

**Action Research: An Exploration of a Music Therapy Student's  
Journey of Establishing a Therapeutic Relationship with a Child with  
Autistic Spectrum Disorder in Music Therapy.**

**A research dissertation presented in partial fulfilment of the requirements for the  
Master of Music Therapy  
at New Zealand School of Music, Wellington, New Zealand**

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**2009**

## **Abstract**

This action research project examines the researcher's journey of establishing a therapeutic relationship with a child with autism spectrum disorder during her practicum. Children with ASD present difficulty in communication and social relationship skills. As a student in training with a limited experience, the researcher had uncertainty and low confidence with regard to her clinical and professional skills which affected her work. In this project, the researcher has examined her own process of music therapy with a child with ASD and shows how she was able to improve her practice and therefore establish meaningful and effective therapeutic relationships with this client population and obtain valuable learning through the training. The study was conducted at a dedicated therapy centre in New Zealand where the researcher was in placement. A total of seven, thirty-minute weekly individual music therapy sessions and four supervision sessions were employed. This process was adapted into the design of action cycles which involved the repeated process of planning, action and evaluation. In-depth analysis of the researcher's work was carried out throughout the cycles, using clinical notes, journal excerpts, supervision notes and video recordings of the sessions. The findings suggest that the researcher was able to improve her practice while attempting to build a therapeutic relationship with the client. Various clinical and personal issues arose such as uncertainty about improvisation, and lack of confidence in professional skills including communicating with parents, which led to disjunction and burnout symptoms. Discussions in supervision aided in in-depth reflection of the researcher's work as well as emotional support. The researcher could ultimately develop 'internal supervisor' and was able to use independent strategies to help develop her work. Implications for training include making personal therapy a compulsory course requirement, providing training on professional skills, and student support groups. Future research may investigate the effectiveness of verbal input in music therapy and the emotional stages of parents.

## **Acknowledgements**

Thanks to,

My Lord, Jesus Christ

for your unconditional love, guidance, strength and wisdom.

Sarah Hoskyns,

my research supervisor, for your support and encouragement.

I would also like to dedicate this research to all hard working  
music therapy students, educators and trainers.

This research received ethics approval from Northern Y Regional Ethics

Committee (Health and Disability Ethics Committees

Ref No: NTY/08/61/EXP

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# **Chapter 1. Introduction**

## **1.1 Overview of project**

This research was conducted to fulfill the requirements of Master of Music Therapy program. I, the researcher, have used an action research design in order to improve my music therapy practice during the practicum, and hence to provide better service. I have examined the process of my own development while attempting to establish a therapeutic relationship with a child with ASD. There were weekly 30 minute music therapy sessions over a period of 7 weeks, together with fortnightly supervisions at a therapy centre in New Zealand.

This chapter will introduce what led me to research this particular topic and my values underpinning my research. In Chapter 2, I will demonstrate some general information about my placement facility. In the literature review in Chapter 3, I will discuss the relevant studies, including autism spectrum disorder, music therapy with ASD and issues in music therapy training. I will explain the methodology of action research and the methods of data gathering as well as ethical issues in Chapter 4. Then, I will demonstrate the story of my research, by illustrating the process of action cycles in depth in Chapter 5. Finally in discussion and conclusion chapters, I will discuss the themes that arose from the previous chapter in relation to the literature and show my own learning resulting from this research.

## 1.2 Motivation for Research

### *Personal stance*

Personally, I have always been intrigued by how people form and maintain relationships. As a child, I was initially shy and often quiet at school and among friends which sometimes made it difficult for me to make friends. Throughout primary school years,<sup>1</sup> however, I realised that having confidence to speak up and being active would make it easier for me to make friends and become popular in class. I worked hard on this and eventually became one of the active leaders at school. Immigrating to New Zealand after finishing primary school, however, changed my outgoing personality again (at school at least<sup>2</sup>) because of the acquaintance with a new culture and a new language. I reverted to a shy and quiet person again, as I was not fluent in English. I was mostly non-verbal in class. For me, it was almost like a disorder; it was difficult to communicate with English-speaking people as much as I wanted to. Throughout the school and university years, being able to communicate effectively with others was a crucial skill for me to work on in order to relate to others better. Also with family and friends, I continued to think about the ways in which I could maintain good relationships with them.

Music played an important element during my school and university years. It continues to help me in forming relationships with others. As a music student from

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<sup>1</sup> I attended a primary school in Korea, where I was born.

<sup>2</sup> I mostly spoke Korean at home and with Korean friends.



school to university years, I was actively involved in school, university and church choirs. I also occasionally performed piano in various occasions both solo and in chamber groups, and accompanied and conducted church choirs. Singing and playing music with others helped in lifting up my self-esteem and provided communal grounds within which I was able to relate to others despite the language difficulties.

### *Professional stance*

During the second year of my music therapy training, in the practicum period at a dedicated therapy centre, most of the clients I worked with were children with autism spectrum disorder. While working with these children, I thought about how difficult it would be for them not to be able to communicate with others which prohibits them from relating with others well.

I have encountered various challenges when attempting to build the initial relationships with these children. As a student in training, I was aware that, from time to time I experienced a low level of confidence in some of the aspects of my practice in sessions. I sometimes felt anxious because I wondered if I would work with the children competently considering my relatively short experience. In addition, I realised that I found the complexity of dealing with parents of children at the centre an extra challenge. I recognised the importance of this process but often became self-conscious about how I worked, as the parents were aware that I was a student. I felt the pressure of having to practice competently and to prove my expertise to counteract the parents' anxiety. It led

me to reflect constantly on how I worked in the sessions and think about how I would work differently in the sessions that followed. Ultimately, I have come to research on how I can improve my practice in order to establish meaningful and effective therapeutic relationships with this client population, and to help children fulfill their potential.

### **1.3 Conceptual Framework**

#### *Humanistic perspective – Creative Music Therapy*

Nordoff-Robbins' Creative Music Therapy model formed the basis in my work with children with ASD. Influenced by humanistic psychology, the Nordoff-Robbins model focuses on the concept that every human being has an innate responsiveness to music (Wigram, Pederson and Bonde, 2002). It focuses on accepting the 'music child' or 'music person', i.e. responding to the intrinsic musical qualities that the child or the person present. Therefore music is at the centre of the experience and its interpretation (Wigram, Pederson and Bonde, 2002). The relationship between the therapist and the client is formed in the music itself (Wigram, Pederson and Bonde, 2002). Its main goals are the development of the client's self-expression, creativity and communication potential (Wigram, Pederson and Bonde, 2002).

#### *Psychodynamic perspective - Transference and Countertransference*

My practice with children with ASD also drew on psychodynamic principles particularly in thinking about therapeutic relationship between therapist and client. The

psychodynamic principles include the clinical concepts of transference and countertransference in discussing therapeutic relationships. It is vital for therapists to be aware of the feelings of countertransference, to reflect carefully and to seek supervision to guide them in their interventions (Brown and Pedder, 1987, Bunt and Hoskyns, 2002, & Wigram et al., 2002). The process of acknowledging and reflecting on the feelings can be aided by supervision and personal therapy (Bunt and Hoskyns, 2002). The client's anxiety often seemed to be transferred to me, which in turn seemed to trigger my anxiety and frustration, often evident in my musical quality. For instance, I was working with a child with ASD who presented a high level of anxiety responses such as uttering negative comments and behaving in inappropriate ways. In response to this, I often felt overwhelmed and helpless, feeling uncertain as to what to do or play, and also sometimes angry and frustrated. Within supervision, I was encouraged to try to understand my own reactions and feelings towards clients and to consider if this understanding could contribute to the process of building up relationships with my clients.

### *Action Research*

I have chosen to employ an action research design for this project because it allows the researcher, i.e. myself to focus on improving my practice through the repeated process of action and evaluation. It is concerned with working "towards change within an individual and the production of knowledge for the direct benefit of that individual" (Hunt, 2005). More specifically, humanist perspective in action research focuses on the interactions between human beings and their influences on each

other (Hunt, 2005). In this paradigm, the researcher is not alienated from the research process but is actively involved as a participant, and all participants are treated more as human beings rather than subjects (Hunt, 2005). Action research draws on critical theory which emphasises the relationship between thought and action that is linked to knowledge and human activities (Hunt, 1995 and Wheeler, 2005). I anticipated that by conducting an action research, I could improve my practice by documenting and analysing my work, and thus build up a therapeutic relationship with a child with ASD more easily.

## **1.4 Research Aims**

My aim for this research was,

**To investigate how I form a therapeutic relationship with a child with autism spectrum disorder in music therapy, from a music therapy student's perspective.**

Action research involves identifying a problem and then systematically working towards solving that problem (McNiff, 1996). The initial problems that I had identified which were preventing me from building up effective therapeutic relationship with my clients were concerned with both clinical and personal issues. 'Anxiety' was the main factor which led to the following problems; 1) the uncertainty of appropriate therapeutic actions in response to the client's actions, 2) my clinical improvisation skills which were influenced by the anxiety, 3) uncertainty about my own clinical skills, and 4) lack of

confidence in professional skills. These points will be illustrated more specifically in Chapter 5.

Through this project, I aimed to answer the following sub-questions:

1. What are the challenges that I encounter when treating a child with ASD in terms of clinical (musical and academic skills, environmental/facility and professional skills) and personal (emotional/psychological) issues? How are these challenges overcome to help improve my practice?
2. How does clinical supervision help during the clinical process?
3. What music therapy methods and principles are employed to establish a therapeutic relationship in this study?
4. How do the child's behavioural and musical responses in music therapy impact on my work?
5. What implications arise for future training of music therapy students?

The next chapter will provide some background information about the placement setting where I took my training.

## **Chapter 2. Background**

### **2.1 Context for the Research**

As a music therapy student in training I worked at a therapy centre which provides music therapy to children with various disabilities aged from 0 to 21, mostly on weekly basis. Many of the children referred to the centre were those diagnosed with autism or autism spectrum disorder. The centre is located in an attractive inner city setting in New Zealand, and parents or school services transport the children to the centre, and a staff member or the parent usually waits in the waiting room while the sessions take place. 5 therapists including head of clinical services are employed at the centre, working onsite as well as in outreach schools, plus a management director and a receptionist.

### **2.2 The Policies and Procedures of the Therapy Centre**

When a client is referred, an initial consultation with a senior clinician is provided to gather information about the client, to assess if the client is suited for music therapy, as well as to inform the parent(s) and caregiver(s) about music therapy and how it can help that client. If the client has been on a waiting list for a sustained period, a pre-assessment meeting with the parent(s) is held when a music therapist is allocated. Here, the music therapist and the parent(s) discuss any changes that took place during the waiting period and other further information. Then, the music therapist holds six assessment sessions with the client, followed by the assessment review meeting with the

parent(s) and/or caregiver(s) to review the footages of the sessions and set up appropriate treatment goals.

Regular supervision is provided to the therapists fortnightly by an onsite supervisor. Descriptive clinical notes are written after each session and are kept in the client's file. Video recording of the sessions is also part of the centre's policy and the recordings are kept in a secure place at the centre. Parents or caregivers are not able to observe the live sessions due to (1) the limited practicality at the centre and (2) to protect the child's confidentiality, unless it is deemed to be necessary or beneficial to the client to include the adults in the sessions.

The next chapter will examine the literature related to my research topic.

## Chapter 3.Literature Review

Music Therapy for children with autism spectrum disorder has grown significantly as an area of clinical practice and research study during the last decade. The writings on the students' perspectives on the issues involved in music therapy training and working with clients exist in the published literature although most of these were not specifically related to the process of treating children with ASD. I will attempt to provide a context to my research topic by examining the literature which discusses the key related areas; children with autism spectrum disorder, music therapy for children with ASD, and issues in music therapy training.

### 3.1 Children with Autism Spectrum Disorder

*Autism* is defined as “a developmental disorder characterised by marked difficulty in communication and social relations and by the presence of atypical behaviours such as unusual responses to sensation, repetitive movements, and insistence on routine or sameness” (APA, as cited in Neisworth and Wolfe, 2005). The term *Autistic Disorder* is under the category of *Pervasive Developmental Disorders Not Otherwise Specified* in DSM-IV-TR (APA, 2000). The unofficial term, *autism spectrum disorder* is used simultaneously with the term *pervasive developmental disorders* (Volkmar, Paul, Klin and Cohen, 2005). It has been used to differentiate Leo Kanner's classic autism and the various spectrums of autistic behaviours (Volkmar, Paul, Klin and Cohen, 2005).



Children with ASD present delay and atypical development in the acquisition of joint attention, social orienting, imitation, and play (Charman and Stone, 2006). Some researchers argue that the poor social and emotional functioning in preschoolers with this diagnosis maybe due to a lack of theory of mind – an inability to think about the thought processes of others (Leslie, 1987; Leslie & Frith, as cited in Trawick-Smith, 2000 and Volkmar, 2007). They may be disinterested in play, but rather more interested in toys or objects which they use with repetitive motor actions (Trawick-Smith, 2000). An alternative explanation to their lack of interest in play maybe that they are able to engage in play but choose not to do so, suggesting they may need more support and encouragement (Trawick-Smith, 2000). Deficits in verbal and reciprocal communication are universally common in these children prohibiting successful social adaptation and acceptance (Paul, as cited in Volkmar, 2007 & Charman and Stone, 2006). *Echolalia* – meaningless repetition of others' speech - is a common feature which these children engage in (Trawick-Smith, 2000). Prizant and Duchan (as cited in Trawick-Smith, 2000) suggest encouraging echolalia is an important strategy to promote communication.

### **3.2 Music Therapy for Children with ASD**

#### *Research*

Research findings support the argument that Music Therapy may be an effective intervention for children with ASD. However, most of the research studies to date are pilot studies raising the need of larger studies to confirm the positive effects and to apply in clinical practice (Wigram and Gold, 2006).

Gold, Wigram and Elefant (2007) assessed the evidence for the effectiveness of music therapy for individuals with ASD through a review of three small studies. The results indicated that improvement in gestural and verbal communicative skills was more likely to occur with music therapy than other similar interventions that do not use music (Gold et al., 2007). It was also suggested that music therapy may be slightly more effective in treating behavioural problems than a similar verbal therapy (Gold et al., 2007). However, the review used only three studies therefore limiting the possibility of generalisation.

Further, Kim, Wigram and Gold (2008) investigated the effects of improvisational music therapy on joint attention behaviours in pre-school children with ASD. The authors define *joint attention behaviour* as “an interactive state of joint engagement that involves the child, the therapist, and objects, or events in either musical form or in play” (Kim et al., 2008, p. 1759). In this research, a randomised controlled trial was used to compare the results of 12 weekly 30 minute improvisational music therapy sessions and 12 weekly 30 minute play sessions with toys. 10 children with ASD between 3 and 5 years of age participated in the study. The results indicated that the improvisational music therapy was more effective in improving joint attention behaviours of the participants than the play sessions with toys. This study was also conducted using only a small sample size hence the results limit the generalisability.

Maitland (2007) studied her own music therapy process with a child with ASD; how the child used music to communicate and how she, as a music therapy student

experienced and interpreted the process. By using a music-centred approach, the qualitative study revealed that the child, who had a significant problem with verbal and nonverbal communication, was able to show significant strengths in his musical communication. Improvisational music therapy involving turn-taking, initiation and imitation provided a structured but flexible medium (Maitland, 2007).

### *Music and child development*

Some of the available literature illustrates a developmental theory perspective to explain the music therapy process for children with ASD. Most literature uses Stern's theory of mother-infant interactions to explain the rationale for using music therapy for children with communication disorders. Stern's interactional theory asserts that the infant from birth builds and develops its sense of self on the actual interactions with the mother (Wigram et al., 2002). It implies that one's real experiences and incidents are the means by which one develops his/her sense of self (Wigram et al., 2002). Implicit (tacit, subconscious) schematic knowledge about relating with others is built at this pre-verbal level (Wigram et al., 2002). Moreover, the pre-verbal communication between the mother and the infant contains the elements of music such as tempo, rhythm, melody, tone etc., which are integrated into the child's mental structures (Wigram et al., 2002). Stern's theory supports the notion that the musical interactions between the therapist and client contain non-verbal knowledge about relationships which are expressed during the interactions (Wigram et al., 2002).

Bunt (1994) illustrates the links between music and child development based on the book, *The Third Ear* by Joachim-Ernst Berendt. According to Berendt, the very first experience that the young embryo encounters is sound – the sound of the maternal hear-beat, blood circulation and other nearby sounds – as the auditory system becomes completely functional by thirty weeks (Bunt, 1994). Studies such as those by Ockelford, Salk in 1960s and Shetler in 1980 suggest that young babies quickly tune to mother's voices and other environmental sounds and respond to them (Bunt, 1994). The young babies' musical experiences naturally occur when listening, singing, humming and playing with sound hence facilitating non-verbal communications with an adult. Songs and lullabies combined with rocking calm the babies (Bunt, 1994). The babies' cooing sounds and loud cries are rhythmically and melodically structured. (Ostwald, as cited in Bunt, 1994, p.77).

Helmut Moog, who tested the developing responses of pre-school children, state that the babies continue to engage in the natural musical experiences throughout their early childhood (Bunt, 1994). One year-olds present increased vocalisations which are elicited by increased motor activity and selectivity in response to certain sounds are also increased (Moog, as cited in Bunt, 1994). It is expected that two year-olds should be able to sing using more tonal and intervallic content and simple rhythms (Moog, as cited in Bunt, 1994). Their movements become more frequent in response to music (Moog, as cited in Bunt, 1994). By the age of five, their awareness of tempo, rhythm, melody and words are developed with some difficulties in maintaining tonality and intervals (Moog, as cited in Bunt, 1994). Researchers assert that the social interaction between the mother

and the child at pre-verbal level contributes to the improvement of the child's development (Bunt, 1994).

Caregivers and infants develop their social relationships through the musical experiences illustrated above such as the exchange of simple vocalisations. The mother and the baby communicate by means of sounds and movements which involves imitation, turn-taking and affective attunement or 'tuning into the child' (Holck, as cited in Wigram, Pederson and Bonde, 2002 & Bunt, 1994). Scholars describe this interaction in musical terms: *tonal qualities* – pitch, timbre and tonal movement, and *temporal qualities* – pulse, tempo, rhythm and timing (Holck, as cited in Wigram et al., 2002 & Gold et al., 2007). Those qualities are sensitively perceived by young infants and this enables them to communicate with their parents at pre-verbal level (Holck, as cited in Wigram et al., 2002). This notion suggests that humans are born with communicative musicality and hence music therapy can be a particularly useful intervention for helping children with communicative disorders (Oldfield, 1995; Trevarthen, Aitken, Papoudi and Robarts, 1999; Holck, 2002 as in Wigram et al., 2002; Gold, Wigram & Elefant, 2007 & Kim et al., 2008).

### *Therapeutic relationship*

Another perspective used in the literature is an interactional theory perspective proposed by Daniel Stern (Holck, as cited in Wigram, 2002). The theory emphasises that "all human development takes place in relationships with others" (Holck, as cited in

Wigram, 2002). In therapy, professional therapeutic relationship provides a fundamental ground by which mutual communication and dialogue between the client and the therapist can be realised and developed over time (Bunt and Hoskyns, 2002 & Holck, 2002 as in Wigram, 2002). The term *therapeutic* implies “the ordinarily good relationship that any two people need to have in cooperating over some joint task” (Brown and Pedder, 1987, p. 54). A *relationship* is “an evolving dynamic process bringing with it the idea of constant movement, growth and change” (Bunt and Hoskyns, 2002, p. 36). In music therapy, the *therapeutic relationship* is formed between the client and the therapist by using music, creating a jointly constructed musical history. Through the cumulative process of musical interactions, the actions of the two parties during the interaction become meaningful and comprehensible to each other (Holck, as cited in Wigram, 2002), therefore promoting the child’s development of communication.

### *Music Therapy methods*

Improvisational music therapy is considered as an effective method for working with those with communicative disorders. Music therapists and researchers claim that it can contribute towards building a trusting relationship, self-expression, social interaction, increasing communicative behaviours and the generalisation of skills to other settings (Trevvarthen et al., 1999).

The notion of ‘structure’ is noticeably discussed in the articles concerned with music therapy methods for children with ASD. Wigram (2002) disagrees with the

argument that music therapy lacks structure therefore it is not an effective intervention for this population. He argues that it depends on the understanding of the degree and the nature of structure. Music therapy involves structure as there are many levels of structure within music, where creativity and flexibility is also promoted, which is especially important for children with ASD who present rigidity (Wigram, 2002). Moreover, Wigram and Gold (2006) assert that improvisational music therapy is an appropriate therapeutic framework for working with this population. A feeling of security is important for children with ASD in order for them to be able to demonstrate their potential communicativeness and creativity safely (Wigram & Gold, 2006). Repetition of ideas is important for direction and familiarity when improvising both tonal and atonal music (Wigram & Gold, 2006).

One example of the implementation of structure and flexibility in improvisational music therapy is comprehensively demonstrated in Oldfield's case in Wigram, Saperston, and West (1995). Here, Oldfield discusses her approach to working with a child with ASD, particularly concerned with the balance between following and initiating. A music therapist is both directive and non-directive to some degree in sessions (Oldfield, 1995). Oldfield's approach involves providing a clear beginning and ending point in the few initial sessions and allowing the child to be freely expressive as much as possible. Hello song and goodbye songs are sung while encouraging the child to sit opposite to the therapist (Oldfield, 1995). In between these points, the therapist supports and encourages the child by mirroring the child's playing through music, sometimes with sung acknowledgements of the child's behaviour (Oldfield, 1995). The

therapist becomes more intrusive after two to three sessions, suggesting different instruments and activities (Oldfield, 1995). Gradually, a pattern is established and the therapist uses this directive approach interspersed with the non-directive one (Oldfield, 1995). Within the structure, the client is able to feel the security and at the same time, can relax and retreat into his/her world during the non-directive moments (Oldfield, 1995).

Holck (2002 as in Wigram, 2002) and Holck (2004) illustrate several response-evoking techniques in music therapy which are used to help children with communication disorders. These include imitation, turn-taking, pausing, musical surprises, theme and variations and musical sequences. Turn-overlaps are conceived as mistakes in a normal conversation however, it can be adapted as a useful technique by a music therapist to create alternation (Holck, 2004). In the case of music therapy with a young boy with autism illustrated in Holck (2004), two clinical ways in which the technique could be used were suggested – as “*interruptions* and as a gradual *taking-over* of the turn.” In addition, Prizant and Duchan (1981, as in Holck, 2004)’s notion of echolalia is of interest. In their study, around a third of the echolalia appeared in connection with some of the nonverbal cues normally seen in turn-taking. This indicates that the child not only repeated the adult’s utterances at the same time, but also gave their own behavioural turn-yielding cues for the continuation of the interplay, for example, looking at him/her, turning or leaning forward to him/her etc. (Holck, 2004). Holck (2004) states that “Prizant and Duchan could show, by focusing on the *function* of the echolalia rather than its *content*, that despite the children’s lack of understanding



of the verbal content of the dialogue, there were social attempts at managing turn-interplay” (Holck, 2004, p. 48).

### 3.3 Music Therapy Training

Studies by Grant & MCarty (1990), Fowler (2006), Prefontaine (2006), Watson (2005), Webster (1988) and Wheeler (2002) are considered with the issues of music therapy training. Most of the key themes discussed in these studies include personal growth and change in music therapy students during the training process. The authors agree that therapy is not just a one-way process of therapist helping the client, but rather it is a process where the two grow together. Students’ perspectives or the authors’ view on their own journey of personal development as trainees are examined in some of the literature. The studies demonstrate the difficulties that are inevitable during the process of learning and change and include the issue of *burnout*, defined as “an emotional exhaustion that begins with unnecessary and extended levels of job stress” (Greenberg, as cited in Fowler, 2006).

Training of music therapy students involves integration of both musical skills and clinical arenas (Bunt and Hoskyns, 2002). Darnley-Smith and Patey (2003) list some essential qualities that a music therapy student needs to possess. These include musicianship, personal suitability, and intellectual curiosity. During the training, the music therapy student learns to connect with the client by using music; he/she must be committed to his/her first instrument and able to be flexible and communicative with it

(Darnley-Smith and Patey, 2003). The authors point out that the student must learn to experience failure, not in terms of their musical skills but in the process of relating through music, because patience is essential when establishing a therapist-client relationship which usually takes time and effort. Moreover, it is stressed that the intellectual curiosity is equally as important as the musicianship and the personal quality. The acquisition of academic skills is important to enhance knowledge about music therapy theory and practice as well as other related disciplines which will enable effective communication with other professionals (Darnley-Smith and Patey, 2003). Critical thinking skills will help the student to hold more than one point of view at a time, thus enabling him/her to analyse the therapy process objectively (Darnley-Smith and Patey, 2003). Furthermore, the student is required to possess flexible, reflective and expressive personalities which will aid in the process of self-learning that potentially will disclose his/her vulnerability during the training period (Darnley-Smith & Patey, 2003).

Prefontaine (2006) and Watson (2005) agree with Darnley-Smith and Patey (2003) who posit that on becoming a music therapist, it is important that one needs to develop musical skills and the knowledge about theory, as well as the understanding and development of personal qualities. Legendre (1993 as in Prefontaine, 2006) states that learning implies one's "continuous process of imbalance and disintegration followed by equilibrium and synthesis after a more or less lengthy period of uncertainty and hesitation leading to new and more evolved structures"(pp. 2-3). Music therapy training involves *experiential learning* by which the students can "bring learning to life"

(Watson, 2005, p. 13). The experiential learning involves “changes in emotions, knowledge and/or capacities in an individual” resulting from a specific event (Dumas, 1995 as in Prefontaine, 2006, p.5). Prefontaine (2006) asserts that to learn from an experience, one must be able to reflect consciously on that experience.

Personal change is inevitable during the experiential learning process and this is often painful (Watson, 2005). In Watson (2005), quotations from some of the students describe the difficult process of confronting personal issues which ultimately allowed greater sense of self-awareness and better identification and articulation of both their struggles as well as the associated positive benefits. *Disjunction* – “a sense of fragmentation of part of, or all of the self, characterised by frustration and confusion, and a loss of sense of self. This can result in anger, frustration, and a desire for ‘right’ answers” (Savin-Baden, as in Watson, 2005, p.13) - and can be present as students go through the phase of transition (Watson, 2005). Engaging with the issue through a reflective process is the most positive way of resolving such challenges and this can be supported by supervision and personal therapy (Watson, 2005).

Similarly, personal development during music therapy training is considered as a significant theme in Webster (1988). Webster (1988) states, that music therapy concerns the relationship between the therapist and client using music as a medium to communicate or express the inner self. In order to establish and maintain an objective view of the therapeutic relationship, a responsible therapist should be able to understand and acknowledge all his/her own responses brought about through the interaction

(Webster, 1988). The author describes her own training experience as unlocking “the door to a world of self-awareness and self-discovery” which she “had never imagined to be so revealing, so painful but also so exciting” (Webster, 1988, p.18). To illustrate, some of the challenges during the experience were pointed out, such as lack of confidence and how this led her to look closely at her own personality, relationships with other people and her childhood. An occasion when the author had an improvisation session with an experienced music therapist helped the process of bringing personal issues to her consciousness.

As in other helping professions, music therapists are also susceptible for burnout. It may result in decreased job productivity and efficacy and/or withdrawal from the profession (Prefontaine, 2006 & Fowler, 2006). Burnout consists of the following main symptoms – “depersonalisation, emotional exhaustion, and a lack of personal accomplishment” (Maslach & Jackson, 1986 as in Fowler, 2006). While there exists little research that examine the causes or the prevention of burnout among music therapists (Fowler, 2002 & Prefontaine, 2006), Fowler (2006) studied the relations between professional well-being of music therapists and personality characteristics and work environment. It was found that professional longevity is associated with positive mental coping strategies or positive attitudes and that positive appraisal and threat minimisation, together with some lifestyle changes such as healthy nutrition, rest and regular physical exercises reduce the risk of burnout and promote professional well-being and longevity. Fowler (2006) suggests that implementing programmes that train

music therapists in these coping strategies may support professional longevity and well-being.

Pre-internship fears of music therapists were examined by Madsen and Kaiser (1999). Subjects were asked to list their three greatest fears in the year prior to their internship. Preparation issue was the most frequently noted fear, followed by the fears of failure, supervisor and placement and physical matters such as money and housing.

Grant and McCarty (1990) studied the emotional stages of fifty-nine music therapy interns over their 6-month internship period. Each subject completed a Likert scale to rate their feeling states concerning personal and professional matters at the beginning and at the end of the internship. The results indicated that the interns' personal and professional ratings were significantly ( $p < .01$ ) impacted if the interns received their first choice in sites; they rated their personal and professional ratings higher. In other words, they seemed to adjust better to the placement if they received their first choice. Those who received stipend throughout the internship rated their professional ratings higher, however not so much on their personal ratings. Those who were married rated themselves higher than those who were single on the professional items, however, not on personal ratings. Population had some significant impact on the professional ratings. Gender, type of facility and outside employment did not have significant impact on overall ratings. Month 4 was a turning point for the interns' personal ratings, with a slight drop from Month 3 to Month 4 then an increase during

Months 5 and 6. Professional ratings increased steadily with significant increases during the first 2 months and the last 2 months.

Wheeler (2002)'s phenomenological study investigated the experiences and concerns of undergraduate students during their music therapy internship. The participants were interviewed midway through the first semester of practicum, once near the end of the first semester and again near the end of the second semester. The results revealed six areas of interest; challenges encountered by students, means of dealing with challenges, involvement with clients, areas of learning, supervision issues, and structure of practicum. Students' main challenges included fear of new practicum placements, wanting more information before beginning clinical work, and more guidance as to what to do in sessions. The students also were concerned about not having much experience working with children and thus having difficulties meeting their needs. The need for better musical skills and being graded were also pointed out. To deal with the challenges, the students employed self-devised strategies to ease discomfort such as visiting the next placement facility ahead of time, increasing the level of involvement, obtaining more knowledge about clients, discussing their musical skills with supervisor, and applying the knowledge gained from the experiential learning in student music therapy group. Positive changes in and responses from the clients contributed to ease the students concerns regarding meeting the clients' needs. Means of dealing with the personal issues included writing journals, being assertive about themselves, and using supervision to help build their work effectively. For better practicum experiences, the students suggested providing an outline of what to look for when making the first

contact, more role plays, building and adapting more resources and having discussions that are more relevant to their client populations in class. Some students thought staying with the same client group for a sustained period was useful, while others thought observing and working with various kinds of client groups would be better for their learning. The researcher points out that the students' perspective is often different from the educators and supervisors, and suggests that increasing the understanding of students' experiences and concerns can be helpful in improving music therapy education and supervision.

In summary, there exists a range of studies concerned with music therapy for clients with ASD, who present deficits in developmental and social abilities. Research studies claim that improvisational music therapy can be an effective intervention for people with ASD, as it can promote communicative and behavioural improvements. The theoretical orientations of music therapy methods are based on theories of mother-child interactions. The concepts are applied in improvisational music therapy where receptive communication is encouraged by the therapeutic relationship between therapist and client. Further, studies concerned with issues in music therapy training reveal various emotional stages of the students during their practicum experience as the training often involves intensive personal development.

## **Chapter 4. Methods**

### **4.1 Methodology**

I have used an action research paradigm for this research project as it focuses on exploring and examining the process of my own clinical work and my reflections on it. Action research implies the process of identifying a 'problem' that needs attention, then undertaking practical actions, followed by collective reflection and evaluation to solve that problem (Wheeler, 2005). Its main purpose lies in improving one's practice through a systemic process of action-reflection cycles. McNiff (1996, p. 13) writes, "Action researchers are intent on describing, interpreting and explaining events (enquiry) while they seek to change them (action) for the better (purpose). The main difference between action research and other research methodologies is that action research requires informed, committed and intentional action as an integral part of the research (McNiff, 1996). The concept has been constructed by Kurt Lewin (1946/1948) who developed the process of *spiral of steps* in the mid-1940s. Through the spiral of action and reflection, goals and ideas of the research may be reformulated from one cycle to another (Wheeler, 2005).

### **4.2 Methods and procedures**

The basic framework for this research involved a series of action cycles. In Stige (Wheeler, 2005, p.409) and Hunt (2005), a five-step process of the action-reflection cycle is demonstrated. The five steps are (1) Problem identification, (2) Fact finding, (3) Making an overall plan, (4) Action/data collection, and (5) Evaluation/data analysis.



### 4.2.1 Action cycles

The five steps have been incorporated into my research with a total of five cycles<sup>3</sup>;

1. Problem Identification: identifying the challenges I have been facing during the course of my clinical work with children with ASD
2. Fact finding: information gathering about the client, and how I think and feel about building up a therapeutic relationship with a child before starting therapy
3. Making of an overall plan: how I might work towards building up a therapeutic relationship with the client
4. Action/data collection: my actions in music therapy sessions
5. Evaluation/data analysis: analysis of the data through categorisation of the themes that emerged.

The first cycle was focused on the preliminary stage of the therapy process involving the whole five steps. Then, each of the following cycles began with a

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<sup>3</sup> I had originally planned each cycle to involve two music therapy sessions and one supervision session, thus researching through four cycles in total. However, as the study progressed, the plan has been modified according to the emerging data, which is demonstrated in Chapter 5.

modified plan according to the evaluation of the previous cycle, therefore employing steps 3, 4 and 5 only.

#### **4.2.2 Data collection**

Data was collected from a number of sources. Descriptive clinical notes written after each session, and video recordings of each session were used for reviewing my actions in the therapy sessions. Supervision notes were used to review the discussions with supervisor. Journal entries were written regularly to reflect on a range of personal responses to the research process.

#### **4.2.3 Peer-debriefing**

Peer-debriefing, an informal discussion with a fellow music therapy student was carried out during the research process. As the project is qualitative self-inquiry, it seemed important to have a neutral point of contact to help check and refine the process of my interpretation and planning. Wheeler (2005) points out the importance of involving others in the research process to help clarify and test out the ideas of the researcher, and peer-debriefing is suggested. This medium of consultation is defined as a “process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer’s mind” (Lincoln & Guba, 1985 as in Wheeler, 2005, p.359).

My peer had reviewed the process of my action cycles. The kinds of observations made by my peer included, 1) acknowledging the difficulties I encountered on the research process, 2) suggesting that I was perhaps over self-critical. Thus, I have reviewed and amended some of my writing to a more objective stance. The discussion of peer-debriefing is not included in the data.

### **4.3 Ethical considerations**

The project was reviewed by the chair of the local Health and Disability Ethics Committee, under the system of 'Expedited Review' in August 2008, application number NTY/08/61/EXP and consent was given in August 2008. I was the main participant of the project. The child with ASD who was on the top of the waiting list of the Centre was chosen. Informed consent was sought for the child from the parents for the review of the child's video recordings, as well as from a clinical supervisor for the review of supervision notes.<sup>4</sup> The names of the client and the parents have been changed within the text, and the name of the supervisor and the place of practicum are disguised to protect their identities.

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<sup>4</sup> See Appendix 1-4 for Information sheets and consent forms for family and supervisor.

## Chapter 5. Findings

### 5.1 The 1<sup>st</sup> Cycle

**1. Problem Identification:** the challenges I encountered during the course of my clinical work with children with ASD

#### **1.1 Clinical concerns**

I have become aware over the course of my placement that ‘anxiety’ has often been a feature of the sessions I have experienced, both my own and the children I have worked with. I think it is likely that the children were often anxious in music therapy (perhaps as part of their ASD diagnoses) and this probably influenced my own anxiety in the sessions. I have wondered if this is something I can understand and manage better. With regard to my clinical skills, the main challenges were concerned with how to deal with and respond to the child’s anxiety therapeutically during the session.

#### *Uncertainty of therapeutic actions*

The level of their anxiety as well as mine was always highest in the initial sessions. When the child showed his/her anxiety in a certain way, for example, uttering negative comments or behaving in inappropriate ways, I was often uncertain as to how to respond. This challenged me building up the initial relationships with the children. I wondered about how I could do this in the most effective way.

#### *Clinical improvisation skill*

I had the feeling that the music I created in the sessions could result in quite inefficient, or even ineffective clinical practice at times. My anxiety in sessions was

revealed in my music which sometimes became over-busy or without direction. I found it challenging to tolerate silences or uncertain moments and felt urgency to fill these moments.

## **1.2 Personal concerns**

In terms of personal development, my main concern during the seven months of the practicum at the centre has been the uncertainty about my clinical skills and the lack of confidence in professional skills. I was aware that I had a relatively short experience among the therapists at the centre and this affected my confidence. I felt pressure that I should work competently as a member of the established therapy centre.

### *Uncertainty about clinical skills*

Although I have been working with a few children with ASD, I did not always feel what I was doing was 'enough' or 'correct'. I constantly had doubts about my plans and strategies in sessions, for example, whether I should provide more structure or less, whether my improvisation was helping to develop the communication with the child effectively.

### *Lack of confidence in professional skills*

I was self-conscious about my competency in professional skills, such as communicating with parents. Close communication with the parents of the clients was an important philosophy at the centre, therefore, meetings with parents were held regularly. At the beginning of my practicum period at the centre, I had no experience in consulting with parents. I had attended and observed a couple of consultations and pre-

assessment meetings that my supervisor facilitated and this was a very new experience for me.

After some observations, I facilitated the pre-assessment meetings by myself. Initially, I felt nervous and incompetent when explaining to parents what music therapy is and how I will be able to help their child. I gradually gained confidence facilitating the pre-assessment meetings as I went through more of these. However, my assessment review meetings still felt difficult sometimes, as they involved discussing my work in depth with parents.

In my first assessment review meeting, my supervisor was present with me for support. I was the main facilitator of the meeting, and explained the assessment process I held with their child. When questions came up from the parents, I did not feel confident when answering them. My supervisor supported when difficult questions were asked. My supervisor and I noticed that the parents were mainly looking towards the supervisor during the discussion rather than me. It was difficult for me to feel that the parents left the meeting with trust in me.

One other incident when I felt a lack of confidence was when my supervisor handed over a client to me, whom she has been working with for a few years. The parent of the child expressed a concern about the change of the level of the expertise. I felt the pressure of having to assert my skills while working with that child.

Therefore, my focus in this action research has been to try to improve my practice by,

- 1) concentrating on the clinical and personal concerns illustrated above,
- 2) trying to understand better what I am doing by documenting and discussing my work, and
- 3) devising and testing strategies to improve my work by going through the action-reflection cycles.

The next stage was to first find out some background information about the client in order to plan the overall therapeutic aims. This was done through a pre-assessment meeting with the parent.

## **2. Fact finding: Pre-assessment meeting with a parent.**

### **2.1 Clinical: Information about the client**

Daniel has been on a waiting list for about a year, so I called for a pre-assessment meeting with his mother, Jane. It took nearly a month to meet with her due to Jane's various circumstances. At the centre, only the parents are invited to the pre-assessment meeting for the easiness of communication. In Daniel's case, this was not possible because Jane had to bring Daniel to the meeting as she could not find a baby sitter for him. It was difficult to engage in a thorough conversation with Jane as Daniel was very active and we were both distracted.

Nevertheless, it was a good opportunity to observe Daniel, as I had not seen him before. Daniel was a likeable and very busy boy. He seemed to have some awareness of others.

*Clinical notes (pre-assessment meeting with Jane and Daniel, 10<sup>th</sup> of October, 2008)*

*“Daniel seemed a happy and very energetic boy. He smiled, giggled and made good eye contact with me. He could say my name, “Na-Ha” (Na-Hyun), which Jane seemed to have taught him beforehand. Daniel seemed to have a good relationship with Mum and communicated well with her using body and vocal gestures.”*

Daniel had been showing some progress since the consultation a year ago. Jane was enthusiastic when talking about this to me. This led me to feel the excitement and a hope that my work would also contribute to his progress.

*Clinical notes (pre-assessment meeting with Jane and Daniel, 10<sup>th</sup> of October, 2008)*

*“According to Jane, Daniel has been receiving multidisciplinary intervention including art therapy, play therapy, music movement and speech language therapy. He is home-schooled, taught by his mother. Jane confidently demonstrated to me how she works with him and passionately talked about her philosophy and strategies. Jane said that the interventions have been helping Daniel greatly which brought positive outcomes since the music therapy consultation. She said Daniel is communicating better, developed a good relationship with family, can*



*better understand instructions, is making good eye contact with people, and his temper tantrums has been reduced. He is intuitive with others, which helps him to read people's emotions. He can read mother's facial gestures and respond to them. Daniel is able to indicate what he wants by uttering short words, for example, he says "Go now" when he is unhappy."*

It seemed that Jane's understanding of music therapy was different to my own frame of reference, and perhaps tied up with the wish to see him learning music and developing skills in a regular way.

*Clinical notes (pre-assessment meeting with Jane and Daniel, 10<sup>th</sup> of October, 2008)*

*"From obtaining general information about Daniel, I talked about possible music therapy goals and how it might help Daniel. When talking about the possible goals, Jane stated that her ultimate music therapy goal is for Daniel to learn how to play piano. It seemed that she did not have a clear understanding about music therapy, so I explained the differences between music therapy and music education."*

## **2.1 Personal: How I thought and felt about building up a therapeutic relationship with Daniel before starting therapy**

Two themes arose from analyzing the journal entries before and after the pre-assessment meeting with Jane and Daniel; *excitement* and *anxiety*.

### **2.2.1 Before the pre-assessment meeting**

I generally like observing and being with children, so I felt excited meeting Daniel for the first time. Also, it was going to be another challenging experience working with a new client which I felt I would benefit my learning process.

However, I was a little anxious because I anticipated that it might be difficult to stay confident about this whole process with the new client. This seemed to have come from the difficulties of facilitating the initial appointment due to various circumstances; Daniel lived in a distant suburb from the centre, Dad has cancer, it was hard for Jane to find a baby sitter for Daniel in order to attend the meeting by herself. Jane seemed to be distressed at times about the difficulties she encountered.

*Journal excerpt (9<sup>th</sup> of October, 2008)*

*“...The meeting has been delayed for a month, due to various circumstances. Although Jane said they will come every week, it does not seem to be guaranteed that they would be able to attend the sessions regularly...Jane seemed distressed and this affected my anxiety level. She seemed to have a lot of expectations for music therapy and I feel the pressure of proving that I am confident enough to make the difference in Daniel.”*

### **2.3 After the pre-assessment meeting**

Daniel was very active and it made it difficult to talk to Jane consistently. This seemed to have affected my anxiety more, which affected the clarity of thought. It led

to the difficulty in explaining about music therapy as fully as I wanted. I also felt the pressure that I need to meet the parent's expectations by showing some difference in Daniel in the next 8-10 weeks. The following journal excerpt illustrates this:

*Journal excerpt (10<sup>th</sup> of October, 2008)*

*"I was glad to see Daniel before starting the therapy. I felt excited to get to know about Daniel and Jane...The meeting felt chaotic...I was frustrated about the fact that I could not say what I wanted to say. I felt pressure that I will need to exhibit my expertise in this field...I was anxious about how well I might do to keep Daniel in the music therapy room for the full half hour...I felt exhausted and stressed after the meeting although I was happy to meet Daniel and Jane for the first time."*

The night before the first session, I had an uncomfortable dream. I dreamt about having to teach Daniel how to play piano. In the dream, I was feeling pressured by this but began to teach him nevertheless. Then unexpectedly, I saw Daniel somehow getting physically hurt which made me feel horrified. The dream seemed to have depicted my anxiety. It brought me the awareness of how I felt.

*Journal excerpt (the night before the first session, 10<sup>th</sup> of October, 2008)*

*"It was a strange and horrible dream. The boy's limbs were cut in pieces, and he was bleeding and shaking, then died. It seems that my anxiety towards having Daniel for music therapy was represented in the dream...I*

*have no idea how Daniel would respond tomorrow...How should I plan the session? What's my goal?"*

### **3. Plan**

#### **3.1 Session 1**

##### **3.1.1 Clinical**

My general aims for the eight sessions to follow were,

- A) To assess Daniel's responses to the therapist and the music.
- B) To build a relationship with Daniel.

To assess Daniel, I planned the session with a minimum of structure – hello and goodbye song, and free improvisation in between to see how Daniel would respond to me, my music and the instruments as freely as possible. If it were necessary, I intended to try a pre-composed song to see how Daniel would respond to that also.

##### **3.1.2 Personal**

To minimize the uncertainty and the lack of confidence, I have set up the following personal goals:

- A) Have confidence about my practice; reassure myself that I have now some experience with children with ASD and that what I am doing is ok
- B) Try not to be self-conscious by reminding myself that I am working here because I am capable

### **4. Action**

#### 4.1 Session 1

It turned out that the initial boundaries were set off as Daniel already entered the therapy room before the session. Before the session had begun, I was not aware that this could have an impact in my first session.

*Clinical Notes (17<sup>th</sup> of October, 2008)*

*“Jane and Daniel arrived early at the centre, straight after another therapy appointment. They waited in the lounge area where musical instruments were stored, thus Daniel could see me preparing for his first session and the instruments have already captivated his attention. Jane and Daniel began to explore the instruments in the therapy room before the session had begun.”*

Daniel presented with a very short attention span and found it difficult to separate from Mum. His attention was primarily focused on his Mum. I tried to gain his attention by matching and reflecting. My music didn't seem to mean much to him. I found myself chasing up Daniel, matching and reflecting his activeness, which led my music to become scattered and nondirective. It felt like I was performing by myself to a couple of audiences who were enjoying their own time; Jane and Daniel engaged themselves in their own interaction as they explored the instruments.

*“The session began with a hello song with guitar. Daniel seemed alerted by this and played with the guitar strings for a few seconds then wondered off. He explored every instrument in the room, going out of the room every thirty seconds to one minute then coming back. When I*

*closed the door, he desperately pushed me away to make sure he knows that Mum is outside. I extemporised the hello song by addressing his name and acknowledging his behaviour. He mostly communicated with Mum, showing her the instruments, coming back and forth. The door had to remain semi open, and Mum stayed sitting down at the door. After the hello song, I continued to try grabbing Daniel's attention by matching his behaviour in my music on the piano, inviting him to play percussions and to clap with me, copying and vocalizing his utterances such as 'Wo-Shy' and 'ahh ahh'. Jane tried to redirect Daniel's attention to me, but it didn't seem to work."*

Jane made some comments during and after the session about Daniel's responses to instruments and my approaches in the session. It seemed she was anxious as the session did not work out nicely and wanted to suggest some of her ideas. I had to assure her that this is only the first session in which I must observe what Daniel brings into the session.

*"During the free play, Jane said that Daniel tends to get distracted by having lots of instruments in the room and the sound of horns gives him stress. After the session, she suggested having a strict structure in the session. I assured her that I am doing my assessment at this stage which means I need to use the free improvisatory approach to help reveal Daniel's responses naturally as much as possible."*

## 5. Evaluation

### 5.1 Clinical

The first session was a challenging experience encountering Daniel's responses to music therapy. He found it difficult to stay attentive for any length of time and to separate from Mum. It was also difficult because the boundaries were not clarified to Jane and Daniel before the session, i.e., to wait in the waiting room. In supervision, my supervisor and I reviewed the video recording of the first session and discussed about the strategies to deal with the difficulties.

*Excerpt from supervision notes (20<sup>th</sup> of October, 2008)*

*"My supervisor made some practical suggestions to deal with the difficulties I faced. To help keep Daniel in the therapy room, it was suggested that I clarify the boundaries to Jane during the week on the phone and suggest to her to stay in the waiting room. The supervisor also suggested some of the ways in which I can explain the fundamentals of music therapy with more clarity and authority."*

### 5.2 Personal

After the first session, uncertainty about my therapeutic and professional skills and anxiety about future sessions were revealed.

*Journal excerpt (17<sup>th</sup> of October, 2008)*

*"I feel the pressure already...I feel guilty about not explaining to Jane the basic boundaries beforehand...I felt annoyed at not being able to*

*explain with more clarity and authority about why and how I am planning to work with Daniel...As Daniel was active, I felt myself becoming anxious and flitting from one instrument to another too, just like Daniel. I stayed in the room, not following him when he went out frequently. I wonder if this was the best way. I also wonder if my vocal improvisation was appropriately done...my vocalisation felt fragmented.”*

These feelings were discussed in supervision. The supervision was a helpful space for obtaining emotional support.

*Excerpt from supervision notes (20<sup>th</sup> of October, 2008)*

*“I expressed the feelings that I had since the pre-assessment meeting. The supervisor assured me that these feelings are normal for students and acknowledged the challenging aspects while reviewing the video clip of the first session.”*

## **5.2 The 2<sup>nd</sup> Cycle**

### **1. Plan**

#### **1.1 Session 2 & 3**

##### **1.1.1 Clinical goals**

- A) To continue to assess Daniel’s response to me and my music.
- B) To communicate with Daniel through musical interactions.
- C) To help Daniel stay in the room with me for the full half hour.



To achieve goal A and B, use the same structure as session 1 and continue to reflect and match Daniel's utterances and behaviour through piano improvisation. To prevent Daniel becoming over-stimulated, try having less musical instruments as Jane suggested.

To achieve goal 3, phone Jane to talk about the boundaries; the importance of staying in the waiting room, the practical reasons why observing from the AV room is not possible; 1) the small window in the AV room from where the therapy room is not a one-way window so Daniel can easily be distracted, 2) the window is high up on the wall so the parent needs to stay standing, and 3) sometimes the AV room is occupied by another therapist for their work, the aims of the assessment and that I'm going to try a number of different things during the assessment period. If Daniel still finds it difficult to separate from Mum, invite Mum to the session.

### **1.1.2 Personal goals**

A) Take my authority and be firm when imposing my strategies.

B) Stay confident by reminding myself that I am allowed to be in charge.

## **2. Action**

### **2.1 Session 2**

It was not possible to reach Jane the day before the session, therefore I explained about the boundaries and my strategies just before session 2 and she agreed to follow this. This made it easier to keep Daniel to be engaged with me and stay in the room for

longer. I continued to reflect and match his actions and utterances in order to communicate with him.

*Clinical notes (24<sup>th</sup> of October, 2008)*

*“Daniel ran out of the music room after 10 minutes, but he could come back to the room with some encouragement. He tried to get out again a number of times but I could persuade him to stay with musical and verbal prompts. I could help him stay in the room and interact with him by reflecting and matching his actions and utterances – ‘wo-shy’ (road sign, indicating the guitar stand) - by improvising mainly on the piano. He touched and explored every instrument in the room, then became particularly interested in playing with a mic stand and a guitar stand. He seemed to seek my attention when he successfully lined up the stands and the guitar in a line. Although he was busy enjoying his own play, he seemed to be aware of me as he occasionally looked at me and checked out my responses.”*

## **2.2 Session 3**

Similar interactions continued in session 3, with increased signs of Daniel’s awareness of me and desire to communicate. Our communication became more dynamic.

*Clinical notes (31<sup>st</sup> of October, 2008)*

*“Daniel looked happy and energetic as he arrived. He repeated uttering ‘wo-shy’ and ‘Na-Ha’ as he arrived. He seemed to be aware of me and what is going to happen today. Jane told me he knows that Friday is a ‘Na-Ha’ day. Daniel readily separated from Mum and came to the room. He pointed at the guitar uttering ‘wo-yai’. I sang hello while also copying his utterance. He got animated by music and began to explore the instruments in the room.”*

I improvised on the piano mainly using two chords and acknowledged Daniel’s actions and utterances by singing. (See appendix 1, pp. 85-87). He kept his interest in the guitar stand, pointing at it while seeking my response (See appendix 1, pp. 85-87). The sudden stops and silences worked well to evoke Daniel’s attention (See bars 14-15, appendix 1, p.84).

Daniel also continued the ritual of lining up the instruments. Safety became a concern.

*“He liked to put the cymbal, snare drum, guitar and the stand all in a strict line, and pointed at them seeking my approval. He moved them around even though they were quite heavy for him; the snare drum and guitar fell off a couple of times. He also tried to climb up on the piano. He repeated this ritual all throughout the session.”*

Daniel's period of engagement in the room was extended in this session. However, he still ran out of the room and I had to constantly call him back. I remained persistent at not allowing him to go until the goodbye song was completely sung.

*"I could keep Daniel in the room steadily for 20 minutes although he ran out again 3 times afterwards. He tried to open the door several times during which I redirected him by singing 'no, no, come back'. After 25 minutes, he seemed to have gotten bored and ran out to see Mum. The waiting room door was open and Jane was sitting outside the waiting room. She kept on telling him to go back to the music room. I fetched Daniel, came back to the room and sang goodbye. He gazed out the door, but didn't run off while I sang. He went out when I said 'Now you can go'. I asked Jane to keep the waiting room door closed next time."*

It seemed that Jane was concerned about my approaches in the session as she raised the issue about using a structure again. There seemed to be still a lack of trust from Jane to me.

*"Jane enquired again about how much structure I am using in the session. I explained that I have the basic structure of beginnings and endings, in which free-play is encouraged in between."*

### **3. Evaluation**

#### **3.1 Clinical**

The strategies that I planned to keep Daniel in the therapy room worked. It also felt that Daniel's awareness of me and music therapy had begun to develop. The communication between Daniel and I continued to take place through musical improvisation, although these happened in short fragmentary moments. Reflecting and matching Daniel's utterances and behaviour helped to keep his attention and develop our interaction.

However, I realised that my piano improvisation was too busy, which seemed to reflect Daniel's busyness as well as my anxiety. This was pointed out in supervision and was evident when we reviewed the recording. I was glad that this was reminded.

*Excerpt from supervision notes (3<sup>rd</sup> of November, 2008)*

*"My supervisor pointed out that my piano playing was very busy with a lot of notes. She suggested that I allow enough pause during the improvisation to 'listen to Daniel' and give him time to respond."*

Also, some practical suggestions were made by the supervisor in order to keep Daniel focused in hello and goodbye song. By working on this, he may also be able to learn the awareness of the presence of the two people trying to greet each other.

*Excerpt from supervision notes (3<sup>rd</sup> of November, 2008)*

*"It was suggested that for hello and goodbye songs, try using 2 chairs and encourage Daniel to sit down to face me, while keeping his legs close to mine."*

From observing Daniel for the last two sessions, it seemed impossible to apply a strict structure which Jane suggested. Opinions about *structure* were also discussed.

*Excerpt from supervision notes (3<sup>rd</sup> of November, 2008)*

*“We discussed the meaning of structure. My supervisor said that increasing internal mechanisms for children with ASD is important for them to gain independence. In other words, if the child is constantly directed, he will not be able to gain independence...In music therapy, structure can imply a set schedule of activities, but also the fundamental structure, i.e. the therapy room, the session time, the basic frame of beginning with a hello and finishing with a goodbye song, and the structure embedded in music itself; beginning and ending with tonic etc... Having two chairs, sitting him on the chairs and getting him to face me and sing the hello song, that itself is a structure.”*

### **3.2 Personal**

Being able to keep Daniel in the therapy room for a longer period of time helped to gain my confidence and an assurance that my therapeutic practice in the session was appropriate.

*Journal excerpt (24<sup>th</sup> of October, 2008)*

*“I felt a sense of achievement when my plans all worked out nicely. It was a feeling of triumph proving that my ideas worked! This helped to regain my confidence.”*

However, I was still feeling frustrated as Daniel kept running out of the room. The doubts about my musical quality reemerged after session 3.

*Journal excerpt (31<sup>st</sup> of October, 2008)*

*“Every time when Daniel approached the door to open it, I felt like I was hanging on an edge of a cliff. I felt anxious and helpless. I was thinking, ‘oh no, not again...!’ I wonder if my music is not working well enough to keep him interested.”*

When Jane enquired again about the approaches, I wondered whether my explanation was still not assertive enough. I still felt that I was not doing an adequate job at getting the message across to the parent. I discussed this in supervision and some suggestions were made. I hoped that it would help Jane to understand the rationale for my strategies.

*Excerpt from supervision notes (3<sup>rd</sup> of November, 2008)*

*“It was suggested that I recommend Jane a case study or an article about music therapy for autism to help her understand music therapy theory and methods. Also, it was pointed out that the language I use should be carefully chosen for more effective communication.”*

It was interesting that my supervisor suggested quite simple, practical things to assist me. Perhaps this also gives Jane something helpful to focus on, when she might be worried for her own reasons.

## **5.3 The 3<sup>rd</sup> cycle**

### **1. Plan**

#### **1.1 Session 4 & 5**

##### **1.1.1 Clinical goals**

The goals remained the same as the last two sessions. I have decided to keep the basic frame of structure but to further enhance the outcome, the following strategies were planned, some of which were suggested in supervision.

- A) Arrange two chairs and help Daniel to sit down and face me to try and engage him in 1-1 interaction.
- B) Arrange smaller instruments for safety.
- C) While reflecting and matching, remember to allow enough space for Daniel to respond to me also.
- D) Try removing the piano stool to stop Daniel from climbing up on the piano.

##### **1.1.2 Personal goals**

- A) Revisit texts about music therapy with autism to review the appropriateness of my approach - *Communicating Through Music: The Balance Between Following and Initiating* (Oldfield, 1995), *Improvisation* (Wigram, 2004).
- B) Recommend a music therapy writing to Mum - *Music Therapy for Children with Autism* (Trevvarthen et al., 1999).
- C) Remember to talk about my emotional stages in supervision

### **2. Action**



## 2.1 Session 4

I could observe that Daniel's awareness of 'music time' with 'Na-Ha' was increasing. He seemed to be looking forward to come to music therapy.

*Clinical notes (7<sup>th</sup> of November, 2008)*

*"Daniel arrived 1 ½ hours early with Mum. He seemed excited by the instruments stored in the storage area. When I went to tell him to stay in the waiting room, he was beating a drum. He pointed at the music room when he saw me and uttered 'Wo-yai'. It seemed that he thought it was time for the session. I asked Jane to leave the door of the waiting room closed until the session begins. As soon as the waiting room door was open, he ran into the music room repeating 'wo-yai'.*

I tried having two chairs and encouraging Daniel to sit down on the chair facing me. It was difficult to have him seated on the chair for any length of time, but he did respond to my playing and singing at least for a few seconds. He continued to enjoy his play which was at times inappropriate and dangerous. However, he seemed to use this behaviour as his way of expressing his desire to communicate with me. A lovely turn-taking took place for the first time on the piano, which was quite unexpected. This gave me a sense of hope that there is a potential for us to connect with each other.

*"He sat down and strummed the guitar strings for a couple of times and ran off to enjoy his own play. Nevertheless I finished the song and began to match and mirror his play. I acknowledged his actions by singing and*

*playing; moving the instruments around the room, lining them up in order, sitting on djembe, climbing up on the piano - he used the little drums and the chair to step up, whenever he thought it was the chance. I had to constantly put him back on the floor. He seemed to enjoy my reactions. I tried to redirect his impulse to climb up to the piano by holding his hands and rowing while singing Row the Boat song. He liked this and wanted to repeat again. After this, he approached the piano and initiated the playing, with his flat fingers, touching the keys several times and giggling. I copied him and he seemed to find it fun. We continued this for a brief moment.”*

## **2.2 Session 5**

Daniel’s engagement continued to increase. He initiated the turn-taking on the piano (see bar 2, p. 88, appendix 2) and enjoyed it very much. To follow with what he initiated, I did not start with the hello song I used in the previous sessions but improvised a new one in accordance with Daniel’s playing (see bar 3, p. 89, appendix 2). Our interaction on the piano was characterised by Daniel playing random notes on the black keys while I provided grounding melodic theme using the black keys based on A flat major to match his improvisation (see appendix 2, pp.88-95). I tried to play less on the piano and ‘listen’ to Daniel more (see appendix 2, pp. 88-95). Daniel responded to my hellos by either playing the keys, or uttering ‘tikka’ or ‘wo-shy’ (see appendix 2, pp.88-95). Additionally, there was a prolonged gaze at me when I went down to the floor and played the guitar

*Clinical notes (14<sup>th</sup> of November, 2008)*

*“As soon as he entered the therapy room, Daniel approached the piano and began to play it. I matched this and improvised a hello song on the piano. The turn-taking was more extended than the last session and from time to time, he came back to the piano and initiated the play during the session. He seemed to enjoy this as he laughed and giggled a lot. After the piano interaction, he also kept on pointing at the guitar. I sat down and strummed it a couple of times with some pause in between. He looked alerted by the sound and gazed at me for a short while.”*

I removed the piano stool which did help to prevent Daniel from climbing up to the piano. However, his busyness and the insistence on the guitar were exhausting for me to deal with. Daniel’s lack of awareness of safety boundaries still remained.

*“Daniel went out and grabbed the guitar from another therapy room. At first, I told him not to bring it with him. He went out for the second time so I let him bring it to our room, then set up the two chairs again to let him know that there are two chairs, two guitars, and you and me. I tried to sit him on the chair, but it was not possible. Daniel repeated saying “2 tika” while playing around with the guitars. Sometimes he stepped on the guitars. I began to get frustrated and put them all on the top of the piano - which I soon regretted as it rather reinforced his attention to the piano. Daniel seemed furious and tried to go up on the piano. I put them back*

*on the floor and attempted to play the guitars with Daniel but this wasn't possible. He uttered 'Go Ho' (Go home) after 10-15 minutes."*

### **3. Evaluation**

#### **3.1 Clinical**

Allowing more silences during my piano playing seemed to have worked to grab Daniel's attention. Also, following his lead rather than starting with the usual hello song in session 5 led to a more dynamic turn-taking experience. More eye contact and attention was evident in session 5. I felt that now Daniel and I were communicating more, as the turn-taking on the piano was taking place nicely and it was mostly initiated by Daniel.

Safety was still an issue at this stage, as Daniel was not aware of the boundaries. He still tried to climb up the piano and stepped on the instruments. I discussed this in supervision. The supervisor talked about the necessity of verbalizing the boundaries. From having the discussion, I decided to try this from the next session.

*Supervision notes (17<sup>th</sup> of November, 2008)*

*"My supervisor questioned me if I told Daniel why he can't climb up the piano. I answered that I didn't because he wouldn't understand and I'm still sometimes unsure about when to choose to verbalise things or not and this prohibited me from doing that. She described the rationale for the need to inform the child by providing an analogy of a mother who is trying to put her child into bed; if the child is put to bed by mother and*

*the mother puts the light off without telling her it's time to sleep, the child will be furious and cry. She suggested using phrases such as 'We need to keep our feet on the floor', 'I need to keep you safe', or 'We cannot step on the instruments'.*"

### **3.2 Personal**

The challenges were still present but I could feel a joy after observing Daniel's excitement for music therapy and having the piano turn-taking for the first time in session 4.

*Journal excerpt (7<sup>th</sup> of November, 2008)*

*"I felt glad that music therapy sessions were becoming one of his joyful time. He responded to me showing increased desire to communicate, although it was exhausting for me having to pull him down from climbing up on the piano."*

Furthermore, revisiting some relevant music therapy texts before session 4 helped to gain a sense of reassurance about my approaches. Reading Oldfield (1995) was an affirming process that what I was doing was appropriate, as I found that my approaches with regards to balancing out structure and freedom was exactly the same as what Oldfield demonstrated in her writing. Reading *Improvisation* (Wigram, 2004) also helped in the process of reflecting on the quality of my improvisation on the piano.

On the other hand, the distressing feelings reemerged after session 5. Those feelings amalgamated with the challenges I experienced at the time in my other clinical experiences as well as the class.

*“With my other clients, it was pointed out that my piano playing was busy too. I was not happy about the recent presentation I did in class... Do I really know what I’m doing? Do I have efficient knowledge about autistic children? Am I doing enough study? I feel I’m right back at the starting point.”*

The uncertainty about my therapeutic skills led me to feel lethargic and helpless. I began to feel some symptoms of burnout, not wanting to go to work and losing the awareness of the positive aspects of the practicum experience.

*Journal excerpt (12<sup>th</sup> of November, 2008)*

*“...through the process of recognizing my weaknesses...all the things that I have already learnt and had many times to practice...led me to reflect on my placement experience so far. I had all this time...it’s nearly the end of my placement and I’m still making the mistakes. I didn’t even feel like going to the centre today. I was awake, still lying on my bed thinking what on earth am I doing this for? What’s the point of going to work and repeating the same process over and over again? Can I prove that what I’m doing with these children is actually contributing to bring out improvements in their daily lives?”*

But, soon I was able to beat the languishment by changing my thoughts to a positive side. I was using my ‘internal supervisor’ to regulate the anxiety myself.

*“It was hard getting up from bed, but after about 30 minutes of battling with my thoughts, I finally got up and headed towards the centre. In my other session, I asked my co-therapist that I want to try out playing the piano again in a less busy manner. I did this well today and I felt better about myself at the fact that I took the criticism meaningfully, acted on it, and have shown some progress at it.”*

Supervision was a valuable process through which I received an emotional support, helping me to look at the positive things I have achieved, and gaining helpful practical suggestions to deal with the emotions.

*Supervision notes (17<sup>th</sup> of November, 2008)*

*“I disclosed the doubts about my competence and the distressing feelings associated with it. I said I’m unhappy because I’m having these negative thoughts about my capability at the end of the placement period when I should be feeling satisfactions. My supervisor told me that the nature of my research which is a constant reflection and evaluation of my practice is reinforcing the self-critical attitude. She pointed out that these feelings seem to be having influence in my session with Daniel too. She acknowledged the difficulties I’m experiencing as a student and how*

*some good interactions were taking place in the sessions due to my effort. From reviewing the video together, she acknowledged how exhausting it is just to 'be with' Daniel. She suggested reviewing my mid-year assessment report in a fair manner as it may help regaining the confidence about my skills. I realised I have a high expectation for myself. I felt much better after the supervision."*

## **5.4 The 4<sup>th</sup> Cycle**

This cycle employed only one session, as the assessment review meeting was scheduled after session 6, which may have significant impact on refining goals for session 7.

### **1. Plan**

#### **1.1 Session 6**

##### **1.1.1 Clinical**

Further strategy was implemented to give Daniel an awareness of the safety boundaries. I planned to,

A) Clarify the boundaries for Daniel at the beginning of the session with both verbal and sung directions: to keep our feet on the ground, not on the instruments, to stay in the room for half an hour.

##### **1.1.2 Personal**

To remain positive and motivated, I promised myself to,



A) Review my mid-year assessment report. Remember the achievements I've made during the practicum, avoid thinking I should be able to manage everything by reminding myself I am a student.

## 2. Action

### 2.1 Session 6

I tried reinforcing the safety boundaries to Daniel verbally and musically, at the beginning of the session and whenever he challenged the boundaries. He didn't appear to understand much at this stage. I decided to use my body as the last resort.

*Clinical notes (21<sup>st</sup> of November, 2008)*

*"I said 'we need to keep our feet on the floor', 'we are staying in the room for half an hour', and sang 'here we are in the music room' several times, to give him the awareness of where we are...Daniel went out to the other music room twice to get another guitar which interrupted another music therapy session. From then on, I literally sat down at the door to keep him in the room."*

Despite the difficulties getting the message across about the boundaries, there were some pleasant moments of extended communication between the two of us.

*"It was delightful when Daniel initiated turn-taking on the piano. He liked chasing each other from both sides of the piano. He also initiated hide and seek around the piano several times. There were lots of*

*laughter and giggles. Daniel played freely as before and continued to check my responses to his actions. He repeated the pattern of ‘breaking’ the stand and ‘fixing’ it again. Staying at the door, I reflected his ritual by improvising a song; he repeated uttering “bo” (broken), “fee” (fix) which he learnt from the song and pointed at the stand and looked at me for my approval. When I began to sing the goodbye song, he looked at me furiously then pushed me away from the door and ran out.”*

### **3. Evaluation**

#### **3.1 Clinical**

At this stage, my attempts at giving Daniel the awareness of boundaries seemed to have worked when I gave him a physical message by sitting down at the door. On the other hand, the length of two-way interaction between Daniel and I were continuously increasing.

In supervision, we discussed my improvisation quality. While thinking about how to provide containment, my supervisor and I tried an improvised role-play on the piano. This has helped to gain better insight into the dynamics of the interaction in the sessions.

*Supervision notes (2<sup>nd</sup> of December, 2008)*

*“Daniel, played by me, sounded scattered, very busy, and had no direction. Supervisor played the therapist; she acknowledged that providing a ground was extremely difficult when trying to reflect and*

*respond to his busyness. We swapped the roles and I played myself as if in the session with Daniel. It was hard to connect with Daniel(supervisor) initially as I was so busy matching and following him, but I managed to reinforce some holding element which helped Daniel(supervisor) to meet me at some agreeing point.”*

### **3.2 Personal**

I was able to regain some confidence as I read through some positive comments in the mid-year assessment report.

*Journal excerpt (21<sup>st</sup> of November, 2008)*

*“Reviewing the clinical report has helped me in acknowledging my achievements. I acknowledge that I am just in the right place of my journey as a student.”*

Additionally, I had a dream again which seemed to depict my feelings associated working with Daniel. This led me to reflect about what kind of feelings and attitude I had towards working with Daniel. I was not sure why Daniel’s Dad suddenly appeared in my dream though.

*Journal excerpt (21<sup>st</sup> of November, 2008)*

*“In the dream, Daniel arrived early at the Centre with his father this time. He was carrying a baby in a carriage which seemed like Daniel’s little sister. Then Jane came in with 4-5 children who seemed like her own. They all*

*wondered around the Centre making noises. I remember feeling distracted and chaotic at the time. I was preparing for the session, and Daniel's Dad initiated a conversation with me. He was nice to me but, I wasn't to him nor Daniel! I was feeling exhausted and nervous when talking to them. Perhaps this dream depicted Daniel's busyness, and my chaotic and anxious feelings in response to it, or my lack of confidence in professional skills, or nervousness about the upcoming review meeting...?"*

## **5.5 The 5<sup>th</sup> Cycle**

To follow with the centre's policy, I scheduled an assessment review meeting with Daniel's parents after session 6. For the review, Graham, his Dad attended the review alone as Jane could not come with him (it was interesting that I dreamt about meeting Daniel's Dad, because I was not advised that he would come!). The review meeting with Graham revealed some interesting facts and ideas about working with Daniel. Thus, it was more appropriate to begin session 7 in a new action cycle with some refined plans.

### **1. Fact finding: Assessment Review**

It turned out to be a valuable opportunity to hear Dad's perspective about the work for the first time. He provided some practical ideas as well as encouragement which helped me feel hopeful. I felt like I met another ally for this battle.

*Clinical notes (28<sup>th</sup> of November, 2008)*

*“I explained the assessment process I took so far as well as about music therapy and my approaches with Daniel. I showed him three video clips, session 1, 4 and 5. He acknowledged the positive interactions that were taking place in the sessions which may help Daniel’s development of communication skills. He also acknowledged the challenges that were associated with the process and assured me that Daniel will show the fruits of my input. He said that Daniel now looks forward coming to music therapy.”*

A discussion took place as we reviewed the video clips. I highlighted the following matters I observed during the assessment so far:

- “1. It was difficult to keep Daniel in the room initially. The boundaries were not clearly informed which made it difficult for him to separate from Mum.*
- 2. Daniel is very active and finds it challenging to stay attentive. He runs out of the room which sometimes interrupts another client’s session.*
- 3. There is a concern of safety; Daniel likes to climb up on the piano and step up on the instruments.*
- 4. Daniel loves coming to Music Therapy and is certainly aware of me.*
- 5. Some expressive and receptive communication has begun to take place. These are short fragmentary moments of rituals which are repeated throughout the session.*

*6. Daniel enjoys my reactions to his inappropriate behavior which reinforces the behavior further.”*

Graham seemed to have a lot of knowledge about working with children with ASD. A few ideas in terms of technical skills were suggested by Graham:

- “1. To help Daniel stay in the room: try reaching out for Daniel’s hand with one arm and play the piano with another arm, to help clarify the message that we need to stay in the music room.*
- 2. To prevent the mirroring becoming a ritual: respond to the utterances but introduce another theme to redirect his attention*
- 3. To prevent Daniel to enjoy the ‘game’ of reactions; redirect his attention to a different a thing when he tries to climbs up on the piano or step on the instruments”*

He also enquired about using the hello song that they use at home. I was not very convinced about this and was confident enough to assert my thoughts.

*“Graham also told me that the parents have their own hello song they use at home. He enquired whether using this song might help Daniel to connect better with me in the session since it’s familiar to him. I suggested that using my hello song consistently will help Daniel to be more aware of ‘our own’ relationship, which is separate from his relationship with parents.”*

Overall, it was agreed that Daniel is certainly engaging in expressive and receptive communication with me and there is a great potential for Daniel to improve his social and communication skills through music therapy.

## **2. Plan**

### **1. 1 Session 7 & 8**

After the review meeting, I sought my supervisor's opinion with regard to the suggestions made at the review meeting. The supervisor advised that those sounded appropriate and suggested some other techniques:

*Supervision notes (2<sup>nd</sup> of December, 2008)*

- “1. Imitating Daniel's utterances as well as introducing another theme at the same time will prevent reinforcing the ritualistic dialogue.*
- 2. Moving the piano close to the door side may help reaching out for Daniel's hand and keep my attention to him when he tries to get out (the piano was usually placed to the wall opposite the door which makes it difficult to watch the door side).*
- 3. Holding and containing; try playing firm and striking chords with pointy fingers, which contrast to Daniel's flat fingers and scattered playing.”*

#### **1.1.1 Clinical**

I planned to try the suggestions made at the review meeting and the supervision in session 7 and 8.

- A) Move the piano to the wall close to the door to reach out for Daniel's hand when he tries to go out of the room,
- B) Try introducing another theme when responding to Daniel's utterances, e.g. "wo-shy, and a chair!"
- C) Try providing a ground in music to contain Daniel's activeness. When doing this, try pointy fingers which contrast with his flat fingers on the piano and strike firm chords.

### **1.1.2 Personal**

Reflecting on the dream after session 6, I thought about my exhaustion that seemed to have cumulated over the 6 week period from working with Daniel. Thus I planned the following personal goals:

- A) Try to be patient when Daniel challenges me by not trying to counteract his every movement.
- B) Eat well and find time to have good rests and to exercise
- C) Keep reminding myself about the progress Daniel and I had made together by reviewing the clinical notes.

## **4. Action**

### **4.1 Session 7**

I tried the strategies planned and these helped to bring a consistent communication between Daniel and I all throughout the session. Daniel showed more



clear responses to my sung instructions and continued to enjoy the turn-taking on the piano (see appendix 3, pp. 102). While Daniel freely played random notes on the high keys, I provided grounding theme on the low keys (see bars 1-6, appendix 3, p. 96). I reflected and responded to his utterances indicating his interest in guitar and reinforced safety by singing (see bars 7-15, appendix 3, p. 97). Although he went out of the room eventually, I was able to keep his attention to me and prevent him from going out of the room once by singing ‘won’t you come back to the room’ (see bars 16-23, appendix 3, p. 98).

*Clinical notes (5<sup>th</sup> of December, 2008)*

*“I sang ‘please sit down’ Daniel responded to my encouragement. This was easier for him than before. When playing the guitar on the chair, he physically came very close and leaned over to me, smiling and uttering repeatedly and also touched my nose. He approached the door very frequently but managed to come back when I persuaded him musically, singing and waving “Come back to the room”. I reached out for Daniel’s hand when he was at the door, but failed to actually hold his hand, as he was very quick. Some fragmentary turn-taking took place on the piano and guitar and this was repeated several times. I tried playing firm, striking chords with pointy fingers. When I redirected his attention from stepping up on the instruments to the chairs, he responded to this and sat down briefly.”*

Daniel was now aware of the structure that I introduced from the earlier sessions. He tended to repeat this in quick tempo, in small sequences.

*“I could see that he tends to repeat the patterns of behavior; sits down on the chair, hands the guitar over to me, touches it briefly, goes off to the piano to initiate the turn-taking, goes off to play with the stand and other instruments, tries to or actually goes out the door.”*

Daniel continued to show insistence on having two guitars and the stands and this ultimately led to a safety concern again. I was helpless when he went out several times which interrupted another music therapy session. I discussed with another music therapist about the ways to prevent this.

*“He repeated his usual utterances, but more today. He repeated “2-tika” (two guitars) frequently and I responded “1 guitar”, as there was only one guitar in the room. Towards the end of the session, he went out of the room and interrupted another client’s session 3 times in order to get the guitar from that room. When I lifted him up, his foot kicked another client which made him upset. I discussed the possibility of locking the door of the therapy room with the music therapist who was working with that client. ”*

## **4.2 Session 8**

Session 8 was scheduled for the following week of session 7, but it had to be cancelled due to my minor injury. Then on the following week, it was cancelled again due to Daniel's sickness, so it was not possible to have a closing session.

## **5. Evaluation**

### **5.1 Clinical**

It was evident that through the last 7 sessions, Daniel and I were able to develop an initial therapeutic relationship. However, there were still concerns remaining with regards to Daniel's and other client's safety. I discussed in supervision about the ethics of locking the door of the therapy room to prevent Daniel from running out and interrupting other's session.

*Supervision notes (18<sup>th</sup> of December, 2008)*

*"I realised it is practically not possible at the centre to lock the therapy room. Nevertheless, I enquired about whether it will be intimidating for him if this was possible. I expressed that I anticipate Daniel may get more frustrated if he can't get out, although it is not appropriate.*

*Supervisor advised that while other music therapists do try locking the door when needed, it depends on the client's capacity to tolerate this. We acknowledged that it is unfortunate not to be able to have an opportunity to try this and see Daniel's responses."*

As the final session was cancelled, I missed the opportunity to manage the closure with Daniel. Some ideas of closing the relationship with Daniel were suggested in supervision.

*“We also acknowledged the pre-mature ending as Daniel couldn’t attend the last session with me. Supervisor suggested that I write a letter for Daniel with some pictures and ask the parents to read it to him to help him understand there will be no music session with me.”*

## **5.2 Personal**

I was exhausted and concerned when Daniel ran out and interrupted another music therapy session. This led me to feel disappointed again but soon I was able to work with my ‘internal supervisor’ again to alter my thinking to keep my self-esteem.

*Journal excerpt (5<sup>th</sup> of December, 2008)*

*“My mind went blank after that exhausting session. I’ve tried everything I discussed and thought about...but I couldn’t help Daniel from running out of the room. But I acknowledge that our communication was taking place all throughout the session and this is an achievement. I should be proud of it!”*

A sense of achievement emerged after observing Daniel’s progress over the last 7 sessions.

*“Another exhausting session! But I was delighted when Daniel sat down when I sang please sit down. The number of times he actually sat down increased this session. I felt a joy when Daniel came so close to me and smiled.”*

In summary, this chapter has provided a demonstration of the 5 action cycles I conducted in which the five-step process of action-reflection has been adapted. I have had a total of 7 sessions with 4 supervisions and 2 meetings with parents. I have refined my plans and evaluated my actions in each cycle to develop therapeutic relationship with Daniel more effectively. Through the process, I have identified various challenges and the appropriate strategies to deal with them, which were evident in the data.

The next chapter will discuss the findings revealed in this chapter in relation to the literature as well as my own learning and some future implications.

## Chapter 6. Discussion

The findings revealed that I have improved my practice and shown some development in the various skills necessary for building up the therapeutic relationship with a child with ASD. This chapter will review how I was able to improve my practice by discussing the themes that emerged through the action cycles, and what I have learnt as a result. Also, implications for training and future research will be discussed.

### 6.1 Improving clinical practice

#### *Implementation of appropriate therapeutic actions*

To build a therapeutic relationship with Daniel, I have used some of the music therapy methods discussed in the literature. For example, as Prizant and Duchan (1981, as in Trawick-Smith, 2000 and Holck, 2004) found in their studies, the child's echolalia seemed to serve as a bridge to make the initial connection with Daniel. Daniel was very quick at learning and copying my verbal cues such as 'careful', 'broken' and 'fixed'. Daniel seemed to give his own turn-yielding cues for the continuation of the interplay by repeating these utterances while playing with the guitars and the stands on his own. He not only uttered the words, but also pointed at what he has done with the instruments and looked at me for my approval. The frequency of such cues increased as the sessions progressed, which seemed to indicate his increased desire to communicate with me.

I was often uncertain as to how to respond when Daniel behaved in inappropriate ways; running out of the room, stepping up on the instruments and climbing up on the piano. Such behaviour might have been due to his pathology, his way of dealing with the anxiety in the room, or it could be that he was just being an ordinary 4-year-old boy. Nevertheless, his behaviour often led me to feel anxious and confused.

Through the process of action cycles, I have learnt how to therapeutically act in these situations. This was aided by consulting with supervisor with regards to appropriate practical strategies, as well as from the parent. These included redirecting Daniel's attention to something else and providing physical cues. Reaching out for Daniel's hand from the piano when he approached the door and adding the verbal statements about the boundaries did not appear to work instantaneously; it would have been interesting to find out if these strategies could contribute to helping Daniel to understand the boundaries in the long term.

When the parent enquired about whether I was implementing 'enough' structure, I was confused and uncertain about to what degree I had to keep the balance of structure and freedom. I discussed with my supervisor regarding the issues around the concept of structure in music therapy and this led me to make appropriate decisions around keeping the balance of structure and freedom in the sessions. This was also aided by reviewing relevant book chapters such as Oldfield (1995).

### *Clinical improvisation skill*

Daniel showed a high level of anxiety in the initial sessions; he constantly ran around, in and out of the therapy room, stepped and climbed up on the instruments, and repeated small patterns of his own activities. By improvising mainly on the piano, reflecting and matching Daniel's moves, I tried my best at 'tuning-in' to what he brought in the moment. However, it rather became so busy which reflected my own anxiety in response to Daniel's actions. This prevented me from giving enough space for Daniel to respond to my music and assess how he does so.

I was able to improve the above problem by in depth discussions in supervision. The discussions in supervision involved thorough analysis of the video recordings of the therapy sessions which allowed the reviewing of my own improvisation skill. I have tried the strategies suggested by the supervisor, such as being aware of my anxiety in the moment and trying to play less on the piano in order to better 'listen' to the child's therapeutic presence, and to provide containment by playing contrasting elements to Daniel's playing on the piano. In addition, the role play on the piano in supervision provided an insight into the dynamics of what the client and I were bringing in the interactions.

## **6.2 Personal development**

### *Emotional stages*



The theme of *disjunction* discussed in Watson (2005) characterised my period of struggles. I have experienced exhaustion, helplessness, and frustration at my own skills when it did not appear to be working. I felt confusion about my strategies especially with regards to the issues of structure when the parent presented a strong opinion about implementing the structure. Moreover, Fowler's (2006) study of *burnout* and its prevention among music therapy professionals seemed relevant to my emotional stages as a music therapy student as well. Towards the end of the practicum period, I wanted to avoid going to work, felt helpless and exhausted, and was unable to recognise personal accomplishment. Furthermore, Wheeler's (2002) study of experiences and concerns of undergraduate students during their music therapy internship also paralleled with the findings of my research. I was concerned about not having much experience and self-conscious about my identity as a music therapy student as much as the parent might have felt anxious about my expertise. I constantly sought for more ideas for the session plans and better improvisational skills which would bring positive outcomes in the sessions.

The above emotional challenges were overcome by personal strategies which resembled those discussed in the literature. For example, Watson (2005) found that the challenges can be resolved by engaging with the issue through a reflective process, supported by supervision. Similarly, the importance of reflective process where self-awareness is promoted is discussed in Fowler (2006). I was able to gain an awareness of my feelings through the self-reflective process aided by supervision. Paying attention to my dreams also helped in this process. Moreover, I have developed the ability to deal

with my emotions independently; I was able to use my 'internal supervisor'. These helped in gaining positive attitude and staying assertive about myself (Wheeler, 2002 and Fowler, 2006). This contributed in obtaining confidence and dealing with some of the burnout symptoms. Furthermore, the client's responses in music therapy influenced my confidence level. Wheeler (2002) found that positive changes in and responses from the clients contributed to ease the students' concerns regarding meeting the clients' needs. I was able to gain sense of achievement when Daniel showed increased awareness of me, initiated and engaged in turn-taking, and responded to my attempts at helping him to stay in the therapy room. It helped me to deal with the uncertainty about my clinical skills by providing an assurance that my plans and strategies brought positive outcomes.

### *Communicating with parents*

I had a lack of confidence in professional skills and this was due to the self-consciousness as a music therapy student. Parents were often aware that I was a student and seemed to have a lack of trust in me and this affected my anxiety level. While working with Daniel, this was still an issue when I communicated with Jane. However, this could be improved by having personal strategies with the help of practical and emotional support from supervision. These included keeping my authority and positive appraisal. As I went through the action cycles, I became more confident in talking to the parents. At the assessment review, I found myself communicating with Graham with a relaxed manner and being able to accept his views as well as assert my approach with more confidence.

### **6.3 What I have learnt**

As discussed in the literature, music therapy training experience can be a process of unlocking “the door to a world of self-awareness and self-discovery, an unexpected journey which is “so painful but also so exciting” (Webster, 1988, p.18). This action research allowed me to develop better awareness of myself, in terms of recognising my skills and my emotional stages, and how to deal with them professionally. First, I have learnt to manage the criticisms professionally, to accept it without taking it personally, observe my skills fairly without being over-critical about myself then act on it to get positive development as a result. Second, I realised that having a high expectation of myself, expecting myself to be able to manage everything can actually have a damaging effect on my emotional well-being, because for students, mistakes and failures are inevitable steps for transition. Acknowledging my status that I am a student, and reminding myself that I am susceptible to the mistakes and ‘it is ok because I am still learning’, has helped to overcome my pressure. Also, this has helped in lifting up my confidence level when dealing with the parents. I have come to accept that the parents too are aware that I am at the learning stage and so my lack of experience and expertise is not something to be self-conscious about or be ashamed of. Third, I have learnt that although it maybe initially challenging to deal with the parents especially if they are anxious, trying to understand their point of view and communicate with positive attitude or forming an alliance with them can contribute to bringing positive outcomes in my practice. Paying attention to their emotional status and maintaining an empathic mind is the key in this process.

This action research has not only allowed me to reflect on and shape up my musical skills but also raised my intellectual curiosity. This included seeking more knowledge about autism spectrum disorder, appropriate and effective music therapy strategies for this population and relevant psychodynamic theories, especially those related to the theme of therapeutic relationships.

#### **6.4 Implications for training**

Through this research, some implications could be drawn for training music therapy students. First, during their course, it would be beneficial to provide the students specific training on dealing with the emotional stages. Fowler (2006) suggests that more information about promoting well-being among music therapists would be available if a specific training program for professional well-being is implemented for music therapists. Similar programs may be facilitated for music therapy students as well during their course, such as providing personal therapy as a mandatory requirement. In my training course, personal therapy was encouraged although it was not a formal requirement for the students. Personally, I did not spontaneously seek personal therapy during my practicum. If receiving personal therapy is a mandatory part of the course, it may contribute to helping students to learn more about self-awareness and how to deal with emotional stages during the practicum, as well as in their future career. Second, specific training on developing professional skills may also be beneficial before encountering the experiences, for example, how to communicate with parents and other professionals in various situations. Third, facilitating student support groups where they meet regularly may help students to overcome the difficulties. Our course involved

regular support group meetings in our area. As a distance student, this was a beneficial space where I was able to meet with the students and share our experiences. It was reassuring to find out that other students also experienced similar difficulties that I had during the practicum.

### **6.5 Considerations for future research**

It would have been interesting for me to observe how Daniel responds to my verbal statements regarding the boundaries in the long term. Future research may investigate the effectiveness of verbal input during music therapy with children with ASD, to what extent this is beneficial, or a comparison of the effects of verbal and musical cues.

There is no doubt that the parents who have children with physical and mental difficulties experience hardship taking care of their children. During the course of my practicum, I have encountered many parents of children with various difficulties. I observed that some parents seemed more anxious and distressed than others. It would be interesting if future studies could examine the emotional stages of the parents with children with ASD or any other diagnosis, and how this impacts the process of music therapy.

## **Chapter 7. Conclusion**

This action research investigated how I improved my practice to build a therapeutic relationship with a child with autism spectrum disorder during my practicum experience. By engaging through the five cycles of action-reflection, I have identified various challenges during the practicum, and could overcome the challenges by in depth analysis of my actions aided by regular supervisions.

The challenges I encountered included both clinical and personal issues. With regards to clinical matters, I wondered about how to respond therapeutically to the child's anxiety responses and how I could improve my clinical improvisation which often reflected the child's anxiety as well as my own. Moreover, I was not convinced about the effectiveness of my clinical skills and had a lack of confidence in professional skills, such as communicating with parents. The struggles led to the emotional stages of disjunction and some burnout symptoms.

I was able to improve my practice by overcoming these challenges through the process of action cycles. Supervision provided both practical and emotional support. By undertaking thorough analysis of video recordings of my music therapy sessions, I could recognise strengths and weakness of my practice and these were discussed with the supervisor. Some practical suggestions regarding my musical and professional skills were made and tried in my sessions. Disclosing my emotional stages in supervision also

helped in gaining positive appraisal. Ultimately, I could develop my 'internal supervisor', the ability to reflect and devise appropriate strategies independently.

In conclusion, music therapy students experience various practical and emotional phases of struggles during their practicum. The challenges may be overcome by in-depth reflection and discussion of their work as well as seeking support from supervision and other relevant personal strategies. It is hoped that this research may 1) contribute to the body of literature concerning music therapy students' practicum experiences specifically with regards to working with children with ASD, 2) promote better understanding of students' perspectives on practicum experience, and therefore 3) indicate suggestions for music therapy trainers and educators, and 4) provide music therapy students some strategies to overcome their challenges during their practicum.

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# Session 3 (1:50 minutes-2:57 minutes)

**Moderato** **Allegro**

Grabs guitar and stand, puts them in line Points at the instruments looks at me Tries moving the snare drum and cymbal

Daniel

Na-Hyun

Yes! They are in line! Da-niel is playing with the

**Moderato** **Allegro**

Na-Hyun at piano

4

Gives up moving them s. drum

WO-YA!

ins - tru-ments, quite hea - vy, Da - niel is playing with the ins - tru-ments

7

Looks at me      Grabs guitar, tries to put it up on the piano      Looks at me      Moves around the room with the guitar

one ti-ka!      Care-ful!      wo-shy

One gui - tar      no no no no      be care-ful with the gui - tar      be

*ff*

8<sup>va</sup> | 8<sup>va</sup> |

12

Looks at me

la la      go - ho

care - ful with the gui - tar      la la la la la la la la la la la



19

Sits down on the floor

Points at guitar

wo-shy!

wo - shy - wo - shy\_ wo wo - shy wo-yai gui-tar

23

Looks at me

wo-shy! go - ho!

wo-shy wo-shy wo - shy\_ wo - shy

26

Stands up

# Session 5

(0:15 minutes-3:05 minutes)

Plays around with guitar      Guitar falls off      Initiates piano, plays with flat fingers, giggles

ti- ka!      ti- ka!

Sitting on the chair, inviting him to sit

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Handwritten musical score for a song, featuring a guitar solo and vocal parts. The score is written on a system of staves.

**Staff 1 (Vocal):** The first staff contains the vocal melody. It begins with a treble clef, a key signature of one flat (B-flat), and a 4/4 time signature. The melody is written in a simple, accessible style. The lyrics "ti-kat!" are written below the first measure, and "wo-shy! wo-shy!" are written below the last two measures. A box above the staff contains the instruction "(Gren: to grab the guitar)".

**Staff 2 (Piano):** The second staff is a grand staff (treble and bass clefs) for piano accompaniment. It features a complex, fast-paced melody in the right hand, characterized by many beamed sixteenth notes. The left hand provides a simple bass line.

**Staff 3 (Vocal):** The third staff continues the vocal melody. The lyrics "Hel-lo Da-niel!" are written below the first measure, "gui-tar!" below the second measure, and "Hel-lo Da-niel!" below the last two measures.

**Staff 4 (Piano):** The fourth staff continues the piano accompaniment, mirroring the style of the second staff with a fast, beamed melody in the right hand and a simple bass line in the left hand.

6

Looks at me      points at the guitar      Looks at me

wo - shy!   care-ful!      be care-ful!      wo-shy!

wo-shy      wo-shy      wo-shy      be care-ful      wo-shy

The image shows a handwritten musical score on five staves. The first staff is a vocal line with lyrics 'wo - shy! care-ful! be care-ful! wo-shy!'. Above the first two measures of the first staff are the lyrics 'Looks at me', 'points at the guitar', and 'Looks at me' in boxes. The second staff is a vocal line with lyrics 'wo-shy wo-shy wo-shy be care-ful wo-shy'. The third staff is a guitar line with lyrics 'wo-shy wo-shy wo-shy be care-ful wo-shy'. The fourth and fifth staves are bass and tenor lines respectively, with lyrics 'wo-shy wo-shy wo-shy be care-ful wo-shy'.



91

9

Looks at me

Runs to the piano

waving

hel-lo Da-niel Hel-lo! Hel-lo!

12

Looks at me

5

hel-lo Da-niel hel-lo

14

hel - lo

15

ti - ka! wo-sby! he care-ful!

hel-lo Da-niel hel-lo! hel-lo gui-tar hel-lo Da-niel hel-lo

Looks at me



93

19

Moves with the chair to the piano

*slowly*

be care-ful hel-lo Da-niel hel-lo Da-niel

22

Looks at me

hel-lo Da-niel

The musical score is written for a piano and a voice. It is in the key of B-flat major (two flats) and 4/4 time. The first system, starting at measure 19, shows the piano accompaniment and the vocal line. The piano part has a melodic line in the right hand and a supporting bass line in the left hand. The vocal line has the lyrics 'be care-ful hel-lo Da-niel hel-lo Da-niel'. The second system, starting at measure 22, continues the piano accompaniment and the vocal line. The piano part has a melodic line in the right hand and a supporting bass line in the left hand. The vocal line has the lyrics 'hel-lo Da-niel'. Performance instructions include 'Moves with the chair to the piano' and 'Looks at me'.

24

Na-ha! Na-ha! ti-ka!

*Rit.....*

hel-lo Da-niel hel-lo Da-niel hel-lo Na-Ha

27

Looks at me Looks at me points at the stand

c-he c-he wo-shy!

hel-lo Na-Ha hel-lo Na-Hyun hel-lo



30

Runs off to the stand and grabs it, plays around

Looks at me

Looks at me

wo-shy! wo-shy! wo-shy! ye-he wo-shy!

wo-shy ye-he he wo-shy wo-

34

Looks at me

Looks at me

care-ful! wo-shy!

shy wo-shy wo-shy be care - ful be care- ful with the stand!

Session 7  
(3:40 minutes-6 minutes)

Handwritten musical score for Session 7, measures 1-3. The score is for four parts: Daniel, Daniel at piano, Na-Hyun, and Na-Hyun at piano. The key signature is one flat (B-flat) and the time signature is 4/4. The score includes a "Giggles" instruction and a "8va" marking.

Handwritten labels on the left: Daniel, Daniel at piano, Na-Hyun, Na-Hyun at piano.

Handwritten musical notation:

- Measure 1: Daniel (treble clef) has a whole rest. Daniel at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. Na-Hyun (treble clef) has a whole rest. Na-Hyun at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass.
- Measure 2: Daniel (treble clef) has a whole rest. Daniel at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. Na-Hyun (treble clef) has a whole rest. Na-Hyun at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass.
- Measure 3: Daniel (treble clef) has a whole rest. Daniel at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. Na-Hyun (treble clef) has a whole rest. Na-Hyun at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. A "Giggles" instruction is written above the staff. A "8va" marking is written above the staff.

Handwritten musical score for Session 7, measures 4-6. The score is for four parts: Daniel, Daniel at piano, Na-Hyun, and Na-Hyun at piano. The key signature is one flat (B-flat) and the time signature is 4/4. The score includes a "ff" marking and a "8va" marking.

Handwritten musical notation:

- Measure 4: Daniel (treble clef) has a whole rest. Daniel at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. Na-Hyun (treble clef) has a whole rest. Na-Hyun at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass.
- Measure 5: Daniel (treble clef) has a whole rest. Daniel at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. Na-Hyun (treble clef) has a whole rest. Na-Hyun at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass.
- Measure 6: Daniel (treble clef) has a whole rest. Daniel at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. Na-Hyun (treble clef) has a whole rest. Na-Hyun at piano (treble and bass clefs) has a whole note chord in the treble and a whole rest in the bass. A "ff" marking is written below the staff. A "8va" marking is written below the staff.



7

Looks at me

Grabs guitar, tries to put it up on the piano

Looks at me

Moves around the room with the guitar

one ti-ka! Care-ful! wo-shy

One gui - tar no no no no be care-ful with the gui - tar be

*ff*

8<sup>th</sup> 8<sup>th</sup>

12

Looks at me

la la go - ho

care - ful with the gui - tar la la la la la la la la la la la

16

Plays with the guitar

Looks at me

Opens the door

care-ful with gui-tar there's one gui-tar to-day one gui-tar to-day

20

Looks at me

Closes the door

care-ful

Reaching out for Daniel's hand

won't you come back to the room won't you come back, be care-

The musical score is written for voice and piano. It consists of two systems of staves. The first system (measures 16-19) has a vocal staff and a piano staff. The vocal staff has a treble clef and a key signature of one flat. The piano staff has a grand staff (treble and bass clefs). The second system (measures 20-23) also has a vocal staff and a piano staff. The vocal staff has a treble clef and a key signature of one flat. The piano staff has a grand staff (treble and bass clefs). The score includes performance instructions in boxes: 'Plays with the guitar', 'Looks at me', 'Opens the door', 'Looks at me', 'Closes the door', and 'Reaching out for Daniel's hand'. The lyrics are: 'care-ful with gui-tar there's one gui-tar to-day one gui-tar to-day', 'care-ful', and 'won't you come back to the room won't you come back, be care-'.



24

Goes to the drum  
and sits on it

wo-shy

pointing at the chair

ful\_ wo-shy and a chair! and a drum! sit-ting on the drum

28

go-ho wo-shy

go go\_ go go wo-shy\_ wo-shy

Comes to the piano

100

33 Giggles

35 Giggles

The musical score is written on four staves. The first system (measures 33-34) shows a treble staff with a whole rest, a piano staff with a triplet of eighth notes, and a bass staff with a whole rest. The second system (measures 35-36) shows a treble staff with a whole rest, a piano staff with a triplet of eighth notes, and a bass staff with a whole rest. The third system (measures 37-38) shows a treble staff with a whole rest, a piano staff with a triplet of eighth notes, and a bass staff with a whole rest. The fourth system (measures 39-40) shows a treble staff with a whole rest, a piano staff with a triplet of eighth notes, and a bass staff with a whole rest. The score includes various musical notations such as rests, triplets, and dynamic markings like 'ff'.



37

wo-shy *gu* wo-shy

40

Giggles

*gu* *gu*

*ff*

3

3

The image shows a page of a musical score, numbered 101 in the top right corner. The score is for a piano and voice piece. It consists of two systems of staves. The first system starts at measure 37. The vocal line has two measures with the lyrics 'wo-shy' and 'wo-shy'. The piano accompaniment features a complex rhythmic pattern in the right hand, including triplets and sixteenth notes, and a simpler bass line. The second system starts at measure 40, marked 'Giggles'. The vocal line has two measures with the lyrics 'gu' and 'gu'. The piano accompaniment continues with similar rhythmic patterns, including triplets and sixteenth notes. The score is written in a standard musical notation with treble and bass clefs, and various musical symbols like notes, rests, and dynamics.

Handwritten musical score on page 102, featuring two systems of staves. The notation includes treble and bass clefs, notes, rests, and dynamic markings such as *pp* (pianissimo) and *ppp* (pianississimo). The score is written in a historical style, possibly from the 18th or 19th century.

The first system consists of two staves. The upper staff is a treble clef with a *pp* marking. The lower staff is a bass clef with a *ppp* marking. The notation includes various note values and rests.

The second system also consists of two staves. The upper staff is a treble clef with a *pp* marking. The lower staff is a bass clef with a *ppp* marking. The notation includes various note values and rests, with a diagonal line indicating a continuation or a specific musical effect.

## Appendix 4. Information Sheet for Parents/Caregivers



*A personal exploration, as a music therapy student, of development in establishing a therapeutic relationship with a child with Autistic Spectrum Disorder.*

### **INFORMATION SHEET for PARENTS/CAREGIVER**

This information is provided to you as the parents/caregiver of a child referred to Therapy Centre. It describes an action research project to be undertaken by Na-Hyun Gang, for the completion of Master of Music Therapy Programme, New Zealand School of Music.

<u>Researcher/Music Therapy Student</u>	<u>Research Supervisor</u>
Name: Na-Hyun Gang	Name: Sarah Hoskyns
Email: nahyunee81@hotmail.com	Position: Associate Professor, Master of Music Therapy programme, New Zealand School of Music
Phone: 021-999-707	Email: sarah.hoskyns@nzsm.ac.nz,
	Phone: (04) 801-5799 x6410

### **About the Project**

While establishing a trusting relationship between the therapist and the client is the foremost step of music therapy intervention, it is one of the challenging aspects of the therapeutic process. For children with Autism Spectrum Disorder, relating with other people is often difficult, as you will know as a parent of a child with this condition. I am a 2<sup>nd</sup> Year student music therapist working at the Centre with children with ASD over the past six months, and I have been intrigued by various challenges while attempting to establish an initial rapport with the children. My research aims to study how I might work towards building up a therapeutic relationship with a child with ASD in music therapy. Through this project, I intend to improve my own practice as a trainee, provide a student's perspective of clinical work as well as consider implications for training. I also hope that this will allow me to provide improved quality of service to referred families such as yours.

I, the researcher/music therapy student will be the main participant of this research, reflecting on my own music therapy practice. I would like to ask you if you would be happy to give consent for me to study the developing music therapy sessions with your child, in order that I can examine an example of music therapy in progress.

### **Project Procedures**

As you may know, it is usual clinical procedure for therapists at the Therapy Centre to film all sessions for clinical review and supervision and for reporting to families on progress. Parents are asked to give consent for the recordings before the commencement of therapy. It is also part of music therapist's practice to take clinical notes of the sessions and receive regular supervision. In order to collect data about my music therapy practice for this research project I will need to review the clinical notes, notes from my clinical supervision and the Centre's clinical video recordings of a child's music therapy. This particular style of research I am proposing poses minimal risks to your child; music therapy will take place under the same conditions whether or not the

research was taking place. No real names will be used in the reporting of the data. A pseudonym will be used to protect the identity of the child and my supervisor and the location and specific nature of the therapy centre will be disguised. There is a chance that your child could be identified, through connection with my practice, but I will make every endeavour to minimize this with the strategies outlined above.

The recordings and the client files are kept at a secured cabinet in the Therapy Centre. They will be stored for ten years, after which they will be destroyed. If you are willing to give permission for the review of the notes and video recordings of your child's music therapy, please fill out and return the attached 'Consent form for parents'.

### **Parent and Childs' Rights**

You and your child are under no obligation to accept this invitation. If you decide to give the permission, you have the right to:

- withdraw him or her from the project at any time without giving reason until the end of the data collection period (withdrawal from this study will not affect your ongoing treatment)
- ask any questions about the study at any time during process of the research
- be given access to a summary of the project findings when it is concluded

If you have any questions about the project, please do not hesitate to contact the Centre's clinical director, my research supervisor, Sarah Hoskyns or myself.

### **Ethical Approval**

This study has been reviewed and approved by the Northern Y Regional Ethics Committee, Ministry of Health, New Zealand. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher,

please contact Sarah Hoskyns (Research Supervisor) or the Northern Y Regional Ethics Committee:

<p>Administrator: Amrita Kuruvilla</p> <p><u>Postal address:</u></p> <p>3rd floor, BNZ building 354 Victoria St PO Box 1031 Hamilton</p> <p>Ph: (07) 858 7021 Fax: (07) 858 7070 Email: <a href="mailto:northern_y_ethicscommittee@moh.govt.nz">northern_y_ethicscommittee@moh.govt.nz</a></p>	<p><u>Courier address:</u></p> <p>3rd floor, BNZ building 354 Victoria St Hamilton</p>
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## Appendix 2. Information Sheet for Supervisor



***A personal exploration, as a music therapy student, of development in establishing a therapeutic relationship with a child with Autistic Spectrum Disorder.***

### **INFORMATION SHEET for CLINICAL SUPERVISOR**

This information is provided to you as the clinical supervisor of Na-Hyun Gang, at Therapy Centre. It describes an action research project to be undertaken by Na-Hyun, for the completion of Master of Music Therapy Programme, New Zealand School of Music.

<u>Researcher/Music Therapy Student</u>	<u>Research Supervisor</u>
Name: Na-Hyun Gang	Name: Sarah Hoskyns
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Phone: 021-999-707	Email: sarah.hoskyns@nzsm.ac.nz,
	Phone: (04) 801-5799 x6410

### **About the Project**

While establishing a trusting relationship between the therapist and the client is the foremost step of music therapy intervention, it is one of the challenging aspects of the therapeutic process. For children with Autism Spectrum Disorder, relating with other people is often difficult, as you will know as a music therapist. From working at the Centre with children with ASD over the past six months, I have been intrigued by various challenges while attempting to establish an initial rapport with the children. My research aims to study how I might work towards building up a therapeutic relationship with a child with ASD in music therapy. Through this project, I intend to improve my own practice as a trainee, provide a student's perspective of clinical work as well as consider implications for training. I also hope that this will allow me to provide improved quality of service to referred families.

I, the researcher/music therapy student will be the main participant of this research, reflecting on my own music therapy practice. I would like to ask you if you would be happy to give consent for me to study the supervision notes in order that I can examine an example of music therapy in progress.

### **Project Procedures**

As you know, it is part of music therapist's practice to take clinical notes of the sessions and receive regular supervision. In order to collect data about my music therapy practice for this research project I will need to review the clinical notes, notes from my clinical supervision and the Centre's clinical video recordings of a child's music therapy. This particular style of research I am proposing poses minimal risks to you; music therapy will take place under the same conditions whether or not the research was taking place. No real names will be used in the reporting of the data. A pseudonym will be used to protect the identity of you and the child, and the location and specific nature of the therapy centre will be disguised. There is a chance that you could be identified,

through connection with my practice, but I will make every endeavour to minimize this with the strategies outlined above.

The supervision notes which will be recorded in the client file will be kept at a secured cabinet in Therapy Centre. Informal notes taken during the supervisions will be kept by myself. They will be stored for ten years, after which they will be destroyed. If you are willing to give permission for the review of the notes from the supervisions with me, please fill out and return the attached 'Consent form for clinical supervisor'.

### **Your Rights**

You are under no obligation to accept this invitation. If you decide to give the permission, you have the right to:

- withdraw from the project at any time without giving reason until the end of the data collection period (withdrawal from this study will not affect the ongoing treatment)
- ask any questions about the study at any time during process of the research
- be given access to a summary of the project findings when it is concluded

If you have any questions about the project, please do not hesitate to contact my research supervisor, Sarah Hoskyns or myself.

### **Ethical Approval**

This study has been reviewed and approved by the Northern Y Regional Ethics Committee, Ministry of Health, New Zealand. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Sarah Hoskyns (Research Supervisor) or the Northern Y Regional Ethics Committee:

<p>Administrator: Amrita Kuruvilla</p> <p><u>Postal address:</u></p> <p>3rd floor, BNZ building 354 Victoria St PO Box 1031 Hamilton</p> <p>Ph: (07) 858 7021 Fax: (07) 858 7070 Email: <a href="mailto:northernny_ethicscommittee@moh.govt.nz">northernny_ethicscommittee@moh.govt.nz</a></p>	<p><u>Courier address:</u></p> <p>3rd floor, BNZ building 354 Victoria St Hamilton</p>
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### Appendix 3. Consent Form for Parents/Caregivers



*A personal exploration, as a music therapy student, of development in establishing a therapeutic relationship with a child with Autistic Spectrum Disorder.*

#### PARENT/CAREGIVER CONSENT FORM

**For review of video recordings**

**This consent form will be held for a period of ten (10) years**

☐ I have read the Information Sheet and have had the details of the study explained to me.

☐ My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

☐ I agree my child's music therapy being video taped, in accordance with the policy of the therapy centre

☐ I agree my child's music therapy being reviewed by researcher Na-Hyun Gang

☐ I agree my child's music therapy notes to be reviewed.

Therefore, I agree to give permission for my child's music therapy to be reviewed and included in the data of this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

## Appendix 4. Consent Form for Supervisor



*A personal exploration, as a music therapy student, of development in establishing a therapeutic relationship with a child with Autistic Spectrum Disorder.*

### CLINICAL SUPERVISOR CONSENT FORM

For review of supervision notes

**This consent form will be held for a period of ten (10) years**

☐ I have read the Information Sheet and have had the details of the study explained to me.

☐ My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

☐ I agree to the notes of my supervision with Na-Hyun to be reviewed by researcher

Na-Hyun Gang

Therefore, I agree to give permission for the supervision notes to be reviewed and included in the data of this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

.....

**Full Name - printed**

.....



## **Appendix 5. Example of Clinical Notes**

*Session 2 (24<sup>th</sup> of October, 2008)*

I explained the boundaries and my plans to Jane before the session (couldn't reach her beforehand). This helped Daniel to separate from Mum. He ran outside the Centre after 10 minutes but it was possible to get him back. I could capture Daniel's attention by responding to his utterances such as 'wo-shy' (road-sign), 'ahh-ahh', 'bo-bo', 'Na-ha' (Na-Hyun), while he played around with the mic stand, guitar stand. I also reflected and matched his behaviours on piano, acknowledging his actions by singing also. He made good eye-contact and showed desire to communicate with me in response to my attempts.

Daniel was obsessive with the stands and liked to line them in order with guitar in the middle. He pointed at his achievement and sought my attention. He explored every instrument in the room. Tried to get out a couple of times more but didn't when I persuaded him to come back by saying 'come here', waving at him.

Daniel didn't seem to understand goodbye. I told him it's time to find 'mama'. He looked a little confused but then went out to find Mum.

Na-Hyun (MTS)

## Appendix 6. Example of Supervision Notes

*20<sup>th</sup> of October, 2008*

Stating the boundaries to Mum and Daniel important

- Explain the fundamental boundaries of MT and strategies
- MT focuses on building up a relationship, engaging and attention (which will help Daniel to learn how to play piano ultimately)
- Practicalities of the Centre
- Claim my authority
- To keep Jane' verbal responses to a minimum

My anxiety and frustration expressed

Try out

- Having Mum in the room
- Having Mum in the waiting room
- Structure in 1 session, no structure in another one?

Since D is having difficulty separating from Mum, it might be good to have Mum initially in the session then gradually work towards turning his attention to me.

## **Appendix 7. Example of Journal Entry**

*14<sup>th</sup> of November, 2008*

*After session 5*

When he went to the door again, I blamed myself thinking what have I done wrong to make him want to go out again? Did I make him too bored? I was trying my best to initiate and maintain the contact but is it working? Should I have prepared a structured song/activity to encourage him? But what's the point of initiating that when D can't even stay seated for more than a second?

I couldn't spontaneously come up with any idea to initiate a game or an activity to try with him when we were fiddling around with the stands. All I could do was just reflect his behaviour on the piano and I'm disappointed about this.