answered detailed questions about the study, and he shared background information about his child. The child co-participant therefore was from the VDNT's caseload.

The child 'Daniel' (pseudonym) was a co-participant. He is a three-year, three month old boy with global developmental delay[7]. He lives with his mother and father, and an older brother and sister. He has a few single words, and is able to walk by himself.

Daniel's mother was a co-participant. She gave feedback throughout the sessions. The SLT was also a co-participant who observed my work through an observation window. Feedback was then given after the first three sessions (cycles).

3.1.2   Ethical considerations

Pseudonyms are used for all participants, apart from the researcher. Therefore, 'Daniel' is the child participant. His mother is referred to as 'Daniel's mother'. The SLT (who was also my clinical liaison at the facility) was referred to as 'The SLT'. Daniel's SLT (who was not part of the CDT team) also observed through the observation window and gave feedback for one session (cycle 4). She was not considered as a co-participant as this was a one-off session so that she could see part of the music therapy process.

The research proposal was submitted to the Central Regional Ethics Health and Disability Committee. Their response was that ethical consent was not needed because I was the main participant. Even though I did not need to give consent, I felt that ethical consent was needed because of the co-participants. Two recommendations were made by the committee: (1) to store the data for ten years after the child participant had turned

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[7] Subsequently, a Magnetic Resonance Imaging (MRI) was undertaken after the research data was collected. It revealed that Daniel also has partial agenesis of the corpus callosum (see Glossary, p.114).

16 years old, and (2) for the researcher to give consideration as to how she will maintain anonymity of data given there is only one participant.
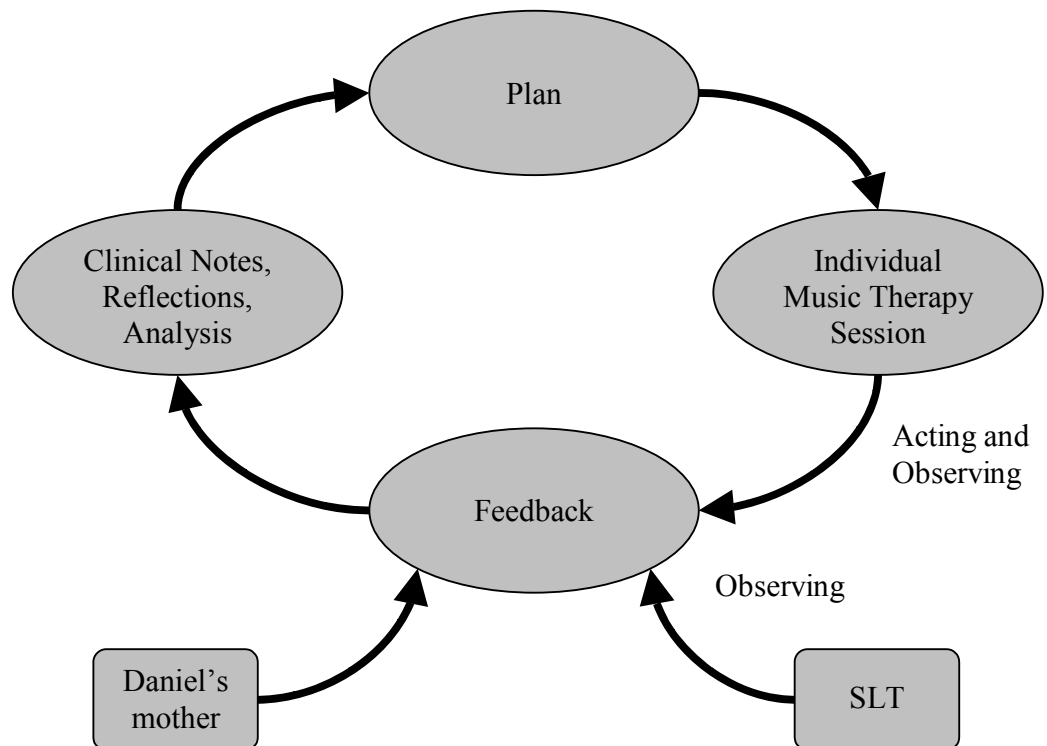
3.1.3   *Action research models*

Figure 1 illustrates a typical action research cyclic model of a self-reflective spiral as described in Chapter 1.3.3.
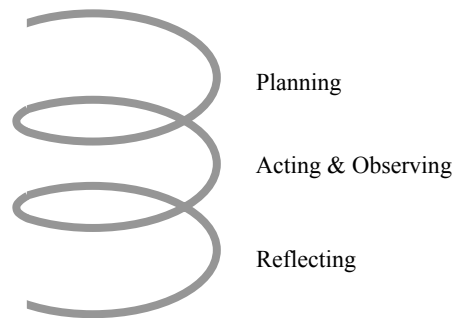
Figure 1: Typical action research model
(Kemmis & McTaggart, 2000, as cited in Koshy, 2005, p.4)

Figure 2 shows the adapted model used in this research.

Figure 2: Adapted action research model

3.1.4   Cycles

Seven action research cycles were planned. In reality, the third session was missed through Daniel's sickness. Each cycle was made up of the three processes – (1) the session was planned beforehand, taking into account the growing reflection and analysis, (2) the session was conducted in consideration of the plan, and (3) the session was reflected on and analysed. This process was carried out in a weekly cycle for seven cycles.

These processes continued for each session, all while I was developing my skills and ideas to improve my clinical work. I had supervision with my clinical liaison (SLT) about any clinical issues, and continued to talk generally with my visiting music therapist as part of my ongoing placement. I also had supervision with my research supervisor in which I discussed the research process of learning.

Apart from the first session, all sessions took place in a room with an observation window. The SLT gave feedback in the first, second and fourth sessions. She viewed the first session on video and the rest through the observation window. Daniel's mother participated and gave feedback in all sessions. After the sessions, I viewed the videoed sessions (apart from session four), wrote clinical notes, reflected and analysed, and planned the next session accordingly.

Additional information that occurred in a specific session is explained in the following subsections.

Introductory period – establishing rapport (sessions 1 – 2)

In session one, I used the ideas and values I had learnt in the music therapy approach in early intervention. This included knowledge from my background reading,

clinical work in early intervention undertaken in 2006, and background information about Daniel. That evening, a telephone call with Daniel's mother discussed the session further.

In session two, I worked on those values as I was establishing rapport. After the session, therapy goals were established for Daniel – taking into the account the feedback from Daniel's mother and the SLT, and my reflections.

Middle period – working on goals for Daniel and myself (sessions 3 – 5)

In session three, Daniel was sick. The plan was kept for the next session, and reflections were made.

In session four, Daniel's SLT also came and observed. After the session, both SLTs gave feedback and discussed music therapy, speech-language therapy, and the goals for Daniel. I then wrote my clinical notes, reflections, analysis, and the next plan, as the session had mistakenly not been videoed or audio recorded.

After session five, I wrote clinical notes and reflections. A few days later, I viewed the videoed session and made further notes, analysis and a plan.

Ending period (sessions 6 – 7)

At the beginning of session six, I explained to Daniel and his mother that the next session would be the last.

In session seven, I reminded Daniel and his mother that this would be the last session together. I wrote some clinical notes and reflections. A week later, I viewed the videoed session, and made further clinical notes and analysis.

3.2   <u>Data collection</u>

There were four methods of data collection. These included (1) video and audio recordings of each session; (2) separate feedback from the SLT and Daniel's mother (which focused on me specifically); (3) my personal journal – diary; and (4) my written clinical session notes. These methods formed the basis for the analysis and subsequent planning for each session in accordance with the nature of action research.

3.2.1   *Video camera recorder and specific music audio recorder*

These devices were used for the sole purpose of viewing sessions in order to make more detailed clinical notes. Then reflections and analysis of my work with the child were made, and a session plan was written accordingly. These sessions were viewed once through in their entirety. I then viewed the session again and paused in specific places and re-ran some activities in order to notate musical examples.

3.2.2   *Periodic feedback*

The SLT gave verbal and written feedback. The written feedback questions came from my *Master of Music Therapy Clinical Placement Manual (Casework and Research, 2007)*. In discussion with the SLT, these questions were deemed to be the most appropriate, beneficial, and thorough way to examine my clinical practice. Some questions were omitted, as they were not appropriate for her to comment on (Appendix 6). The SLT and I agreed that this form would be a good way to keep some regularity throughout the research process, as the purpose was to improve my clinical practice. The SLT gave feedback for the first three sessions only because I felt that I needed to develop her own ideas and the feedback had helped in developing these skills.

As mentioned above, Daniel's mother gave verbal feedback after the majority of sessions.

3.2.3   Journal – diary entries

Diary entries were made into a journal after each session. These included immediate reflections and subsequent reflections after viewing the sessions.

3.2.4   Detailed clinical notes and analysis

Clinical notes were written after each session. Further observations were written after viewing each videoed session. They were used in conjunction with my diary, and the feedback from the SLT and Daniel's mother, in order to analyse my work. This analysis formed the plan for the next session.

3.3   Materials

Speech-language therapy techniques were used in the music therapy sessions, as I had learnt some appropriate techniques from working with the SLT, throughout 2006. Sessions followed the typical clinical approach of music therapy in early intervention. These were (1) that a parent/caregiver was usually present in the therapy session. Therefore, Daniel's mother was involved in each session; (2) sessions were conducted either in the family home or at the rooms in the hospital facility. In this case, all sessions were conducted in the rooms at the facility; and (3) musical activities and instruments, and objects/toys were used.

3.3.1   Musical activities and instruments

These included (1) singing – familiar songs, lyric substitution, and improvised songs on Daniel's play, and (2) improvisations with percussion instruments. Those instruments offered were a small drum, tambourine, drum/tambourine, and shaker.

3.3.2   Objects/toys

These included two different coloured balls, Alphabet puzzle with pop-out spongy letters, an Old McDonald puzzle, Swiss ball, car, bus, rainmaker, coloured counting blocks and a parachute. Picture cards with these objects/toys and instruments on it were placed on a numbered schedule. Other cards included hello and goodbye gestures and a lamb (for *Mary had a little lamb*). A full-length standing mirror in the room was also used.

4 Results

Each cycle is described separately under the following headings (1) plan summary, (2) clinical notes summary (with the session durations noted in parentheses), and (3) research diary - reflections. Some cycles include additional material in the form of: (4) video reflections, (5) feedback from the SLT and Daniel's mother, and (6) research diary reflections after feedback. Throughout this section, different fonts are used to differentiate between the video and diary reflections, and the feedback. This is to make it easier for the reader to follow the 'different voices'.

The research diary entries, video reflections, and feedback are partial entries due to the word limit. Examples of a full entry of the video reflections, research diary reflections and feedback from the SLT are included in Appendices 7 – 9. Musical examples are included in Appendices 10 – 20.

Summaries of the clinical notes do not include all the activities due to the word limit. Therefore the most relevant activities related to the improvement of my clinical practice are described.

4.1 Cycle 1

4.1.1 Plan summary

- Begin with a *Hello song*. Assess Daniel's level of expressive, receptive, spontaneous, and social communication through song, vocal play, and playing musical instruments.

- Songs: Actions and visually related objects – mixture of familiar nursery songs[8] and own compositions: *Hello and Goodbye songs*, *Walking song*, (Appendices 10 – 13). Counting and colour songs – *Rainbow*, and *12345, Once I caught a fish alive*, were also included as Daniel's father advised that he would be responsive to these sorts of songs.

- Vocal play: Will he vocalise with me using sounds, (e.g. 'ba, da, and ma')?

- Musical instruments: (1) Will his responses increase in relation to a particular instrument/s? (2) Does he request them? (3) Can he participate in playing them and will he take turns through a structured song? (4) Can we improvise together and vocalise? (5) Does the use of any familiar children's songs (*Oh we can play on the big bass drum*) with substituted lyrics increase his participation?

4.1.2   Clinical notes summary (55 minutes)

Daniel was reluctant to come into the room. When he pointed to the car, I gave it to him and sang the *Hello song*. He passed the car to me and I passed it back, supported by musical sounds ("ready, steady, go… brum…and pass to Daniel, Mummy, or Catherine"). When I offered him the bus, he briefly looked at it, and then continued playing with the car. Then he picked up the car, crashed it in to the bus and we both vocalised (Appendix 14). In *Wheels on the bus*, he played with the people inside the bus and did not sing. He took my hand, pointed to the musical instruments and stacked them, as well as the coloured blocks. I sang the *Rainbow song*, using the lyrics that related to the colour blocks (red, yellow, green and blue). I also modelled how to play

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[8] *Twinkle, twinkle little star*; *Wheels on the bus*; *Old McDonald*; *Row, row, row, your boat*; and *If you're happy and you know it*.

the instruments. Daniel gave the tambourine to his mother and the three of us had a musical improvisation. This was followed by a brief drum and shaker improvisation with Daniel and me (Appendix 15). After a phone call interruption, another brief improvisation occurred. He then played with the rainmaker (an unfamiliar object for him). I made several attempts to engage with him through turning it upside down and making sounds ("weeee…turn turn turn…weeee"). He did not vocalise, nor give any eye contact. I introduced a *Walking song* to encourage interaction and movement. He whined, pulled his mother's dress, and held onto the rainmaker. I showed him the Old McDonald puzzle, and sang the song (accompanied by the guitar). He gave no eye contact. When I sang it again, without the guitar, he gave eye contact, smiled, verbalised some of the animals in the musical gaps, and made a 'duck' sound. I sang, played the guitar, and rolled a ball to him to encourage interaction – substituting the usual lyrics to *Roll the ball* in the *Row, row, row your boat* melody:

Roll the Ball (adaptation of Row, row, row your Boat)

Traditional.   Lyrics adapted C. Wilkinson, 2007

Names were also changed to include Mummy and Catherine. Then I put the guitar away and sang, as it was difficult to play and roll the ball simultaneously. He gave eye contact to both adults. He picked up the rainmaker, rolled it to me, and I sang, "*If you're happy and you know it turn the rainmaker*", (with the guitar, and then with my voice only). He did not join in the actions nor give eye contact. He moved towards the musical instruments and stacked them. When I said, "It is just about time to finish Daniel", he vocalised "aah ↑↓" and I said, "I'll bring them next time". In *Twinkle, twinkle little star*, he sat on his mother's lap, vocalised, smiled, gave eye contact, and said, "star" and "are" in the gaps. He vocalised in the *Goodbye song*, gave eye contact, and said, "bye ke" (which sounded like the beginning of my name) and pointed to the door.

4.1.3   Video reflections[9]

"Daniel didn't push me away…seemed fine with close proximity…rolled the rainmaker to me…initiating play?…should have extended with music…Daniel did not want to join in the Walking song…the way I introduced the activity?…When Daniel was stacking the instruments – I should have made up a song to connect with him and be involved with his play…Rolling the ball…Daniel seemed more attentive when I used my voice only."

4.1.4   Research diary – reflections[10]

"*I was a little anxious…I wonder if just my voice would be more beneficial? Is the guitar a barrier?…When I said, 'come and let's play', Daniel smiled and bought the*

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[9] See full entry as an example in Appendix 7.

[10] See full entry as an example in Appendix 8.

shaker to the space…It is really amazing watching your work on video and listening to it…Daniel initiated a game of passing the car to me, to which I thought well let's go with this…but is this music therapy?…good way to establish relationship…It was interesting that things I didn't plan, seem to have had just as much, or even more impact on the child than the planned activities."

4.1.5   *Feedback from the SLT[11] and Daniel's mother[12]*

SLT:

"Range of activities, gave lots of feedback but would be good to summarise key information…You allowed time for Daniel to respond and looked for non-verbal and verbal responses. Daniel was more engaged with animated facial expressions and face-to-face contact…Good increased engagement in car and instrumental activities. Continue to do this and think gestures and body position…Initially confident but at times appeared unsure. Sometimes unclear with Mum. Confident ↑↓ as confidence develops you can increase physical support…appropriate songs, music purposeful. Repetitive lyrics and strong tempo used – good for Daniel."

Daniel's mother:

"I enjoyed it and Daniel enjoyed it – he had a good experience. You did form a good relationship with him. It's hard to read Daniel so don't feel bad that you don't pick up all his cues – don't know what he's thinking sometimes. He enjoys songs like *Mary had a little lamb, twinkle, row, row* – something with a good strong beat 4/4. His brother plays the guitar. He likes a strong melody. He was cheerful after the session when we met a friend. Likes Maisy. Want to work on communication skills – so he can talk to other people and request. Giving pauses for responses – turn-taking and waiting."

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[11] See full entry as an example in Appendix 9.

[12] As it is short, the full entry is presented here.

4.1.6   Research diary reflections after feedback

"*Was the session too long? (55 minutes)…discuss with Daniel's SLT's about his*
goals…Mum's comment: "Daniel gets sung to a lot?"…similar plan for 21/2/07 but
make some changes…picture symbols?…short and long term goals for Daniel?"

4.2   <u>Cycle 2</u>

4.2.1   Plan summary

- Have fun and discuss the activities with Daniel's mother.

- Use the guitar for the *Hello and Goodbye songs* and if he requests it.

- Sing familiar and composed songs. *Wheels on the bus* – few verses and include
  his name to encourage more participation.

- *Roll the ball song* – slower, repetitive, and bounce ball for variety. Roll and
  shake the ball on the parachute to extend activity. Musical instruments –
  improvise and sing appropriate lyrics to facilitate turn-taking, and include
  vocalisations.

- Try *Walking song* again when it feels appropriate. Movement songs – any that
  he particularly enjoys – Hi5 and Wiggles?

- Introduce picture cards – choice making.

- Observe his (a) meaningful non-verbal communication (turn-taking, eye contact,
  and joint attention) and (b) meaningful verbal communication (request with
  words, 1-2 word phrases).

4.2.2   Clinical notes summary (35 minutes)

Initially I said, "Shall we sing?" Then I said, "Let's sing", as Daniel said, "No".

I waved and sang *Hello*. When he chose the ball (from the bag), we rolled it and sang,

Roll the ball. Then he threw it to me and said, "ke" (for 'catch'). After I suggested

playing the instruments, he shook the shaker once, passed the tambourine to his mother,

and then the drum to me. Almost immediately, he took the instruments from us, stacked

them. I tried to play the drum as he did this. A drum/shaker improvisation followed

(Appendix 16). Then there was another musical improvisation with the

drum/tambourine (Appendix 17). When we had finished with the instruments, Daniel

explored the bag, and pulled out the car. I made sounds and sang about the "*Wheels on

the car*". After a brief pause, he vocalised. I tried to extend his play by using the guitar

and my voice. He said, "No" loudly. He strummed the guitar once and I sang, *Twinkle,

twinkle little star* to keep his attention. He was attentive for the first two phrases and

then said, "No, Mum" (the session had been in duration for 31 minutes). I showed him

the 'wheels' and 'star' picture cards (with relation to the songs). I pointed at the cards

asking, "Which one?" Daniel said, "No". I sang, *Mary had a little lamb*, (as Mum had

just said that he liked the song). He said, "No", then saw the letter 'A' on the mat and

said, "A". I rolled the car to him and sang as we sat in a triangular shaped formation.

After one phrase, he got up, and walked in circles towards the door. I tried the *Walking

song* as he was mobile but Daniel said, "No". Then we sang the *Goodbye song*.

4.2.3   Video reflections

"Model hand-over-hand for actions…Verbal phrases of praise…Be more direct and "let's play"…sing straight away with music to keep attention...When it appears that Daniel's concentration has finished put the activity away…When I don't understand Daniel's language, ask Mum…*Walking song* – wasn't strong enough with my beat. I didn't try and take his hand to encourage him to join me…Start the *Goodbye song* straight away…Sit in a triangular formation for turn-taking activities…Daniel saw 'A' on the mat – should have sung the *Alphabet song*…may have increased his attention?…Pictures – how can I use these more effectively?"

4.2.4   Research diary – reflections

"*I find it difficult to convey my thoughts with verbal communication…TRUST IN THE MUSIC! Need to be more directive…I struggle with (this)…I find it difficult to think about verbal 1-2 word phrases and use them…trying to balance music and verbal …Daniel seemed to lose interest after 30 minutes…Thirty minutes of hard work will be more beneficial than 45 minutes of unfocused work…At the top of my plan…have fun; explain to Mum as you go…Ball activity and improvisations went well – kept Daniel's attention…he is now comfortable with me and I feel more comfortable with him.*"

4.2.5   Feedback from the SLT and Daniel's mother

SLT:

"Feedback to parent is very important – try and talk about it as activities are happening…Be careful with interpretation of Daniel's responses – not sure he was always indicating "no"…Ball – could have changed lyrics to sing about clients' actions (e.g. "Daniel rolls that ball away and it hits the wall")…More verbal commenting needed (1-2 words phrases repeated) of client's actions…Good use of facial expression.

Increased eye contact at Daniel's level…Mum initially appeared anxious – may have helped to run through today's session plan and what wanted Mum to do (e.g. join in play with Daniel) to put Mum at ease…↑ confidence noted. Sometimes hesitant when introducing new activity. Need to initiate more when client interested in an activity…Good to close/move toys away and leave 1 or 2 out. ↑client's attention and focus noted…Use words such as "one more time". Perhaps waited too long sometimes as lost client's interest and made you appear unconfident. Client directed close of activities mainly…Good music – try 'upping' enthusiasm, volume, variation worked well, good that you used guitar less today as you could join in play with Daniel, guide actions…Limit pictures to two at a time – Object: point to object. Song: sing first phrase when offering choice."

Daniel's mother:

"Daniel enjoyed it – he's getting used to you now."

4.3   Cycle 3

Daniel was sick therefore the session was cancelled.

4.3.1   *Research diary – reflections*

"*I was disappointed that the session was cancelled because of the action research process of examining my practice, week-by-week. However, I was more concerned that Daniel was sick and I hoped that he would get better soon. I will keep my planning, reflections and analysis for next week.*"

4.4   <u>Cycle 4 (Daniel's SLT also observed the session)</u>

4.4.1   *Plan summary*

- Activities – *Hello song*, ball, bus, car, alphabet, pictures (modify effectiveness), instruments (more improvisations, extend play), bag (zip up when finished activity), choices (two only), parachute (encourage Daniel to try it), familiar songs, and *Goodbye song*.

- Keep his mother involved in the activities.

- More praise of his verbalisations is needed.

- Keep him focused by relating to his play through the music.

- Try less guitar, have more musical variation – especially tempo and rhythm, a strong and confident voice and be more playful. These all seem to engage and hold his attention.

- Use meaningful language, give a warning near the end of an activity, and be close in proximity to Daniel (my face and hands). Individual Plan (IP) stated – he loves ABC, counting and good rhythmic songs.

- The principal music therapy goal is to develop Daniel's communication skills. The subsidiary goals are: (1) to engage Daniel, and extend his joint attention through play, (2) to engage in turn-taking, (3) to encourage non-verbal and verbal communication, and (4) make choices.

4.4.2   *Clinical notes summary (45 minutes)*

Daniel cried and whined on arrival. I discussed with his mother that he may not always mean 'no'. It could mean, 'don't rush me…or not now'. He played with the car

that I gave him while I sang *Hello song*. He looked and played with the picture cards briefly and then walked away. I directed him and his mother to sit in a triangular formation. When we rolled the car and sang I changed the tempo, which seemed to hold his attention. Through the *Alphabet song*, Daniel gave eye contact, smiled and laughed. In *Wheels on the bus*, I changed the lyrics, which related to Daniel's play:

Wheels on the Bus (adaptation)

Daniel smiled and gave eye contact. When I played different rhythms with the people on the mat and sang about them, Daniel imitated some vocalisations and numbered the people. Through the *Goodbye song*, Daniel whined.

4.4.3   Research diary

"*It was difficult getting back into focus because of a week's break…flustered when Daniel's SLT turned up…didn't have time to get worried about it…expect the unexpected!…When Daniel initiates an activity or if I say, "let's do this" then I need to start it straight away with music…Daniel seemed interested in the picture cards so how do I use them constructively?…Why was Daniel so attentive (eye contact, smiling, laughing 4x through) in the Alphabet song?…At his level, sung slowly once through,*

then subsequent times with 'gaps' for joining in and gentle calm voice…When closer

proximity – Daniel would respond with more joint attention. Therefore, CLOSER =

joint attention, smiling, eye contact, vocalising – seem to all increase…I was more

directive with Daniel's mother about sitting in a triangle to invite more turn-taking and

interaction…Joint attention as a goal – How do I help him in the therapy sessions? (1)

Get at his level – eye contact↑, vocalising ↑, verbal words ↑ (2) Use voice only rather

than guitar (3) Improvise on what Daniel is doing at the time – using familiar melodies

and steady rhythms through my singing voice (4) Make sure Daniel's mother is in an

appropriate position for Daniel to give her feedback…improvising around activities is

improving and trying to practice – actions, using objects and making up songs."

4.4.4   Feedback from the SLT and Daniel's mother

SLT:

"Be more specific and objective with goals and link to activities…Watch for
communication intent of child…Use more animated facial expressions when
introducing activities. Expectant facial expressions when pausing for client's
response...Experiment with proximity and physical guidance…Attempted to talk to Mum
more...Sometimes confident…No obvious structure to session…Very much child
directed activities…Explore ways to extend child's play to ↑ joint attention…Try 'up
tempo' songs – Daniel to use his gross motor skills."

Daniel's Mother:

"I will use 'finish' sign at home…Good session – Daniel was more interactive."

4.4.5   Research diary reflections after feedback

"Some joint attention but then he played with the object and fixated. Try singing

to see what he would do and if no response then finish activity with 'one more time and

then we'll finish'...Start music with confidence, be more directive not passive...Keep in mind 1-2-3 word phrases when singing songs...don't focus on it too much as it is not a therapy goal for Daniel."

4.5   <u>Cycle 5</u>

4.5.1   *Plan summary*

- Activities – *Upbeat hello song*, ball, *Alphabet song* (sing through once, and repeat using extension of language and objects as advised by SLTs), familiar songs, car, *Goodbye song*, and less guitar.

- Explain to his mother the purpose of the pictures. Be at his level – clear, strong, confident voice. Clear warnings of activity endings.

4.5.2   *Clinical notes summary (40 minutes)*

Daniel cried when I sang the *Upbeat Hello song* (Appendix 11). I then put the guitar away, and went back to the original *Hello song*. I used a gentle voice, waved at him and his mother. I included his mother in the *Hello song*, and then she sang hello to me (modelling waving). He gave brief eye contact in the *Alphabet song* (slow tempo, rhythmic and quiet voice). The second time through (louder voice), his eye contact increased, he occasionally vocalised, and sang some of the letters. When I offered the cards to him to put beside their corresponding number on the schedule, he seemed confused and looked in the bag. He picked up the car and said, "car, car" to which I imitated back. I did not try and shape this immediately with music and he lost interest. He played with the car and gave no joint attention (I was sitting opposite him). When playing with the bus, I joined in and sang (Appendix 18). Then Daniel picked the drum up off the floor, put it on its side, rolled it to me, and then to his mother. We had good joint attention for two minutes. We sat in a triangular formation and he gave eye contact

as he rolled the drum while we sang, *Roll the drum* (instead of *Roll the ball* as previously described). He played two steady crotchet beats on the drum, lay on the floor briefly and said, "tir(ed)". He stood up, put the drum away, and looked at the star picture. I sang, *Twinkle, twinkle little star* without the guitar, and modelled the actions. He smiled, vocalised, filled in "are" at the end, and gave good joint attention for 30 seconds. We finished with the *Goodbye song*, and Daniel said, "bye" during the song.

4.5.3   Video reflections

"Hello song – too boisterous?…Picture cards – Daniel seemed interested but confused…When Daniel makes any communicative response…extend it and get involved in his play…Don't ask long worded questions…Praise more when Daniel communicates…Daniel responded to the lamb song – did the picture help?"

4.5.4   Research diary – reflections

"Took guitar away, too dominant?…Quieter hello song…I can understand when SLT says that I match Daniel's passive mood – I try and do that sometimes but he needs active arousal too…established a relationship and could push him now…encourage him to be (physically) active for some of the session…As SLT pointed out – should be looking at quality not quantity of the interactions and how I can increase this quality…Got video and music recording – it is difficult…different hats on all at once…"

4.5.5   Feedback from Daniel's mother

"Good activities on the cards, they were good." (I told her where I found the images.)

4.6 Cycle 6

4.6.1 Plan summary

- Activities planned – original *Hello song*, and *Goodbye song* (voice only, no guitar). *Alphabet song* (relate to functional communication in Daniel's daily routine, joint attention, objects – a *apple*, b *bus*, and c *car*), ball, car or bus activity (two choices only), Swiss ball (encourage active movement), instruments (improvisations), familiar songs (mirror to encourage actions – *Twinkle*, tap rhythms with people on the bus – *Wheels*), picture schedule, leave out Old McDonald puzzle.

- Clear warning and ending of activities.

- Increase energy level through the session (quiet then more active, then quiet to end) – initiate the change. Close proximity needed.

- Positive communication – re cards, vocabulary selection – learn phrases, be more directive.

- Prepare for closure – next session.

4.6.2   Clinical notes summary (38 minutes)

I explained the cards to Daniel and his mother when the session began. In the *Hello song*, I waved and he sat on his mother's knee and smiled. Then his mother sang hello and waved. In the *Alphabet song*, he gave good joint attention by filling in some of the letters in the gaps and looking at the objects related to the letter. We *rolled the ball* and sang (as described previously), after I directed Daniel and his mother to sit in a triangular formation. His mother threw the ball for variety. He then had good joint attention for 90 seconds. He watched, smiled, and giggled as his mother and myself bounced on the Swiss ball. He protested when offered a turn, even when his mother said that she would hold him. I sat on the ball and bounced instead singing – *Bouncing on the ball* substituting the lyrics to *Row, row your boat* melody (as described previously). Daniel then jumped with his mother for two seconds, and then walked away. I tried to extend this with the *Walking song*. He protested as he walked in a circle with his mother. He then sat down and rolled the ball to me. I then rolled the ball to his mother. He was attentive for 45 seconds and filled in the gap of "Mummy" when I sang, "*roll, the ball to*?" I then took his hand and sang, *Row, row your boat* but he pulled away. His mother 'rowed' with him instead. He gave no eye contact. When I got the car out of the bag, I made "brum" sounds. He smiled. He played with the car but gave no eye contact. I warned him that the activity would finish and he followed me to the picture schedule. After 31 minutes, he yawned. We played the drum briefly before I sang, *Twinkle*. He vocalised parts of the melody. I 'twinkled' my hands in front of the mirror. He looked in the mirror and yawned in the gap for 'are'. He twinkled his hands by his side with physical support from his mother. He waved and gave eye contact in the *Goodbye song*. It was reiterated that the final session would be next week.

4.6.3   Video reflections

"Could be closer in proximity to Daniel… tolerated movement activities…did not vocalise or show enjoyment. Challenging for him: gross motor skills?…Should I have had a 'closure' card or something to represent this?…Was more directive with beginning, ending and throughout the activities…Conveyed my thoughts to Daniel's mother more, which I think helped…Daniel was responsive to the cards."

4.6.4   Research diary – reflections

"*No guitar – took away stress and I could focus more…letting Daniel put the cards away – his turn, kept focus and more involved…seemed more joint attention…I'm more confident…giving time to play but keeping quality of joint attention…enjoyed session and felt more comfortable. Why? Had fun, let things flow, and trusted in music and my abilities…more interaction with Mum…better session overall.*"

4.6.5   Feedback from Daniel's mother

"That was a good session."

4.7   Cycle 7

4.7.1   Plan summary

- Quiet – loud – quiet session. Have fun.

- Set activities on schedule.

- Guitar will not be used.

- Bounce on the Swiss ball (encourage Daniel to participate in active movement).

- *Walking song* (include or improvise on walking).

- Acknowledge that this will be our final session. *Goodbye song* (change lyrics – "thanks for the music Daniel").

4.7.2   Clinical notes summary (50 minutes)

When Daniel entered the room, he headed towards the picture schedule, made "ttt" sounds, smiled, and followed my finger as I pointed to the pictures. He gave eye contact and said, "Okay". He sat in a triangular formation for the *Hello song*, without verbal or physical prompting. He gave eye contact, smiled and vocalised afterwards with a high pitch "da" (six times). I imitated this, and then sang hello to Mummy and waved. She sang hello to me and waved. In the *Alphabet song*, he filled in the 'letter gaps' when I pointed to the letters. He gave occasional eye contact, and pointed to the objects. When the activity finished, he walked over to the schedule, took the card off and put it in the bag. When he played the tambourine and I played the shaker, he gave no eye contact. I swapped instruments with him and sang a song (Appendix 19). He gave eye contact and played the shaker occasionally as I sang. He stopped playing with physical prompting. When his mother and I both stopped playing, so did he. Daniel briefly vocalised, which I tried to extend with imitation. He did not respond and put the instruments in the bag. In the *Walking song*, I changed the lyrics to "run, run…jump, jump", then adapted it to:

Daniel is Walking

Daniel did not respond. When I bounced the ball twice, he ran to stand opposite me. He smiled and stretched out his arms. Then he threw the ball to me and I passed it to his mother as we were standing in a triangular formation. We vocalised throughout:

Aaahhh Manuscript

Then we sang, *Wheels on the bus* with variations (Appendix 20). Daniel looked at the next activity on the schedule and said, "Star". I used the mirror to encourage him to look in it and see himself doing the actions to, *Twinkle, twinkle little star*. He did not do the actions. Instead he vocalised, filled in the gap – "sky", smiled, walked around and then sat on his mother's knee. He waved and said, "bye, bye" in the *Goodbye song*. After he put the goodbye card in the bag he said, "bye, bye, bye" and headed for the door.

4.7.3   Video reflections

"I was at his level and kept the music flowing…Daniel did some lovely talking and gave joint attention in the *bus song* – pitch matching and filling in the gaps…I was making rhythms with my hands and fingers on the mat and with the objects too. Improvising on the spot – spontaneous – more responsive from Daniel. Using variations of familiar melody and improvising rhythms worked well."

4.7.4   Research diary – reflections

"I felt more directive…trusted in the music…initially feeling a little sad and anxious before the session started because it was closure…just have fun and enjoy it – give Daniel and Mum another positive experience…I increased my facial expressions, was in close proximity and at his level which helped, (and) singing about what Daniel was doing…Less afraid to do 'crazy' things…Go on my intuition because more often than not it works…Confidence was up and therefore Daniel seemed to be more engaging…Mum gave positive feedback about the sessions…Felt more comfortable with lying on the floor…felt happy and relaxed after the session…Felt that I was just starting to make progress (with Daniel) and then had to end…my confidence had increased (which) seemed to help Daniel and his Mum…talking, using cards, directive."

4.7.5   Feedback from Daniel's mother

"It's been great hasn't it Daniel? It was really nice, great thank you. He certainly got increasingly engaged in activities." Mum felt that Daniel enjoyed the experience and seemed more comfortable as sessions progressed – "He was also used to the environment".

4.8 <u>Results tables</u>

Two tables were created from the results described above. The first table describes the cyclical process of musical activities and objects used in therapy. Songs are listed first, then objects[13]. The second table describes the cyclical process of each therapeutic concept that arose in therapy. My feelings are described first, then other concepts. These tables show which ideas I kept, modified and/or did not use again throughout the cyclical process. When N/A is used – this means that (1) this activity did not occur, or (2) that the technique was not commented on in that particular cycle.

The main points relating directly to the research aim of improving my practice will have an asterisk (*) beside them to show what will be discussed further in the discussion. The reader may find it easier to find the asterisk on the table when referring to it in the discussion.

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[13] This includes anything that is tangible – musical instruments and toys are included.

Table 1: Musical activities and objects used

ACTIVITIES and OBJECTS	CYCLE 1	CYCLE 2	CYCLE 3	CYCLE 4	CYCLE 5	CYCLE 6	CYCLE 7
*1. Hello song	1. Quiet voice, and guitar	1. Quiet voice, and guitar		1. Quiet voice, and guitar	1. Upbeat, louder voice and guitar	1. Quiet voice, and no guitar	1. Quiet voice, and no guitar
*2. Wheels on the bus	2. Vocalisations, play, and sang the song	2. Few verses only, and include Daniel's name		2. Lyrics more related to Daniel's play	2. Lyrics more related to Daniel's play	2. Not used	2. Lyrics more related to Daniel's play
*3. Twinkle, twinkle little star	3. Song, actions, and guitar	3. Song, actions, and guitar		3. Not used	3. Voice only, actions, and left gaps	3. Voice only, actions, left gaps and mirror	3. Voice only, actions, left gaps and mirror
4. Walking song	4. Sang first few phrases with guitar	4. Tried again when Daniel stood		4. Not used	4. Not used	4. Sang when Daniel stood	4. Adapted lyrics to Daniel's movements
5. Row, row your boat	5. Not used	5. Planned, but not used		5. Not used	5. Not used	5. Sang song, took Daniel's hand	5. Not used
*6. Alphabet song	6. Not used	6. Not used		6. Sang, and left gaps to join in – natural phrase endings	6. Sang once without break, then with gaps, and related to a few objects	6. Sang once without breaks for the words, then with gaps, and related to a few objects	6. Sang once without breaks for the words, then with gaps, and related to a few objects
7. Old McDonald	7. Song, guitar, and left musical gaps	7. Not used		7. Not used	7. Sang, and showed picture card of lamb	7. Not used	7. Not used
8. If you're happy and you know it	8. Guitar, then voice only, and actions	8. Not used		8. Not used	8. Not used	8. Not used	8. Not used
*9. Goodbye song	9. Quiet voice, and guitar	9. Quiet voice, and guitar	Daniel sick	9. Quiet voice, and guitar	9. Quiet voice, and guitar	9. Quiet voice, and no guitar	9. Quiet voice, no guitar, and changed the lyrics, as it was the final session
10. Musical instruments	10. Rainbow song, 2x improvisations	10. Improvised, and lyrics to facilitate turn-taking		10. Improvised, and lyrics to facilitate turn-taking	10. Improvised, and lyrics to facilitate turn-taking	10. Improvised with drum briefly	10. Improvised, and lyrics to facilitate turn-taking
*11. Ball	11. Guitar, and roll the ball song	11. Roll the ball song – slower tempo, repetitive, and bounced the ball.		11. Roll the ball – varied tempo and rhythm, repetitive, and bounced the ball	11. Not used	11. Roll the ball – varied tempo and rhythm, repetitive, and bounced the ball	11. Bounced and threw the ball – variety in pitch, tempo, and rhythm
*12. Car	12. Vocalisations, and turn-taking	12. Sounds, 'wheels on the car song', and play		12. Roll the car song – tempi changes	12. Related music to play	12. Related music to play	12. Related music to play
13. Parachute	13. Introduced – had not experienced it before	13. Tried to roll ball on top of it to extend activity		13. Tried introducing again	13. Not used	13. Not used	13. Not used
14. Rainmaker	14. Sounds and play	14. Not used		14. Not used	14. Not used	14. Not used	14. Not used
15. Swiss Ball	15. Not used	15. Not used		15. Not used	15. Not used	15. Introduced – bounced and sang	15. Not used
*16. Picture cards	16. Not used	16. Introduce cards without schedule		16. Re-introduced cards – showing numbered schedule	16. Schedule with cards to put on when finished	16. Schedule with cards to take off when finished	16. Schedule with cards to take off when finished

Table 2: Therapeutic concepts

CONCEPTS	CYCLE 1	CYCLE 2	CYCLE 3	CYCLE 4	CYCLE 5	CYCLE 6	CYCLE 7
*1. Being anxious	1. Anxious	1. Not anxious		1. Heightened as SLTs observing	1. N/A	1. Comfortable	1. Tinge of – closure issues
*2. Being directive	2. Partly directive	2. Partly directive – but corrected myself, and was more aware		2. More directive	2. Directive	2. Directive	2. Directive – felt comfortable
*3. Being playful and having fun	3. Sometimes but needed to increase	3. Written at the top of plan – sometimes		3. N/A	3. Increased	3. Fun, less stress, and gave time to be playful	3. Less self-conscious about being playful. Fun, happy, and relaxed
*4. Being spontaneous	4. N/A	4. Sometimes – changed lyrics to relate to Daniel's play		4. More related to Daniel's play	4. Related to Daniel's play – more natural	4. All participants were spontaneous	4. Natural, not conscientiously thought about it
*5. Feeling confident	5. Most of the time	5. Up		5. Most of the time	5. N/A	5. Entire time	5. Entire time
*6. Enjoying sessions	6. Sometimes	6. N/A		6. N/A	6. Whole time	6. Whole time	6. Whole time
*7. Use of facial expressions	7. Okay – Daniel was more responsive with increased animation	7. Okay – increased eye contact at Daniel's physical level		7. More animation was needed	7. N/A	7. N/A	7. Less self-conscious
8. Waiting for the client's responses	8. Good waiting for both verbal and non-verbal	8. Good, but waited too long sometimes so Daniel lost interest		8. N/A	8. N/A	8. N/A	8. N/A
*9. Proximity with the child	9. Near Daniel, consider gestures and body position for increasing engagement and interactions	9. Close – at Daniel's physical level		9. Could be closer and needed to use physical guidance	9. Close to Daniel – particularly my face	9. Close – but needed to be closer	9. Very close – face and hands
10. Age appropriate activities for the child	10. Range of appropriate and purposeful music	10. Variety good, needed to 'up' enthusiasm in music		10. Tried 'up tempo' songs	10. N/A	10. N/A	10. N/A
*11. Positioning of the participants in sessions	11. N/A	11. Triangular formation: encouraged turn-taking		11. Triangular formation was appropriate	11. Triangular formation	11. Triangular formation	11. Felt more comfortable lying on the floor
*12. Using professional language with a parent	12. Lots of feedback given – but sometimes unclear	12. Feedback important but had difficulties in articulating responses		12. Attempted to improve language	12. N/A	12. Felt more comfortable – especially when I had explained cards	12. Felt comfortable talking to Daniel's mother
13. Balancing music and verbal communication	13. N/A	13. Was difficult		13. Attempted – but not main focus	13. N/A	13. N/A	13. Felt more natural
*14. Use of the voice	14. Daniel attentive	14. Increased volume and Daniel more attentive		14. Increased variety	14. Increased variety	14. Used only – focused more	14. Used only
*15. Use of the guitar	15. Wondered if this was a barrier?	15. Limited use so I could join in more with Daniel's play. Only used for hello and goodbye, other songs and if Daniel requested		15. Limited use, hello and goodbye songs only	15. Limited use, hello and goodbye songs only	15. Not used – felt freer	15. Not used – felt freer

(CYCLE 3 column: Daniel sick)

5 Discussion

My research question was: *How can I improve my music therapy practice with a preschool child with special needs over a seven week period?* In this section I will focus primarily on me with reference to my co-participants, especially Daniel, as his responses influenced the way I changed and refined my practice. As mentioned in the *Code of ethics* (2006), our responsibility as therapists is to have our clients' best interest at heart. This discussion will examine the development of my work through my interactions with Daniel. Ideas will be discussed in conjunction with the four areas described in the literature review. The asterisk ideas from the two tables will be discussed under the area of action research as they relate to the cyclic process.

5.1 Aspects of music therapy practice

5.1.1 Good Practice

As the research is focused on the improvement of my clinical practice, it was vital to consider 'what is good practice'. Dileo's (2000) thoughts on core values reminded me that although I was caring, empathetic, and had some prudence, I lacked courage.

In this profession we can help our clients, only if we have courage and confidence in ourselves. The issue of self-awareness was highlighted throughout my research. Throughout each cycle (as well as the process as a whole), the use of my clinical notes, video observations, and feedback from other participants was helpful for my critical reflections. I felt that constantly reflecting on my practice helped me to begin to understand myself better. I now know those aspects of myself that I need to nurture in relation to my work – especially confidence.

5.1.2 *Development of Skills*

Having the ability to change, grow, and develop with my clients has been a struggle at times. Wheeler's et al., (2005) discussed two key ideas important to the profession – the development of (1) verbal therapy skills and music skills, and (2) supervision, self-reflection and personal therapy. These ideas were valuable in terms of my critical thinking in improving my practice.

I became aware that I was not speaking with Daniel's mother in an appropriate and professional manner. I needed to make clear what I was thinking about, in regard to the activities in the sessions, and what would benefit Daniel. I also needed to consider her ideas and concerns, and be supportive. Working on good listening skills and empathy (Jonsdottir, 2002), helped to build a relationship with his mother and I felt more confident as cycles progressed. I would practise voicing my thoughts at home, as the SLT suggested. This led me to speak with more confidence and assertiveness.

Expressing my ideas to the parents in an appropriate manner was challenging. This is due to the fact that I am a young person and not a parent myself. I found that practising at home (as the SLT suggested) was helpful. As parents look to you as the professional for reassurance and guidance, they need to have confidence in the service you are providing.

In order to help develop Daniel's communication skills (joint attention and turn-taking), my musical skills needed constant refining. I had to continually be spontaneous, and improvise around his play. Daniel's responses made me reflect constantly on the use of my singing voice and guitar simultaneously. In the songs I mainly refined the tempo, volume and rhythm with my voice (*Alphabet song* and *Roll the ball song*). Using my voice as an instrument with variety helped me engage with him, which developed

into fun, playful and enjoyable experiences (Appendices 10-20). The main refinement was using music and play together. Singing about Daniel's play allowed for joint attention and turn-taking (Hibben, 1992; Kern, 2005). This is particularly evident in *Wheels on the bus* (Appendices 18 and 20).

Supervision, self-reflection and personal therapy were essential to my growth as a therapist. Dileo (2001) also mentions the importance of supervision. Throughout the research I had supervision from my visiting music therapist about general issues relating to my practice. I also had supervision from my research supervisor in which we discussed important aspects of critical thinking and reflection in the process of improving clinical practice. This supervision was a necessary and important part of the action research process. It helped me come to the realisation that when I observed my practice, I was only touching the surface. There were many more layers to my practice that needed to be addressed. This realisation will help me in my future practice.

As mentioned by Bunt and Hoskyns (2002b) and Wigram, et al., (2002), self-reflection is important to the development of the therapist. I realised that before this research began, I had not been as reflective as I should have been. My diary was a valuable source, because it allowed me to be more critically reflective on specific clinical issues – especially those techniques that were effective when working with Daniel and his mother. Through reflection I closely examined and critiqued (1) why certain things happened in the sessions, (2) why I reacted in a certain way, and (3) how could I change those things in order to refine and improve my practice. Examining my weaknesses was necessary, as it made me challenge myself into facing my fears. It led me to feel more confident as a student music therapist. I will definitely keep a diary for future reflections.

In training, I had peer supervision. We reflected on clinical issues and participated in musical improvisations – we were either the 'clients' or the 'therapist'. I have not experienced personal individual therapy with a music therapist. This will be the next part of my journey, when I have finished training.

Coulson's (2006) caution to 'be close but don't intrude' was an important reminder. I did not want to intrude on Daniel's space, so I sat near him, initially. However, after feedback from the SLT (another reflection of Coulson), and Daniel's mother, I realised that in order to engage him more, I needed to be closer. Over the cycles, I moved even closer to him, almost 'en face' (Bunt, 1994). Daniel seemed to be far more engaged because he gave eye contact, smiled, laughed, occasionally vocalised and filled in the word gaps.

In relation to professional development and gaining confidence in my abilities, I had to take risks with my own therapeutic ideas and believe in myself (Brown, 1999). Through this action research process I was able to examine those skills I already possessed and work towards improving them, as well as developing new skills. Watching the sessions on video was scary, initially. This was because I was anxious at seeing all my mistakes. However, as I saw aspects of my clinical practice that I felt worked well, I had the confidence to take risks and try and improve on other aspects.

I also noticed from watching the video sessions and reading my clinical notes that my observational skills were not as good as I had originally thought (an idea highlighted by Hoskyns, 2002). After viewing the video of Cycle 1, I became aware that I had missed subtle communication attempts by Daniel (through his body language and facial expressions). From this I planned to focus on Daniel's communication attempts more so that I could reduce those number of attempts that I had missed. The process of

watching myself on video definitely honed my observational skills. In turn it helped to be more reflective about my practice.

5.1.3   Value of feedback given from the SLT

I found the SLT's feedback about Daniel's communication skills extremely helpful. In particular, (1) using only basic 1-2-3 word phrases, (2) how to constructively use the picture card schedule, and (3) how to begin and end activities. Other advice in relation to working in this field included sitting very close to Daniel, being more playful, and using more exaggerated facial expressions! This feedback meant that I had a better understanding of Daniel's communication abilities and I refined my practice accordingly. This supports the ideas by Aldridge, (1996), Cassidy, (1992 as cited in Peters, 2000), Kennelly, et al., (2001), and Peters, (2000).

Learning from other professionals' experiences is valuable. As Twyford, et al., (2005) noted, having other therapists' input helped me to see Daniel from all points of view (an integrated approach to therapy).

This advice helped me to develop my 'internal supervisor'. I now feel that I have the ability to reflect and change without as much external support.

5.1.4   Value of feedback given from the Daniel's mother

It was valuable to receive feedback from Daniel's mother because she best understood Daniel and I was able to learn many things about him that I would not have known otherwise (Kern, 2005).

In cycle 1, Daniel's mother said she had enjoyed the sessions, and felt Daniel had too. In relation to music, she said that he was "sung to a lot", and liked familiar songs, a good strong musical beat (4/4), and a strong melody. He often watched DVDs,

and in group situations would watch others, and not join in the song actions. This information was significant when working with him. This is where having good listening skills when working with children and their families is a significant part of early intervention (Aldridge, 1996; Hoskyns, 2002; Jonsdottir, 2002; Kern, 2005; Oldfield, 1999; Rickson, 1995).

Through listening to Daniel's mother and taking on her feedback, I consciously tried to get Daniel actively participating as much as possible in therapy so that, (a) he had a part to play in the singing, and (b) he would begin to further develop his communication skills of joint attention and turn-taking.

Daniel's mother felt that as each session progressed, Daniel became used to the environment and therefore felt comfortable. In cycle 4, she said that she would use the Makaton sign of 'finish' at home.

In cycle 7, Daniel's mother commented that she would try and use some of the therapy techniques, and focus on the quality of her interactions with Daniel – particularly holding his joint attention, as this was a skill both his parents and Daniel's SLT wanted to develop.

5.2 <u>Early intervention in music therapy</u>

The research was conducted in the field of early intervention. The main therapeutic goal focused on helping Daniel to develop his communication skills, particularly joint attention and turn-taking. This was in the hope that these skills can help him in the future to have more meaningful interactions and socialisation with others.

5.2.1   Common Threads

The common threads in this field that related to my research included – listening to parents; being playful, spontaneous, and having fun; exaggerating my voice, body language and facial expressions; working in close proximity of Daniel; working with other professionals (especially the SLT); using toys to help establish rapport and provide comfort; singing songs, and playing musical instruments.

Using music in association with play appeared to encourage Daniel to respond through non-verbal gestures or words. As his parents indicated that they wanted him to have the communication skills to able to talk with others and request things, I needed to display the pragmatic features of 'being a child'. I found that as the cycles developed and I increased my playfulness, spontaneity and fun in the songs relating to his play, the more likely Daniel responded with eye contact, smiles, laughter, vocalisations, and the occasional verbalisation (when given space in the music). I think our interactions were also enhanced by my increase in assertiveness. Even though Daniel seemed to enjoy the familiar nursery rhymes by filling in the gaps, his responses of one-word and sometimes two-word utterances seemed to be more purposeful when I played and sang with him using familiar songs. This was particularly evident in *Wheels on the bus* (Appendices 18 and 20), and *Roll the ball* (Section 4.1.2).

In the *Wheels on the bus* (Appendix 20), he also made a three-word utterance, "All day long". In cycle 2 he initiated an activity with the ball by looking at me and saying "ka" ('catch') when he threw the ball. Through the music it appeared that Daniel's communication skills of joint attention and turn-taking were developing. Cohen (1994) also noted that children find singing a fun way of practising speech.

This approach of being close in proximity to a child is related to Bunt (1994). I used both indirect and direct contact with Daniel. I found that using the position of 'en face' appeared to maintain his attention, and therefore we could have more joint interactions. It took me until cycle 4 to be seated very close to him.

In cycle 1, we played with instruments, which appeared to capture Daniel's attention. However, he did not seem to want to take turns in playing the instruments. This changed in cycle 2 when I felt that he trusted me. I started to become more directive and changed our seating position to a triangular shape, which made turn-taking more inviting between Daniel, his mother and myself. This was because Daniel and I were starting to develop a trusting relationship. As he appeared to feel safe with me, I was able to take risks in order to encourage joint attention and turn-taking (Alvin, 1975; Bunt, 1994; Coulson, 2004, 2006; Peters, 2000; Wigram et al., 2002).

5.2.2   Picture Cards

When developing communication skills, picture cards of objects are often used by SLTs. I used picture cards on a schedule. They appeared to help Daniel with: (1) understanding what activity was happening, (2) associating the words with a picture, and (3) responsibility – each time an activity finished it was his turn to put the cards away.

As Daniel showed interest in the picture cards, I was able to use them constructively without having to spend many sessions trialling the best way to use them. The SLT had earlier found that having a schedule shown before the session started, and then taking the cards off when the activity was completed, helped the child know what to expect in the session. It gave the session structure, and allowed for spontaneity and creativity within activities (Hoskins, 1988).

5.2.3   Session lengths

In cycle 1, I reflected on the 55-minute session – "was it too long?" However, this was the assessment session so I felt the time length was necessary. This happened because I was trying to see the way in which I responded to Daniel as a therapist in order to establish a relationship with him.

In cycle 2, feedback from the SLT regarding the energy levels of Daniel and myself led to another discussion on the session lengths. The SLT wondered whether 30 minutes was a more appropriate session duration for Daniel. The research information sheet advised that sessions would be 30-45 minutes. This time frame was discussed with Daniel's mother who deemed it to be appropriate.

When reflecting on Daniel's joint attention, the SLT, Daniel's mother, and myself wondered whether it was better to have 30 minutes of focused joint attention rather than 45 minutes of intermittent focused joint attention. We discussed what we felt would be the optimum session time for him. It was decided that it might be more beneficial if there were more activities, each with shorter duration. Sessions would still be 30-45 minutes depending on Daniel's responses. In reflection over the next few cycles, he appeared to be more focused and engaged in the activities with this approach.

In cycle 7, the session lasted 50 minutes. Even though this was a slightly longer session, it seemed to flow, and be more interactive. I wondered whether this was to do with having a variety of shorter activities; or, was Daniel more attentive and responsive because of the therapeutic techniques I had refined, i.e. closer proximity ('en face'), assertive, being playful, and relating the music to his play. I felt that as our therapeutic relationship developed, my techniques had improved and they related more to Daniel's needs, and therefore he was more responsive.

5.3 <u>Music therapy and communication</u>

Song and speech are important in developing communication skills. I decided to use song as much as possible throughout the cycles.

It appeared that through structure, modelling and repetition in the music (Skewes and Thompson, 1998), Daniel was able to fill in the gaps, and sometimes he joined in verbally when encouraged by my voice, body language and facial expressions. He appeared to use his language appropriately when singing songs. This supports the idea that singing songs may help improve speech (Cohen, 1994; Erkillä, 2004; Kennair, 2000; Loewy, 1995; Nordoff & Robbins, 1983; Stansell, 2001; Wylie, 2000).

I felt that memorable melodies, simple rhythms and harmonies, repetition, and clear structures (Mackenzie & Hamlett, 2005; Oldfield, 1995; Wylie, 2000) encouraged Daniel to participate in singing. I mainly used lyric substitution that related to his play or in turn-taking songs. This approach appeared to encourage his joint attention and turn-taking (as discussed by Mackenzie & Hamlett). Vocal turn-taking was also used, however, 1-2-3 word phrases were the main focus, as he had developed a few single words.

As turn-taking is important in developing communication skills, this was encouraged in sessions as much as possible. Silence in the music became important for several reasons. It allowed for Daniel to process the auditory stimuli and then have time to respond. I found that the silence as well as my expectant facial expressions helped to hold his attention. They also marked the musical boundaries of when he was to respond. This related to Sutton's (2001) research about the importance of turn-taking, and silence within the child-therapist relationship in music therapy.

Daniel and I had a few musical improvisations on the instruments and some vocalisations. The improvisations featured more in the first few cycles. I felt that these helped grow our therapeutic and musical relationship because they encouraged us to share in making different sounds (Appendices 14-17). Daniel's joint attention seemed to be held with the use of imitation in the improvisations (Bunt, 1994; Pavlicevic, 1997; Tyler, 2000; Wigram, et al., 2002).

As discussed, communication is fundamental for human interaction. As the therapy goal was to develop Daniel's joint attention and turn-taking, it was vital for me to focus on my voice, body language and facial expressions when communicating with Daniel (Aldridge, 1996; Greenspan & Wieder, 1998). Over the cycles I continually refined these features and found that my voice and facial expressions featured more prominently in later cycles than body language (especially cycle 4).

5.4   Action research and the two tables

Koshy (2005) described action research as 'consistently refining practice'. The two tables show the musical ideas and therapeutic concepts that I refined throughout the research process of the seven cycles. The main ideas that I found to be the most valuable will be discussed in this section. As noted previously, these are indicated by an asterisk in the table.

5.4.1   Table 1 – Activities used

I found that simple songs seemed to be the most effective for Daniel in terms of helping him develop his communication skills (joint attention and turn-taking). My improvised songs had a simple melody and rhythm. Other songs used more prominently had familiar melodies with substituted lyrics, which related to Daniel's play at that

moment (Appendices 18-20). It seemed that the best way to deliver these songs, was to only use my voice. I was able to control the way in which I used all the musical elements. Therefore, the use of a simple or familiar melody, duple time, varied tempi, mainly loud dynamics with a warm tone, and different articulation of staccato and legato appeared to hold Daniel's attention more successfully. This led to more joint attention and turn-taking interactions.

The drum, tambourine, drum/tambourine, shaker, rainmaker and guitar were used to build a therapeutic relationship with Daniel and build on turn-taking skills (Alvin, 1975; Barrickman, 1989; Bunt, 1994; Peters, 2000; Shaw, 2006). Daniel seemed to relate to the drum, drum/tambourine and shaker.

Objects

Within the early intervention approach, early childhood development objects are used. In this research I used different medium sized balls and a large Swiss ball, alphabet puzzle, Old McDonald puzzle, car, bus, parachute, picture cards, and a full-length standing mirror. These were to help Daniel relate those words to a concrete object and/or picture, which helped to develop his communication skills (Hoskins, 1988; Wallace, 1996).

5.4.2   Table 2 – Therapeutic ideas

My facilitation as a therapist

When I started music therapy sessions with Daniel, the SLT described them as 'child-directed'. As the cycles progressed, they became more adult-directed. I tried to keep a balance, as this seemed to be more comfortable for both Daniel and myself. I interpreted my lack of 'adult-direction' in the sessions to mean that I was not assertive enough with Daniel or his mother. This contributed to my lack of confidence.

Therefore, I needed to be 'more assertive'. I struggled with finding the right balance between being assertive enough, but not being too pushy. This idea related to my tone of voice. It seemed that the best way to help Daniel understand me was with a warm but firm tone of voice. His mother appeared more comfortable with me as well and therefore my discussions after each session with her were less awkward.

I phased out the guitar through the cycles. This seemed to be more valuable to both Daniel and I, because I felt freer delivering the music with my voice and I could relate to Daniel's play more easily (Loewy, 1995). I could be at his physical level (either lying on the floor or seated in a triangular formation), use animated facial expressions, and sing without worrying about my restricted guitar skills.

Being playful, spontaneous and having fun

Throughout my first interaction of passing a car back and forth to Daniel in cycle 1, I questioned my role – is this music therapy or something else? Perhaps play therapy? However, even though I was not singing any words, I made musical sounds and was 'with' Daniel. This was essential in establishing our therapeutic relationship. Over the cyclical process, my playfulness increased, and by the sixth cycle it felt more natural and not forced. Reflecting back on cycle 1, I can now see that this interaction was indeed music therapy, as it was the first step in developing our relationship – making sounds, having fun, and involving myself in Daniel's play, which related to the early intervention approach (Wallace, 1996).

In cycle 2, the plan was to have fun. I relaxed and allowed myself to be less serious and more natural. I allowed myself to let go of the self-consciousness I felt when trying to be playful. This made my spontaneity increase, which made the sessions fun, and I enjoyed myself. I felt that Daniel also enjoyed the experiences because he

became more responsive (i.e. eye contact, smiling, laughing, vocalising and verbalising). I allowed myself to 'be with' Daniel, immerse myself in his play (which was fun), all while working towards developing his communication skills of joint attention and turn-taking. I felt that being spontaneous within sessions was essential – 'being with' the child, being 'in the moment', and having flexibility within a structured activity.

In cycle 5, he began the bus activity by taking the people out of the bus (Appendix 18). The spontaneous music that accompanied this activity was simple and immediate, which resulted in fun, and enjoyment for the three of us. The activity also lasted nearly eight minutes.

Enjoyment and aspects I was pleased with in my practice

In cycle 1, I felt anxious about my work. This was because I was going to be videoing and then analysing myself closely, which I had not done so before in a rigorous way. I wanted to form a good relationship with Daniel and his mother, and not be too anxious by the video recorder. Music therapy was a new experience for them and I wanted it to be a positive one. As the cycles progressed my anxiety decreased, although in cycle 4, it was heightened slightly as I had two SLTs observing the session. However, that anxiety quickly passed as I immersed myself in the session with Daniel and his mother. Through cycles 5 – 7, I felt that as my skills were being refined, I became more comfortable and natural. This resulted in my sense of enjoyment in the sessions. I was pleased that I was able to adapt the songs more easily, and they became more spontaneous, natural, and instinctive.

5.4.3   Action Research Papers

The main themes described in the literature were (1) the importance of reflective practice as a framework for self-reflection and personal development; (2) to learn more by doing and seeing our actions rather than reading books; and (3) collaboration with others is valuable. (Nicol, 1998; Schön, 1983).

Nicol's (1998) paper in particular, related directly to my study because of the methodology of action research. I had questions about my practice and the action research model seemed the most valuable method because of its cyclical nature. I feel that I have now begun to develop my skills in order to communicate meaningfully with others about my practice, and also how to think even more critically about it.

Both Nicol (1998) and Schön (1983) discussed reflection and collaboration, which are important aspects of the action research method that helped to contribute to the refinement of my practice.

The 'stimulation of ideas' (Nicol, 1998) from the SLT made me question my work more critically, which encouraged me to improve my practice. I did not find it difficult receiving feedback from the SLT and Daniel's mother as Nicol suggests may be a problem. However, I felt slightly uncomfortable when two SLTs observed my work in cycle 4, because I was not expecting them. When we discussed the session afterwards, at times I found it difficult to convey my thoughts. I felt that as a student music therapist I did not have much to offer to the discussion compared with the experience of the two professional therapists. Nevertheless, as part of the process of refining and improving my clinical practice, speaking to others in an appropriate manner was an area that needed improvement. It will continue to be a skill that I will develop.

6   Conclusions

The skills required to work as a student music therapist in the field of early intervention were challenging for me. In order to provide appropriate therapy for Daniel's needs, I had to critically examine, reflect, and refine my musical and therapeutic skills, to which there are many. I was able to do this through the action research model of 'self-reflective spirals'. I found this model to be the most beneficial in refining my practice, because I became more acutely aware of myself, and the skills that I needed to refine in order to provide appropriate therapy to reach Daniel's communication goals of joint attention and turn-taking.

The problems I faced as a student music therapist were to do with certain aspects of my practice. These were, to improve my professionalism with a focus on confidence; assertiveness; playfulness, and spontaneity; musical skills; and therapy skills. On reflection, I can say that these aspects of my practice have improved.

A limitation of this study is that it cannot be generalised. However, I have found that it has helped me to understand the appropriate approach in early intervention when working with a child like Daniel. I think the action research model of 'self-reflective spirals' would be valuable to other student music therapists who want to critically examine their work in order to improve good practice.

I think that action research has a place in music therapy research. I found that it relates closely to natural clinical practice. It has instilled in me the need for rigour and reflection in my ongoing practice. I can also build on the skills I have learnt, and adapt them when working with another child like Daniel in the area of early intervention.

This research process has been extremely valuable in my continual growth as a student music therapist. It has been a small but significant part of my music therapy training. I now have a better understanding of my practice and myself. I can now say that I feel confident and look forward to future work as a music therapist within the field of early intervention.

I thank Daniel for teaching me how to play!

Appendix 1: Information sheet

NEW ZEALAND
SCHOOL of MUSIC

<u>Music Therapy Research Information Sheet</u>

February 2007

<u>Research title</u>: Music Therapy with a preschool child with special needs: processes in improving the therapist's clinical practice.

You and your preschool child are invited to take part in a music therapy research project as part of the music therapy student's/researcher's University postgraduate degree. The research will take place at   . There is only one participant in this research. This is so that the research can be studied in detail and therefore may give some comprehensive conclusions about music therapy in early intervention. If you and your child decide to take part, it would be for seven weeks in succession.

Music therapy is the use of music as a tool to help a person reach specific goals. Music therapy is able to take a person's enjoyment of music and use it to achieve non-musical goals. It is this particular focus on non-musical goals that separates music therapy from other disciplines such as music education, music lessons and recreational music. For e.g. Music therapy can help a child who has difficulties with communication, turn-taking and/or attention span.

You and your child's participation are entirely voluntary (your choice). You and your child do not have to take part in this study, and if you and you child choose not to take part, your child will still receive music therapy. If you and your child agree to take part you are free to withdraw from the research at any time, without having to give a reason and this will in no way affect your future music therapy treatment. Participation in this study will be stopped should any harmful effects appear or if you decide that it is not in your child's best interest to continue.

The research will last for seven weeks, with one music therapy session a week. This means that music therapy will be offered to your child for seven weeks in succession. If for some reason, your child or yourself becomes sick for a week, this week will not be made up at the end, as this is the reality of working with children and will be part of the research. Therefore, for example if the child misses one week of music therapy, they will receive six sessions, rather than seven.

The first two sessions will be for assessment and the third and fourth sessions will be for treatment. The fifth and sixth session will be treatment as well as preparing for closure. The seventh session will be for closure.

Each session will have a duration of 30-45 minutes. Before each session, the music therapy student/researcher will describe the plan that she has for each session. After the session, the music therapy student/investigator will ask for you, as the parent/caregiver, to give feedback as to how you felt the session went in regards to your child's responses and actions by the music therapy student/researcher. The music therapy student/researcher will also ask for feedback from the Speech-Language Therapist who will be watching the session – either through the observation window, or from the corner of the therapy room.

Then after each session the music therapy student/researcher will write notes, reflect, analyse and plan the next session, all while developing their own skills and thoughts to improve their clinical work.

The aims of this research are:

1. This action research is for the music therapy student/researcher to examine her own clinical work with this population and develop and improve her practice accordingly.

2. This action research is to give other practitioners an insight into the clinical work of music therapy with these children and their families.

3. It is hoped that this research will help other therapists (not necessarily music therapists alone), in working with preschool children and their families. Early intervention is very important in the help and growth of a child's development. Practitioners may gain knowledge about techniques that are more beneficial for therapy when working with this population.

The research investigates one preschool child and parent/caregiver through the process of music therapy. The child will not have received music therapy before. The research will reflect and analyse each music therapy session from the very first session through to the final session. You and you child were chosen as participants from the roll of children receiving therapy from   . Also, your child has been picked as someone who has shown an interest or has been stimulated by music.

Pitched and non-pitched musical instruments will be offered to the child each session as part of their music therapy programme. There will be a video camera used purely for the student music therapy student /researcher to reflect and analyse her own work with the child and then plan accordingly for the next session. There also may be a specialised music-recording player – purely for clarity of musical responses.

The videotapes that record each session will be kept at   in a locked cupboard. The only persons who can access these are therapists who have an interest in working with your child. These tapes will remain at   at all times. After the

research has finished these tapes will be returned to the New Zealand School of Music and remain there for ten years and then destroyed.

Risks

1.   *Your child may hurt themselves whilst playing instruments.*

The music therapy student/researcher will endeavour to have instruments that have minimal risk. Movement activities will be assessed accordingly with the physical and mobility development of the child.

2.   *Your child may hurt themselves whilst participating in music and movement activities.*

Movement activities will be assessed accordingly with the physical and mobility development of the child.

3.   *Your child and yourself may be at a slight risk of being identified. This is because authorised personnel specifically involved with the therapeutic care of your child may be able to identify you and your child as participants.*

Every attempt will be made to disguise identities by using pseudonyms.

Inconvenience

The only inconvenience to you and your child is that the music therapy sessions will be on the same day, at the same time for seven weeks. The music therapy student/researcher and yourself would decide the day and time that is suitable for both parties.

Dates:
Wednesday February 14
                                21
                                28
                  March   7
                                14
                                21
                                28

Times: 10.45am-11.30am

Benefits

There is no financial benefit from this research. The benefits that the music therapy student/researcher hopes will be achieved are, by the end of the seven-week music therapy programme, your child will have (1) reached some specific therapeutic goals outlined in the assessment and (2) had some enjoyable musical experiences.

It is also hoped that some of the music therapy techniques used may be helpful for you as the parent/caregiver, and you may employ some of these in the home environment in order to continue developing your child's developmental skills.

It is also hoped that through the process of reflecting and analysing the music therapy work, that the music therapy student/researcher will be able to take away with her some knowledge and understanding about working with preschool children, that she can pass onto others.

Conclusion of the research

After the music therapy sessions have concluded, there will be a period of three-four months whilst the research paper is being written. If you wish to have a copy of the written work, this will be available to you and your child. If you wish to have a copy of the videotapes of the sessions, these will also be available.

Queries/Concerns

This study has received ethical approval form the Health and Disability Central Branch Ethics Committee.

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone:

Mid and lower North Island – 0800 42 36 38 (4 ADNET)

Please feel free to contact the music therapy student/researcher, her supervisor at the New Zealand School of Music, or supervisor at   at anytime if you have any questions/concerns about this study.

Catherine Wilkinson,
Principal Researcher,
Music Therapy Student,
New Zealand School of Music

Sarah Hoskyns,
Associate Professor,
Director of the Music Therapy Programme,
New Zealand School of Music

Speech-Language Therapist

Appendix 2: Consent Form – Child

NEW ZEALAND SCHOOL of MUSIC

<u>Music Therapy Research Consent Form – Statement by Relative/Whanau of the Child Participant</u>

February 2007

<u>Research title:</u> Music Therapy with a preschool child with special needs: processes in improving the therapist's clinical practice.

I believe that_____(participant's name) would have chosen and consented to participate in this study if he/she had been able to understand the information that I have received and understood.

I understand that taking part in this study is entirely voluntary and that my child may withdraw from the study at any time. This will not affect her/his music therapy sessions.

I understand that the music therapy treatment will be stopped if it should appear to be harmful to my child.

I understand that authorised personnel specifically involved with the therapeutic care of my child may be able to identify him/her. Therefore, I understand that my child's participation in this study may not be entirely confidential. However, a pseudonym will be used to help disguise the identity of my child.

This study has been given ethical approval by the Health and Disability Central Ethics Committee. This means that the committee may check at any time that the study is following appropriate ethical procedures.

I believe that my child would agree to his/her GP being informed of his/her participation in this study.   **YES/NO**

Signed: _____   Date: _____

Printed Name: _____

Relationship to Participant: _____

Address for results: _____

_____

Appendix 3: Consent Form – Parent

NEW ZEALAND
SCHOOL of MUSIC

Music Therapy Research Consent Form – Statement by Parent/Caregiver Adult Participant

February 2007

Research title: Music Therapy with a preschool child with special needs: processes in improving the therapist's clinical practice.

I understand that taking part in this study is entirely voluntary and that I may withdraw from the study at any time. This will not affect the continuation of music therapy sessions.

I understand that the music therapy treatment will be stopped if it should appear to be harmful to myself.

I understand that authorised personnel specifically involved with the therapeutic care of my child may be able to identify me. Therefore, I understand that my participation in this study may not be entirely confidential. However, a pseudonym will be used to help disguise my identity.

This study has been given ethical approval by the Health and Disability Central Ethics Committee. This means that the committee may check at any time that the study is following appropriate ethical procedures.

I have read and I understand the information sheet dated _____

I would like a copy of the results of the study.   **YES/NO**

I agree to take part in this study.   **YES/NO**

Signed: _____   Date: _____

Printed Name: _____

Relationship to Child Participant: _____

Address for results: _____

_____

_____

Appendix 4: Consent Form – SLT

NEW ZEALAND
SCHOOL of MUSIC

Music Therapy Research Consent Form – Statement by Speech-Language Therapist Participant

February 2007

Research title: Music Therapy with a preschool child with special needs: processes in improving the therapist's clinical practice.

I understand that taking part in this study is entirely voluntary and that I may withdraw from the study at any time. This will not affect my involvement in the continuation of observing future music therapy sessions.

I understand that authorised personnel specifically involved with the therapeutic care of the child participant may be able to identify the child, parent/caregiver and myself. Therefore, I understand that my participation in this study may not be entirely confidential. However, pseudonyms will be used to help disguise all identities.

This study has been given ethical approval by the Health and Disability Central Ethics Committee. This means that the committee may check at any time that the study is following appropriate ethical procedures.

I have read and I understand the information sheet dated _____

I would like a copy of the results of the study.   **YES/NO**

I agree to take part in this study.   **YES/NO**

Signed: _____   Date: _____

Printed Name: _____

Address for results: _____

_____

_____

Appendix 5: Consent Form – Main Participant and Independent Clinician

STATEMENT BY PRINCIPAL INVESTIGATOR

February 2007

Research title: Music Therapy with a preschool child with special needs: processes in improving the therapist's clinical practice.

I, CATHERINE WILKINSON, declare that this study is in the potential health interest of _____(name of child participant) and that participation in this study is not adverse to _____(name of child participant)'s interests.

I, CATHERINE WILKINSON, declare that this study is in the potential health interest of _____(name of adult participant) and that participation in this study is not adverse to _____(name of adult participant)'s interests.

STATEMENT BY INDEPENDENT CLINICIAN

I confirm that participation in this study is not adverse to

_____ (child participant)'s interests.

I confirm that participation in this study is not adverse to

_____ (adult participant)'s interests.

Signed: _____   Date: _____

Printed Name: _____

Appendix 6: MTS's Master of Music Therapy Feedback Form

FEEDBACK FORM – SPEECH-LANGUAGE THERAPIST

DATE:

1. Does the student demonstrate adequate skill in assessing clients to identify areas of strength and need?

2. Does the student develop goals and objectives that are appropriate for clients' need and level of functioning?

3. Does the student show an adequate level of awareness of client responses?

4. Does the student use appropriate eye contact/facial expression with clients?

5. Does the student demonstrate posture/stance/body language that communicates interest?

6. Can the student communicate observations, thoughts, and ideas with the parent effectively using verbal feedback?

7. Does the student demonstrate a warm positive regard for: the child and the parent.

8. Does the student appear confident in his/her interactions with clients?

9. Is the student able to keep clients on task, and/or to redirect them as needed?

10. Does the student acknowledge clients for their involvement with individualised praise/feedback when appropriate?

11. Does the student allow time for client responses?

12. Does the student demonstrate the ability to:

    (a) Bring activities to a clear close/end?
    (b) Bring sessions to a clear close/end?
    (c) Bring programmes clear close/end?

13. Does the student choose music appropriate for client age group and special needs?

14. Does the student choose music appropriate for intended use/purpose/client skills?

15. Does the student generally use her singing voice and instruments with appropriate dynamics (to suit lyrics, size of group and client need)?

16. Does the student generally use appropriate tempo/timing in musical interactions?

17. Does the student generally play an accompaniment that is appropriate for the planned purpose?

18. Does the student generally provide the clients with the appropriate balance of musical support and space when accompanying or improvising with clients?

19. Other comments.

Appendix 7: Video Reflections – Full Entry

14 February 2007 (Cycle 1)

"Minimal responses in question-asking but Daniel didn't push me away; he seemed fine with close proximity…Phone ringing interruption was annoying. Is there a way to suggest politely that Daniel's mother could turn her phone off for the session, or have it on silent?…When Daniel rolled the rainmaker to me – was he initiating play? I should have extended with music. I think Daniel was giving a cue to play and I missed it!…Daniel did not want to join in the 'walking song'. Was it the way I introduced the activity? Does he prefer to play alone? Perhaps I didn't finish the rainmaker activity clearly?…When Daniel was stacking the instruments – I should have made up a song to connect with him and be involved with his play…Rolling the ball – I should put the guitar away: don't need it! Daniel seemed more attentive when I used my voice only."

Appendix 8: Research Diary – Full Entry

14 February 2007 (Cycle 1)

"*Today I met Daniel and his Mum for the first time. I was a little anxious but tried not to show it, as I knew that Daniel and his Mum would be anxious too. I had a plan organised for the session, as this was the first assessment session. The room we were in was quite small and the SLT was unable to see the session through the window and was also away, so she had to look at the session afterwards.*

At first, Daniel did not want to come into the room and Mum was very good at encouraging him – i.e. there are lots of toys in here to play with. Daniel looked around the room and noticed the objects on the table – bag (with objects inside). The guitar case was covering the other two objects, however Daniel managed to see a glimpse of the car! The car was what he wanted and he was not going to sit on the floor with us and sing "hello" until he had it. I got up and got the car and sang the Hello song. Daniel seemed to be interested in just the car until I said hello to Mummy, then he looked at me and then Mum. Daniel is very keen on cars at the moment (said Mum).

Then Daniel initiated a game of passing the car to me, to which I thought well lets go with this for a time because he is wanting to pay with me. I thought it's this music therapy? But I thought that as part of the therapy process I needed to connect with Daniel and because he had initiated the game I thought this is a good way to establish that relationship. I made it into a game using sounds like brum and ready, steady, go and 1,2,3,go. Even though Daniel did not vocalise or fill in any of the gaps I left for him, he looked at me occasionally and played with the car game for a couple of minutes.

When I introduced the bus to Daniel with the people inside he seemed interested. I thought now was a good time to introduce the song 'Wheels' because I had the object there too. Daniel looked at me once when I sang the first verse (with voice and guitar). Then when I stopped the guitar and was playing with the people in the bus going "up and down" he responded with "up" in the gap and "d" for down in the correct place. For the other verses Daniel played with the bus and didn't seem to be interested or engaged with the song. I was playing the guitar as well.

I wonder if just my voice would be more beneficial? Is the guitar a barrier? Something for me to hide behind because I'm scared? I don't know what I'm scared about? Maybe singing the wrong thing? Use for the hello and goodbye song, and leave out for the other songs because then I have more freedom – the use of my voice, which I thought was strong, but it really isn't that strong. SLT thought I should lie on my stomach and sing – so I was on Daniel's level. That's not as silly as it sounds – practice singing like that my help my projection. I know that my voice can hold a melody – i.e. I've got pretty good pitch so I think that's what I should try, because on several occasions throughout the session, Daniel responded to my voice more than the guitar. I think this is interesting because I thought he might like to play the guitar. However, they do say that the voice is the first thing in communication and perhaps I need to just follow my natural instincts with singing – which I enjoy, then I wouldn't be so worried about my guitar skills.

Naming the objects in the book wasn't music but it helped me to learn a little about Daniel's expressive and receptive language. He was able to name most of the objects. When I asked him the colour of something he responded sometimes with the colour but sometimes with the object? Did he not understand the question? Not have the vocabulary for that colour. SLT said that learning colours can be up to 4 year-old

developmental skill. I was actually really impressed with the amount of objects Daniel

knew. When he saw an object he didn't know he looked at me and pointed. So therefore

it appeared he didn't have the language to say 'what's this', 'can you tell me what this'.

However Daniel's non-verbal communication seems to be good and he communicates

well with gesture – pointing, looking.

Playing with the blocks was fun. Daniel let me sit with him and play with the

blocks and count with him whilst he stacks them. I sang the Rainbow song whilst he put

the colours on the stick block. I don't know if he was interested in the song – he did not

fill in the gaps – perhaps I will try this next time with him.

Then when we went and saw what was in the bag, I pulled out a shaker and

shook it and gave it to Daniel. Straight away Daniel smiled and took the shaker and

shook it. When I took the tambourine out I didn't actually model what to do with it,

which was silly, and maybe this is why Daniel didn't seem to be interested in it – i.e. to

play it, throughout the session. I also pulled out the drum and played it. When I said

come and let's play, Daniel smiled and bought the shaker to the space and sat near

Mum.

I enjoyed this little period of the session as the three of us had fun playing our

instruments, taking turns and I felt like Daniel was listening to my voice and rhythm as

he followed the beat and the tempo – followed with me. I almost felt like – yeah this is

what it means to be a music therapist – having fun, having a child join, communicate

through music – i.e. instruments, vocalising, and seeing the enjoyment that he was

having – facial expressions – looking at me, seeing Mum enjoy herself too.

With the rainmaker, Daniel seemed to be fascinated and played it with it – turning it over and watching the beads fall. One moment we had in the session where I was improvising and making glissandos and Daniel imitated my sounds. It was interesting that things I didn't plan, seem to have had just as much, or even more impact on the child than the planned activities. I think though as the session goes along and you are getting to know the child you relax a little and just let the music speak for itself.

This period of enjoyment and successful experience continued through the use of the ball – it started with row, row and went to roll, roll the ball. Taking turns passing the ball as we sang. Without the guitar I could be more involved, Daniel seemed to respond more through his body position, gestural expressions and attention.

The Walking song did not work so well. I'm not sure that it was the actually music, just the way I introduced the activity. Daniel was enjoying playing with the rainmaker, as he hadn't seen one before and wanted to play with it for longer. I thought that he was getting too fixated on it and wanted to change. I guess that was a bad move, it should have been what Daniel wanted. Perhaps using music with the rainmaker and then put the rainmaker out of sight and continue on. Like the car was put out of sight and Daniel was distracted by something else that I showed him.

Old McDonald song was semi-successful as Daniel filled in the puzzle as he sung the animal in the gaps of the song. He did not make the noises though. As Daniel's parents said he liked puzzles I thought this would be a good activity to introduce into the session.

Happy and you know it wasn't really successful either – Daniel was more focused on the rainmaker. Whilst talking to Mum she said that Daniel seems to not join in actions songs – he likes to watch and moves with them but doesn't do the actions.

Before we sang goodbye, I sang twinkle to wind down. This was interesting as Daniel came over sat on Mum's lap and watched me throughout the song. I used the guitar – plucking quietly and singing quietly. Daniel was attentive and he seemed to enjoy the calm music. He filled in the gaps of "star" and "are" and smiled. He also listened to the Goodbye song while Mum rocked him. He had a sad face at the end and vocalised what sounded like "bye" or his version of "bye" and headed for the door.

It is really amazing watching your work on video and listening to it. You realise not just the things you shouldn't have done but also those moments that are really special and you think "wow, that's what they mean by the power of music". Experiencing it for yourself is quite indescribable. I think working with Daniel is going to be a very interesting experience and I hope that through the power of music I can help him in some way."

Appendix 9: SLT Feedback – Full Entry

14 February 2007 (Cycle 1)

THERAPY SKILLS:

Assessing clients to identify strengths and needs?

- Range of activities.

- Discussed skills with mum.

- Needed support to be more specific with assessment (e.g. receptive vs. expressive language).

- Gave lots of information in feedback – would be good to summarise key information to feedback (written and verbal).

Develop goals and objective

- Needed time to process assessment information so unable to give clear goals after session.

- Area Catherine needs to develop.

Awareness of client responses

- Allowed time for child to respond and looked for range of verbal/non-verbal responses.

- Easier to analyse on video rather than on the spot.

- Catherine able to reflect on other ways to gain response.

Eye contact/facial expression

- Obviously more conscious of use of eye contact and facial expression.

- Client more engaged when animated facial expression and face-to-face eye contact used.

Posture/stance/body language communicating interest

- Good when playing with car and musical instruments - ↑ engagement from client noted during these activities.

- Need to continue to use above to engage client and draw them into activities.

- Think about use of gestures and body position.

Communicating observations

- Gathered lots of information.

- Needed support to summarise content clearly. Need to think about key information.

Warm/positive regard

- Good for both client and caregiver.

Evaluate effectiveness of sessions

- Good reflection on own performance – identified strengths and weaknesses.

- Need to explore ways to evaluate client's responses.

Confident

- Good initially with hello song and car.

- At times appeared unsure of what to do next as seen by hesitation and pauses.

- May help to have predetermined session plan with 2-3 planned activities.

- Sometimes unclear communication with mum – stopped mid-sentence, used vague vocabulary.

- Other times appeared confident with feedback to mum by looking directly at her and asking a specific question.

On-task and redirect as necessary

- Car – used voice and play to keep client on task.

- Range of activities to keeps client's interest.

- Used verbal prompts to redirect occasionally – need to develop use of visual and physical prompting.

Acknowledge clients involvement and give feedback

- Used verbal praise to acknowledge verbal responses.

- Need to think about specific feedback, e.g. good talking, great turn-taking, good strumming etc.

Time for client responses

- Good mix of waiting in anticipation. Think about ways to use body stance/positing and facial expression to encourage client response.

End

- Good finishing song – would be a good opportunity to feedback to Mum also.

MUSICAL SKILLS:

- Developing range of songs appropriate for client age group and special needs
- Catherine chooses music appropriate for intended use/purpose/client skills.
- Generally uses her singing voice and instruments with appropriate dynamics. Discussed using just voice sometimes to draw client in.
- Uses varied tempo/timing. Noted repetitive lyrics and strong tempo – good for this client.
- Generally plays an accompaniment that is appropriate for the planned purpose.
- Catherine is good at giving the client space. As her confidence develops she can increase her physical support.

Appendix 10: Hello Song

Appendix 11: Upbeat Hello Song

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Appendix 12: Goodbye Song

Appendix 13: Walking Song

Appendix 14: Vocalisations with the Bus

Appendix 15: Drum/Shaker Improvisation

Appendix 16: Drum/Shaker Improvisation

Appendix 17: Drum/Tambourine Improvisation

Appendix 18: Wheels on the Bus adaptation
(related to Daniel's play)

2   Wheels on the Bus adaptation (related to Daniel's play)

girl on the bus goes in in in, the girl on the bus goes in in in, the boy on the bus goes

in in in, the boy on the bus goes in in in, and last one, the boy on the bus goes

in in in, and Dan iel shuts the door.   "Ooh, cough, cough"

Daniel coughed x2 (his mother
wiped his nose)

"Should the bus go for a ride? Let's go for a ride,
Daniel. Where's the bus going to? Can the people
go for a ride?"..."Ooh, they're getting out again...

The peo ple on the bus get

out out out,   out, out, out,   "Oh...through   out, out, out, the peo ple on the bus get
                                    the door"

out, out, out, and then we close the door. Yay! Door shut!   "Bye, bus"

Daniel pushed bus (without the
people) away from the group

Wheels on the Bus adaptation (related to Daniel's play)   3

The peo ple are ly ing on the mat, on the mat,

Daniel picked up the
people and lay them on
the mat.

on the mat, the peo ple are ly ing on the mat and

now they're stan ding up up up!   "Oh no! One
fell over!"

"aaahh" (low
pitch)

One, two, three, four, five, six...

Daniel began to stand the   One   Daniel sighing
people up in row (as I   and looking for
counted).   bus.

"Bus come back", bus come back, bus, bus, bus...ooh, where's the door gone?   The
Oh, it's on that side!" Daniel was trying to find the door of the bus to open.

peo ple on the bus get in, in, in, in, in, in, in, in, in, the peo ple on the bus get

4

Wheels on the Bus adaptation (related to Daniel's play)

in, in, in,   all   day   long.   The   peo ple on the bus get   in,   in,   in

in, in, in,   in, in, in, the   peo ple on the bus get   in,   in,   in,

in,   in,   in,   and   now they're all   in!

"Shall we go for a ride? Let's
shut the door, push to Mum,
weeeeeeeeee..........................

The

bus   goes from   Mum to Cathe rine

Mum: Weeee...."I'm getting wet!"
(MTS and Mum move away from
the window and both laugh!)

Cathe rine to   Dan iel and

20:28

Dan   iel   to   Mum...

Daniel crawled
away...finished activity.

Appendix 19: Shaker/Tambourine/Drum Song

Appendix 20: Wheels on the Bus
(Daniel joining in)

2

Wheels on the bus (Daniel joining in)

ah, ah, ah, the peo ple on the bus are   ah, ah, ah,   all   day   long.

day   long.

Daniel picked up the bus and
some of the people fell over.
He said "uh oh".

The peo ple on the bus have   fallen   down,

fallen __ down,   fallen __ down the   peo ple on the bus have   fallen __ down,

all   day   long.   Daniel pushed the people over, then
picked them up and said, "up".   The

peo ple on the bus are   standing __ up,   standing __ up,   standing __ up, the

accelerando...Daniel was tapping the
people on the mat to my beat as I got
faster.

peo ple on the bus are   standing __ up,   all   day   long.

Wheels on the bus (Daniel joining in)

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Glossary

Action research definitions:

1. Action research has '…a clear intent to intervene in and improve one's own understanding and practice, and to accept responsibility for oneself' (McNiff, et al., 2003, p.16). It also involves 'informed, committed and intentional action' (McNiff, et al., p.21).

2. Action research is '…an enquiry, undertaken with rigour and understanding so as to constantly refine practice; the emerging evidence-based outcomes will then contribute to the researching practitioner's continuing professional development' (Koshy, 2005, pp.1-2).

Other definitions:

Agenesis of the Corpus Callosum (ACC) is '…a rare birth defect in which the structure that connects the two hemispheres of the brain (the corpus callosum) is partially or completely absent' (National Institute of Neurological Disorders and Stroke, 2005, http://healthlink.mcw.edu/article/921361458.html).

Global developmental delay (GDD) is '…a significant delay, usually two or more standard deviations below the mean, in two or more domains (gross/fine motor skills, cognition, speech/language, personal/social skills, or activities in daily living' (Shevell, Majnemer, Platt, Webster, and Birnbaum, 2005, p.678).