

**Collaborative music therapy; Determining the benefits and  
challenges of collaborative work from a student's perspective**

**By**

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## **Abstract**

This study describes the benefits and challenges experienced by a student music therapist on placement at a special school in New Zealand. While working alongside an experienced music therapist at the school, and taking external supervision from another, I was able to reflect the challenges and benefits of this unique collaboration. The process of collaboration is complex especially when collaborating parties have differing roles that potentially create power differentials. Findings have been generated from secondary analysis of my reflective journal and clinical data collected while on placement. The findings explore the diverse range of possible benefits and challenges of the interactions that the collaboration enabled. The study concludes that despite the many challenges in maintaining a successful collaboration, it provides therapists with many extra opportunities for our participants, as well as a flexible learning environment for a student music therapist.

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## Chapter One

### Introduction

#### Project Summary

As part of the requirements towards my Master of Music Therapy, I completed a placement as a student music therapist at a special education school. I was required to complete 750 hours of clinical practice throughout the year. My facilitator for this clinical placement was a music therapist who had worked at the school for 2 years. I had three days of clinical practice each week and we had decided to work collaboratively for two days of that. This was to give me a mixture of both collaborative and independent work, which would be likely to contribute significantly to my developing skills as an independent music therapist. However the process of collaboration is complex, especially when collaborating parties have differing roles that potentially create power differentials. Within this study I examine the benefits and challenges of collaborating with another music therapist as a student music therapist. This was an observational study as my data was generated from secondary analysis of the clinical notes and reflections I recorded as part of my usual clinical practice.

#### Contribution to Knowledge

This study seeks to explore the process of collaboration between a senior music therapist and a student. An understanding of potential benefits and challenges of such collaboration could provide insight which would support the training, education and practice of music therapists. The findings could contribute to more effective collaborations between music therapists, and other professionals.

## Objective

1. To examine the process of collaboration between an experienced music therapist and music therapy student, and to identify the benefits and challenges that potentially arise.

## Chapter Two

### Defining Collaboration

Collaboration is commonly defined as the act of working with someone to produce something (Simpson & Weiner, 1989). In the context of music therapy, the therapists are working together in shared pursuit, or shared “production”, of their participant’s therapeutic goals. Within collaboration each party may have common goals; participants’ goals and outcomes; and goals of self-interest; professional development, and personal motivations (Hayes & Kelly, 2000). Additionally they may also have differing goals, and there can be different degrees of collaboration depending on the style of team (Twyford, 2007). For therapists these teams range between unidisciplinary, multidisciplinary, interdisciplinary and transdisciplinary.

- <b>Unidisciplinary:</b> Each professional works alone in their own discipline
- <b>Multidisciplinary:</b> Professionals provide separate treatment, however, may seek expertise of other professionals and are often aware of each other’s goals. Often there is liaison regarding client needs and progress.
- <b>Interdisciplinary:</b> The team of professionals works collectively to determine goals and implementation plans however still deliver treatment independently, respecting professional boundaries
- <b>Transdisciplinary:</b> Professionals work together across traditional boundaries and combine their work to share the responsibility of treatment plan implementation and goal achievement

Depending on the style of the collaborating team, there can vastly different expectations and interactions within the collaboration. The collaboration within this study differs from these traditional styles, as we are professionals of the same discipline.



## Chapter Three

### Collaboration in the Helping Professions

The process of collaboration has been long utilised and studied within the other helping professions. Throughout schools, hospitals, and multiple therapies, professionals often have to work together to achieve common goals. In this chapter I will explore the collaborative processes and functions of collaboration in these fields. Additionally I will examine how these collaborations may provide additional challenges or benefits to these fields.

### Collaboration in Education

In recent decades co-teaching has become one of the most common forms of collaboration found in schools (Cook & Friend, 1997). Cook and Friend define co-teaching as “two or more professionals delivering substantive instruction to a diverse, or blended, group of students in a single physical space”. An important part of this definition is that they specify “professional” rather than teacher, as they explain that co-teaching can be collaboration between teachers and a variety of other professionals including special educators and therapists. Different professionals can offer varying and complementary perspectives and approaches, which can result in unique outcomes. Cook and Friend list the main possible outcomes of co-teaching as increasing instructional options for students, increasing program intensity and continuity, reducing stigma for students with special needs, and increasing support for teachers and related service specialists. They stress that ongoing communication is very important to the outcomes of successful co-teaching. Without this communication, small differences in expectations can grow into large annoyances, which hinder the collaborative relationship. Within the collaboration both parties must be continually planning together to ensure that the intention of one doesn’t contradict the other. This ongoing planning and communication would distinguish a collaborative relationship from simply working alongside one another. In addition to benefits for the class environment, collaboration can support professional development by providing informal learning opportunities for teachers

and other specialists (Richter, Kunter, Klusmann, Lüdtke, & Baumert, 2011). In a study of the contexts of teacher-learning, “experiencing friction”, “getting ideas from others”, “experimenting”, and “considering own practice” were widely self-reported by secondary-school teachers as having successful learning outcomes (Bakkenes, Vermunt, & Wubbels, 2010). These learning experiences can largely be met within a collaborative relationship. The on-going planning and communication needed for successful collaboration would incorporate many of these learning experiences supporting Richter et al.’s assertion that collaboration would provide learning opportunities (2011).

### **Collaboration in Primary Medical Care**

In the field of primary medical care, professionals of diverse specialties will often be required to collaborate in the treatment of a patient. Medical specialists of various expertise, technicians, nurses and GPs all bring various skills to the treatment of a patient. As well as skills, they all bring separate knowledge of the patient. The accumulative knowledge of a patient’s progression of symptoms, administration of drugs, and history can be distributed among multiple carers and so without collaboration some of this knowledge can be isolated leading to misinformed decisions. These misinformed decisions can lead to serious and even fatal consequences for both carers and patients. Misreported diagnoses, drug administrations or histories can all lead to serious harm, and so care for patients demands a combined collaborative effort from carers. In a review of literature on primary care collaboration, several essential elements in successful collaborative practice were identified (Way, Jones, & Busing, 2000). The essential elements that Way et al. identified were responsibility and accountability, co-ordination, communication, co-operation, assertiveness, autonomy, and mutual trust and respect. They noted that the challenge for practitioners wishing to collaborate was in determining how to implement these elements in usual practice. Trust and respect were noted to bind all of the other elements together, as without it, none of the other elements can be relied upon (Norsen, 1995). Other studies within primary care also identified enhanced communication as an essential and beneficial part of healthcare collaboration (Jaques, 2014). In a cluster-randomised trial a collaborative

care approach was found to be more effective in treating depression than usual care management by patient GPs (Richards et al., 2008). The study used four established UK-specific criteria in developing their collaborative protocol (Wagner, Austin, & Von Korff, 1996). The criteria used to distinguish their intervention as collaborative were: (1) a multi-professional approach to patient care; (2) a structured management plan; (3) scheduled patient follow-up; and (4) enhanced inter-professional communication. Enhanced communication is often cited as an important factor in primary care collaboration, and so a significant modern revolution in primary care collaboration is that of electronic records. Such records have proven invaluable for epidemiology, helping prevent and treat community wide health issues (Calman, Hauser, Lurio, Wu, & Pichardo, 2012). The ability to easily share knowledge allows healthcare professionals much easier access to collaboration with their peers, but is not without risks. Easier access and distribution of patient information can lead to easier breaches of patient confidentiality. The discussion of confidentiality risks highlights an important aspect of collaboration, specifically the need to be able to trust the person or organisation you are collaborating with. Throughout the previously mentioned studies, communication is commonly cited as a key factor in successful collaboration. Open and honest communication between collaborating professionals in helping the professions may need to include private and confidential information. Because of this it is extremely important that both collaborating parties can trust one another to uphold their ethical obligations. Even if all professionals fulfil their ethical obligations, there are still risks to confidentiality in the modes of communication utilised by professionals. Both physical and electronic information share the risk of being inappropriately misplaced or disseminated. The reach of government surveillance also puts patient privacy at risk, with errors in the past resulting in dissemination of confidential patient information (Malay, 2013). As such, the communicative tools that enable successful collaboration make our private information more vulnerable. Because of this, when a professional is to engage in collaboration, they must both trust their fellow collaborator, and ask themselves whether the beneficence of the collaboration is worth the increased privacy risk. In a survey of Canadian physicians and patients, most felt that the benefits of

computerization for enhanced sharing of information outweighed the risks of confidentiality risk (Perera, Holbrook, Thabane, Foster, & Willison, 2011).

## Chapter Four

### Specific Relationships between Collaboration and Music Therapy

In many instances music therapists will collaborate with professionals of other disciplines. Music therapists are often employed in facilities where they work alongside many other health professionals, and so there have been some publications on the dynamics and outcomes of music therapists working collaboratively with practitioners of other allied health professions (Travaglia & Treefoot, 2010; Turner & Tyas, 2012). Turner and Tyas' paper describes collaboration between a music therapist and occupational therapist to aid rehabilitation of a participant afflicted with a brain injury. The study briefly describes the therapists' reflections of collaborative work; within their joint sessions Turner and Tyas experienced nervousness about working with another discipline. They found that they dealt with this by remaining flexible and making sure that their thoughts were communicated to one another. Travaglia and Treefoot's study involves collaborative planning and discussion rather than joint-sessions. The focus of their study is the interdisciplinary collaboration of a music therapist and a dance therapist each working individually with the same participant. The therapists shared goals, insights and techniques with one another, which they believe encouraged a supportive and holistic approach to their sessions. They described how their collaboration provided more perspective on their participant, and also helped them to identify theoretical understandings and foundations of one another's work which they could then incorporate into their own. An additional benefit for the therapists was that they felt their collaboration provided them with additional positive feedback and support about their work, which they posited, could reduce burnout.

This consultative style of music therapy collaboration has also been studied in the context of New Zealand schools (Rickson & Twyford, 2011). Music therapists not only collaborate through individual therapeutic interventions, but also by changing the environment and attitudes within a school through consultation. Through such

collaboration, music therapists can work with teachers to build an environment in which they can continually support student learning and development with music. The dynamic of this style of collaboration is notable for the music therapist's role of empowering the teachers. Rickson & Twyford noted that teachers had some initial nervousness about their musical abilities (2011). Because of this, an important factor in teachers successfully utilising the collaborative consultation was the development of their own musical identity. Without developing their musical confidence teachers would have difficulty in sustaining their use of music to support students.

In the United Kingdom most questionnaire respondents said that they had utilised collaborative multidisciplinary approaches (Twyford, 2007). They reported collaborating with a range of other professionals including teachers, speech therapists, occupational therapists and physiotherapists. The music therapists largely considered these collaborations to be effective. Within the questionnaire the music therapists also identified the perceived professional and personal impacts on their work. They categorised these as either "benefits" or "concerns". The beneficial outcomes were deemed as very significant for the growth of the therapists, and the respondents described them with phrases such as energising, supporting and informing. It was acknowledged that there were issues in bridging different professional and theoretical frameworks and so it was essential that collaborating professionals engage in ongoing communication and negotiation.

One of the most notable examples of collaboration in music therapy is found in the teamwork of two of music therapy's most prominent pioneers, Paul Nordoff and Clive Robbins. Nordoff and Robbins collaborative work grew out of the complementary nature of their different areas of expertise; Nordoff was a talented musician, and Robbins was gifted in his ability to interact with disabled children; and their individual areas of expertise complemented one another in their practice (Kim, 2004). Such collaboration provides a good example of the way that music therapists may provide one another with new and novel perspectives and skills.

Music therapists work in many places that can be quite emotionally evocative and stressful and so burnout is a prevalent issue in the profession (Clements-Cortes, 2013). Many therapists can feel emotionally exhausted by their work, and unsupported and/or misunderstood by professionals of other disciplines in their workplace. In a study of burnout among music therapy faculty, music therapists revealed that creating and utilising support structures was an important tool in combatting burnout. Such support structures are a good example of current utilisations of collaboration amongst music therapists. Many music therapists seek clinical supervision in order to share ideas, receive support and keep up-to-date on current research. A survey of American music therapists found that one third participate in regular supervision (Jackson, 2008). Despite the low participation in supervision, almost all respondents felt that it was important. The study suggested that it could be very difficult to find another professional who is willing to provide supervision.

It is important to note that collaborative practice is quite different from clinical supervision. Clinical supervision gives therapists an opportunity to reflect on their practice, with their supervisor providing them with objective insight. This practice is employed to provide therapists with the means to continually develop professional skills and insight (Kennelly, Daveson, & Baker, 2015). In the absence of adequate supervisors, some suggest that collaborative working can provide many of the benefits of supervision (Vaillancourt, 2011). Within many professional fields it has long been the norm that training and research has taken place alongside peers and mentors. Due to its long success in other practices, Vaillancourt suggests that music therapists could embrace such apprenticeships as part of their training. A mentor gives students someone with whom they feel safe to express their professional fears and worries, as well as their triumphs and joys.

In a survey of music therapy students, supervision has been found to be a very valuable tool for reflection and growth while students are on practicum (Wheeler & Williams, 2012). Within their study, Wheeler & Williams' found a variety of aspects

of supervision that students found helpful or unhelpful. The students were concerned with the infrequency of supervision, as they would get no further feedback or evaluation on what they'd been told to improve upon. Another concern raised was the difficulty of having their practice judged when they had yet to learn all of the necessary skills. A potential benefit of co-working as a student could be that the two therapists would provide each other with on-going feedback. Some of the initial practical learning curve may also be softened, as the student would have a mentor to take the reins when they are in a situation where they have yet to learn the necessary skills.



## Chapter Five

### Power Relationships in Collaborative Endeavours

In previous collaborative studies it has been found that the effectiveness of collaborations is impacted by power differences in the collaborators (Rueda & Monzó, 2002). In their study of collaboration between teachers and para-educators, Rueda & Monzó found that power differences negatively impacted collaborative relationships, and concluded that differences in authority must be minimised in order to enable successful collaboration. While many traditional social power imbalances such as race and gender are involved, there are also many more such as teacher and student, evaluator and the evaluated. Rueda & Monzó recommended that collaborators must establish clear and specific guidelines for their respective rights and responsibilities as a means of promoting accountability within the relationship. It is argued that the reason that power is such an important factor in collaborations is because unlike cooperative arrangements, collaboration requires an “equitable relationship based on the sharing of power” (Hayes & Kelly, 2000). Hayes & Kelly stress that the core of a collaborative relationship is the negotiation of power. These definitions are based heavily upon post-structuralist concepts of power (Butler, 2006; Foucault, 1972).

## Chapter Six

### Methodology

A qualitative design was employed for this study as I sought to examine my experiences to uncover the benefits and challenges of collaborating as a music therapist. Qualitative methodology is considered a valuable approach for studying human experiences (Aigen, 1998). For this qualitative study I used secondary analysis of data generated in my clinical practice. As the study was retrospectively observational it did not affect my usual clinical practice.

The study focussed on 6 months of clinical practice in a special education school where I was practicing music therapy. My practice was for three days a week. For two of those days I worked collaboratively with an experienced music therapist who had worked at the school for two years. While carrying out my practice I kept clinical notes on all of my sessions, as well as a reflective journal where I documented my personal thoughts, and reflections.

I then analysed my data using thematic analysis. This process involves coding sections of the data according to emerging themes (Schwandt, 2007) (see pp.14-15).

### Justification for the Design

In a study seeking to discover the benefits and challenges of collaborating as a music therapist there are many designs that a researcher could employ. They could create a questionnaire and try to learn therapist' perceived benefits and challenges. As the researcher is student in this case we sought specifically to examine the student experience and perspective of collaboration.

This study used a qualitative methodology as it sought to examine the challenges and benefits of collaborative music therapy; I wanted to know about the qualities

and characteristics of the collaboration rather than any measurable outcomes. It is important to note that due to the qualitative nature of this research its findings cannot be generalised (Braun & Clarke, 2006). Instead the findings of this research should serve to provoke reflection in those who read them. Secondary analysis of data such as this is a useful methodology for music therapy students as it allows for examination of usual practice. No participants are involved, although permission needed to be obtained to use clinical data for research purposes.

### **Data Sources**

Clinical data was gathered in the form of clinical notes and personal reflections throughout my clinical placement. My clinical notes generally documented my observations during sessions, as well as important interactions, events, and goal progress. An example of this data source can be found in appendix A1.1. From these notes and journal I isolated and extracted all parts pertinent to our collaboration. The screening criterion I applied to these extracts was to consider whether they would have happened in the absence of our collaboration. These extracts served as the basis for my raw data. Informed consent was obtained from the school and from those directly involved, for this data to be used for research purposes.

### **Data Analysis Procedure**

The first stage of my data analysis was to code my raw data. I compiled all of my extracts into a single table where they could be coded. I read my extracts multiple times and familiarised myself with them. With this familiarisation I began to look for the various types of interactions, observations and features of collaboration. In this way I could identify the most interesting and meaningful features of the data. I coded these features with a variety of words and short phrases which described what was happening in them. Many of the extracts had multiple codes because they had many features within them. I read and reread these extracts and codes multiple

times to ensure I agreed with the attributions I had made. An example of my initial codes can be found in appendix A1.2

Once I had my initial codes I collated them all together along with their relevant data extracts. An example of these collated codes and extracts can be found in appendix A1.3. From this I could begin searching for themes. To do this I began searching for the common features of my codes. I then tried writing broad descriptions of these features. These descriptions were to be my themes. As I continued to review my themes I found that some of these descriptions encompassed one another and so in reviewing them they came to collapse into one another and create new themes. Once I had these themes I could then explore and define them in my findings. Through this contextual exploration of my themes I could then try and discover the benefits and challenges of collaborating as a student music therapist.

## **Ethical Considerations**

### **Confidentiality**

I obtained informed consent from the school and my collaborating music therapist to use my notes from this placement as data for secondary analysis

Apart from myself and my supervisor, all names in this study have been de-identified. Due to both the small nature of New Zealand's music therapy community, and the small number of special education schools in the south of New Zealand, there is the risk that my co-therapist may be identified. This risk was discussed with my co-therapist prior to them giving informed consent. The names of my clinical participants will not be used in any publications or reports associated with this research.

### **Storage of Data**

All electronic data were stored on a password-protected computer, and physical copies were store in a locked filing cabinet. All data would be kept for the legally required length of five years.

### **Relevance for Maori**

As this study sought to determine the benefits and challenges of collaborating with another music therapist, the values and culture of the music therapists was likely to be an important feature. In this study, the qualified music therapist I collaborated with was of Māori heritage and approaches practice using the Māori health model of Te Whare Tapa Whā (Rochford, 2004). As a Pākehā I had to learn to both embrace and utilise this approach when we collaborated. As such, this research is likely to be of interest to Māori as an example of cultural collaboration. Some of my clinical participants are also of Māori heritage. Having a collaborator who is Māori provided the opportunity to maximise cultural sensitivity in practice.

### **Project Management**

Dr Daphne Rickson was the supervisor for the project.

It is important to note that while the collaborating music therapist had responsibility to facilitate my placement and report on my progress, the therapist was not my placement supervisor (another visiting music therapist had this role). It is also important to note that I discussed this proposal with my collaborating music therapist and obtained informed consent.

### **Data Ownership**

The school owns all clinical data. Permission was obtained to use this data for research purposes.

## Chapter Seven

### Findings

In this findings section I outline the benefits and challenges of practitioner collaboration between me and my music therapy colleague, including the perceived impact of our collaboration on our music therapy participants. Themes have been derived from coding of raw data. The nature of the topic demands significant reflection on each of the themes. The degree to which certain aspects of our collaboration were beneficial or challenging can be quite subjective depending on the context and the reader's understanding of music therapy. Presenting each theme and exploring them in turn has enabled me more readily to contextualise their possible impact, and helps with the flow of the dialogue.

**Having two therapists allowed sessions to continue when circumstances would otherwise disrupt them.**

One of the benefits of having a co-therapist is that when one of us is unable to continue the session, whether due to health, participant disruptive behaviour, or other obligations, the other therapist can carry on with the session. This means that participants don't miss out on sessions as they might otherwise. Having a co-therapist also covers me in a learning capacity. As a student I'm frequently trying new things and the cover of another therapist helps me learn to at a comfortable pace. A dilemma with that is the possibility that I become comfortable with allowing my co-therapist to take over, rather than having to respond immediately. However, I also understand that as a therapist I need to take time to reflect in the moment, and that there can be benefits to slower paced sessions. I am also aware that a few seconds of reflection can seem like a very long time and this can be uncomfortable for me as a music therapy student even when it is quite appropriate. So I am learning to be comfortable with space. For example, having a co-therapist also allows me to withdraw from direct interaction with learners while I am considering what I might do next.

Whether this aspect of our collaboration is a benefit or challenge depends on our perspective. Firstly we could examine how participants were affected. For the participants we were able to prevent disruptive behaviours from impacting negatively on other participants' experience of the session. In music therapy in a school setting there are not always teachers or teacher-assistants available to provide this assistance, and so the therapist may need to intervene when students engage in violent or disruptive behaviour. When I would take a session by myself this would usually temporarily disrupt the session as I tried to manage the behaviour, particularly if the participant was violent. This would often lead to other participants growing angry towards their disruptive peer which would only further aggravate their behaviour. With collaborating therapists, one of us could manage difficult behaviours before they would disrupt the other participants, allowing them to make full use of their session.

For me as a student, this aspect of our collaboration is a balance of benefits and challenges. Whenever I lack the necessary confidence or a particular skill in a session my co-therapist can cover for me. This cover can save me from the embarrassment of faltering in a session and prevent my inexperience from adversely affecting the session for participants. Conversely, the students are aware that I am a student and if I were to make a mistake it would be an honest one. Making mistakes while developing new skills is perfectly natural and would perhaps serve to strengthen rapport between myself and the participants. Seeing somebody makes mistakes and cope with them can be very helpful. The ability to make mistakes and keep trying is a great demonstration for young people of what is required to develop skills. Embracing the safety that my co-therapist provides me with may have at times prevented me from demonstrating this valuable skill to participants. As my participants were young students, many of them are currently learning new and difficult skills which can be very frustrating for them, and more honest demonstration of my learning process could have been invaluable.

An additional benefit of being able to cover one another is that we can protect our health when necessary. As a student I wasn't used to making as much music as I did on practicum, and sometimes my voice or hands would begin to ache from overuse. On these occasions my co-therapist was able to take over for my ailment, singing if my throat was faltering, or playing guitar if my hand was aching. This is particularly beneficial as protecting our health is a very important part of maintaining our professional practice.

**Having two therapists allowed our routine to be more reliable for participants.**

My co-therapist already had an established routine with some of my participants which I had to adapt to. This was certainly useful when I was first beginning my practicum and was inexperienced in establishing a routine within a school environment. Many of the students took comfort in routine and having two therapists allowed our routines to be more reliable for them.



Internationally children with intellectual disabilities are more likely to live away from their biological families, and less likely to be placed with a foster-family once in residential group care (Mcconkey, Kelly, & Craig, 2014). As such, many of our music therapy participants had experienced difficult and sometimes traumatic experiences while growing up, and demonstrated symptoms of attachment disorder (Pasiali, 2014). Specifically it seemed that they were wary of being let down, and it was therefore extremely important that we were reliable and consistent in our response to them. We would need to be available at the same time and in the same place each week so they would eventually trust us; and in turn begin to trust other adults in their lives. This trust we built together was crucial to our ongoing therapeutic relationships and the participants' developing inter-personal and social skills.

**In our collaboration, each of us brought established rapport with many of the students to the session.**

My co-therapist has had music therapy sessions with many of my participants in the past, and as such has developed relationships with many of them. This was often very beneficial as the therapist already knew many of our participants' likes and dislikes, as well as successful strategies for supporting and facilitating particular participants. Another benefit of these established relationships was that we each had separate knowledge of expected behaviours and could let one another know if any behaviours were atypical. Expectations that things would happen in a particular way were also held by the participants; in their previous sessions with my co-therapist, the participants had developed a particular concept of what a music therapist is, and what they do. They then expected the same of me in our sessions, with participants requesting music and activities they had learned with my co-therapist some of which I did not know.

This aspect of our work together was initially quite challenging as it placed quite a large amount of pressure on me when I was first beginning my practicum. My co-therapist had established very high expectations for both my participants and other

staff which I felt I had to meet. When I would have to explain to participants that I didn't share my co-therapists repertoire I felt like I was letting them down and perhaps damaging my perceived "legitimacy" as a music therapist. Fortunately, this challenge was soon overcome as the participants got to know me and we established our own relationships. Forming my own separate therapeutic relationships with the participants allowed them to experience and understand the way that music therapists have different methods much like their teachers.

Another benefit of my co-therapist's established rapport with participants was that it allowed me a degree of trustworthiness. Many of our participants had established strong therapeutic relationships with my co-therapist. For many of the students, my co-therapist was the only music therapist they had met, and so they had defined their concept of a music therapist. In this role the students had come to trust the therapist, and by extension a reputation as a music therapist. My association with my co-therapist and music therapy meant that I could share in the positive reputation and student concept of music therapy that my co-therapist had established. So while my perception was that student expectations put a lot of pressure on my performance, they also allowed the students to trust me. The students welcomed me to their school and were eager and open to my therapeutic role. This openness allowed me to much more readily establish my own relationships with the students.

As I and my co-therapist took many of the participants separately for individual sessions, we soon established quite separate connections with them. These separate relationships were beneficial in group sessions as the students could seek familiarity from one of us while still having new experiences with the other. Additionally, we could inform each other of our individual participants' preferences, progress, and behaviours so we would be prepared for the students we saw less often.

**I could follow someone's lead and learn from them while still developing my skills.**

One of the particularly beneficial aspects of collaborating as a music therapy student is that when you're feeling unsure in your abilities or direction you have somebody to follow and emulate. As a student you can observe your co-therapist's practices, learn what is effective, and follow their lead.

As music therapy in New Zealand is still a young burgeoning profession, the opportunity to observe and work alongside other music therapists is rare. Because of this, not all practicum placements for music therapy students are facilitated by an experienced music therapist. In my placement I was fortunate to have a music therapist to learn from first-hand. Observing and emulating my co-therapist was beneficial and challenging in a variety of ways. For example, while I often sought to emulate my co-therapist, due to skill or our separate personalities, this wasn't always possible. This could be disheartening while I was still developing my own distinct therapeutic style. To overcome this it was important that I accept that while I can learn from my peers, we cannot fully emulate one another.

**Having two therapists meant that where necessary we could create more complex music as well as respond to a greater range of dynamic and sonic environments.**

My co-therapist and I each brought unique musical abilities and repertoires to our sessions. Using these abilities we were able to musically support one another through harmony and rhythm. This musical support allowed us to create music with more harmonic and rhythmic richness than would be possible with only one musician. This musical richness may offer more compelling and emotionally evocative music for our participants. Conversely, our musical competency may be alienating and intimidating for participants if not reserved for appropriate times. Often in sessions some of our participants would create very loud music. In group sessions this could sometimes make facilitating the group difficult. By having two therapists we could sing loudly in unison and create a more powerful musical feature for our participants to share in. This dynamic flexibility allowed us to facilitate participants in situations where group cohesiveness would otherwise be lost. Similarly, my co-therapist had a much higher range than me and their voice could cut

through particularly loud moments. Our combined vocal ranges gave us much greater flexibility in finding the available sonic space of a session, allowing clear lyrics and melodies, as well as giving participants a choice of pitches to sing with.

The participants across our sessions had a wide variety of musical preferences and physical abilities. Our combined musical flexibility was very beneficial in helping us meet the varied preferences across our diverse range of participants. While our ability to create louder music was beneficial for many of our participants, some of them had quite low volume tolerances and so we had to be much more careful to play quietly.

**Our collaboration meant that we could provide emotional and motivational support to one another, through empathy and encouragement.**

Throughout our sessions my co-therapist and I could provide one another with motivational encouragement and emotional support. As we were practicing the same therapeutic role we could empathise with one another about the challenges faced within it and therefore better support one another through them. This empathy was also present within sessions, with my co-therapist recognising and intervening when I was having difficulty with particular skills or client behaviours. This was particularly valuable to me as a student, wherein I am constantly learning and practicing new skills, and many behaviours were new and challenging for me. My co-therapist could also recognise moments that were significantly positive experiences for me, and would discuss these with me after sessions. This would motivate me and help affirm that I was fulfilling my role satisfactorily.

Engaging in collaboration with another music therapist was beneficial as it allowed us to regularly interact in recommended ways to avoid burnout. Due to the personal and emotional nature of music therapy, there is a high rate of burnout in the profession (Clements-Cortes, 2013). Our discussions about the challenges found in sessions as well as the significantly positive experiences served to maintain our enthusiasm for our work.

**Having two therapists in our sessions allowed us to engage in more complex experiences with the students while still having consistent music-making.**

Often one of us would be able to facilitate students to dance, act or share instruments. Without a second therapist these tasks could interrupt the music-making and disrupt the flow of the session. The additional therapist allowed our students to engage in a variety of complex experiences using the music of the other. Many of our participants enjoyed dancing with one another and we could direct new pairings amongst them as they danced, encouraging inclusiveness and making sure nobody missed out. Some participants weren't as interested in dancing and would join "the band" with the other therapist and make music for the others to dance to. Another popular activity among the students was acting, and we could often create impromptu musical theatre for the students, in which they'd play different roles and sing to one another. This was a difficult activity to implement and benefited greatly from having two therapists who could move between the instruments and the scene created by the students. This activity was very effective in encouraging usually quiet and withdrawn students to engage in reciprocal play and conversation through song.

Many of the students attended drama classes at school and enjoyed dancing in their spare time. The participants enthusiastically created music in a therapeutic environment where they could utilise and perform skills they had already acquired. These complex tasks were a way of meeting some participants' half-way, especially when they felt less confident about making music.

**I found that throughout our collaboration I grew to rely on my co-therapist, and even become dependent upon their skills.**

Over the course of my practicum I found that I had begun to rely on my co-therapist in sessions. There were times where I felt unsure about what to do and would wait to follow their lead rather than taking the initiative. Early in the practicum I relied upon my co-therapist for opportunities to lead. I would follow their lead until they would offer me the guitar. These interactions of dependence are perhaps more

typical of the teacher-student relationship than a usual collaboration of music therapists. These opportunities to have somebody cover my inexperience certainly provided a “safety net” which helped me feel comfortable in my student role, but possibly created a dependence on my co-therapist, and perhaps slowing my growth as an independent therapist.

As the practicum is of a fixed-term it should be utilised to develop and foster a student’s skills as an independent music therapist. However, as the co-therapist may be relied upon to perform the tasks the student cannot, the student has opportunity to be dependent on them. This dependence can present both a challenge and a benefit to the student’s development. Ideally the co-therapist must slowly withdraw their leadership, and provide opportunities for the student to be in charge. In this way the student can learn without becoming overwhelmed or too dependent on their co-therapist. Conversely, the student can remain dependant on their co-therapist and be under-prepared to practice independently. Without a co-therapist the student wouldn’t risk becoming dependant but instead may be overwhelmed by the pressures of beginning practice. Beginning practicum can be a very scary time for a student, and the pressures may even put them off pursuing the practice (Wheeler & Williams, 2012). Some initial dependence on a co-therapist is therefore most likely beneficial, as long as it is not nurtured for the entire duration of the practicum.

### **Learning Opportunity**

As my co-therapist was also my practicum facilitator they often gave me opportunities to grow in sessions. When I was first beginning my practicum my co-therapist would offer me opportunities to lead in sessions which would allow me to learn and practice as and when I was confident and competent. Over the course of the practicum, as I grew more confident these became less frequent, as we grew to share in the leadership role.

As discussed in the previous finding, a student could possibly be left under-prepared for independent practice if they are too dependent on their co-therapist. As such,

this was a very beneficial aspect of our collaboration. My co-therapist would often hand me a guitar, indicating for me to lead a session, thus giving me a chance to exercise my own skills and ideas without their leadership. My co-therapist would've had to determine when he considered it appropriate for me to lead. The necessary frequency of these opportunities is difficult to determine as it would vary from person to person, and depends on the subjective opinion of the co-therapist in the "teacher" role.

**Having two therapists often allowed us to more directly facilitate the needs of individual participants.**

Within a group setting we would often have to facilitate participants' needs to enable them to fully partake in a group experience, or to protect their health. Having a co-therapist meant that either one of us could quickly attend to students who were having difficulties. These difficulties ranged from emotional to physical ailments, but also included participants needing help with an instrument. We could demonstrate to students how to use instruments as well as joining them in reciprocal playing. Some of our participants had health issues that they would need assistance with during a session. By having an extra therapist to facilitate them they could still experience the session while we could assist them in maintaining their health. Sometimes one of us would need to help a student who was disrupting the group, and we could take them aside and try helping them while allowing the rest of the group to carry on their session. Many of the students enjoyed the individual attention and would ask for help.

This aspect of our collaboration was very beneficial in ensuring our participants could fully participate in our sessions. Some of our students had physical disabilities and sometimes required assistance in playing an instrument. The opportunity to move amongst a group of students throughout a session aided us in developing individual relationships with its members. Whenever a student needed assistance they had somebody they could ask without having to worry about disrupting the session for others. Sometimes the assistance a student needs is just the individual

attention and acknowledgement of their music. Having a second therapist allows us to give students that attention. A possible challenge of being able to individually facilitate students is that it may encourage them to interact solely with the therapists rather than their peers. A common goal in our group sessions was to facilitate interactions between peers who would only communicate with their elders. Another challenge was that students would vie against one another to get the attention of the “roaming” therapist. This would sometimes have participants pushing in front of one another to obscure others. Of course, these behaviours also occur in sessions with one therapist, but participants were often aware of the availability of assistance of the second therapist.

**Throughout our collaboration, my co-therapist and I had a large amount of shared responsibility for our sessions.**

My co-therapist and I had shared responsibility for the implementation of our joint sessions. Sometimes one of us would make a seemingly poor decision that would make the session more difficult. In these situations both of us would be affected by the decision. This shared responsibility could be both a benefit and challenge as we share in each other’s work, regardless of outcome. Due to the imbalance in the respective amounts of experience in our collaboration, it could be hypothesised that our shared responsibility is more in my favour. Because of this, this aspect of our work was likely far more beneficial for me than my co-therapist. Additionally my practicum has a limited timeframe, and so any mistakes I make will be put behind me when I must go, whereas my co-therapist is employed at the facility and would possibly have long-term issues to deal with if I was to make a mistake. The challenges of our shared responsibility perhaps show the commitment it can be for somebody to facilitate a student music therapist.

Whenever one of us did make a mistake in a session, we wouldn’t blame one another. Instead we tried to support one another by looking forward and planning what we’d do differently next time.



**Collaborating with an experienced music therapist meant that I had someone to defer to.**

Throughout our sessions I would often defer to my co-therapist for advice on how to proceed. Sometimes I would encounter new and challenging situations in sessions and need my co-therapist's guidance to navigate them. Other times I would defer to my co-therapist because I wanted to know their thoughts on a particular session or participant. Due to their greater experience I felt that my co-therapist would generally have a better observations and ideas on what to do. This aspect of our collaboration was enabled by two important factors. Firstly there is the fact that one therapist has much more experience than the other, and therefore presumably more knowledge. Knowing of my co-therapists experience gave me an innate respect for them and trust in their presumed knowledge. Secondly the nature of our collaborative relationship, where my co-therapist was also my facilitator, meant I felt I could safely approach for knowledge or advice. My lack of experience was a known factor in the relationship and deference to my co-therapist would've likely been anticipated by them. In other relationship dynamics I may hesitate to defer to someone else for fear of appearing inexperienced or inept. The benefit of being able to defer to my co-therapist was strongly influenced by their lack of judgement of my inexperience. This lack of judgement could be a product of the teacher-student relationship formed by our assigned roles of student and facilitator.

**Having two therapists meant that goals could be set with the observations of more than one person.**

My co-therapist and I would spend time discussing participant goals together. We could share our separate observations with one another which may have helped us form a more complete picture of a participants strengths and needs. With clear needs established we could confidently set goals for our participants. One of the challenges in our goal-setting was that sometimes in sessions my co-therapist would pursue goals that they hadn't yet discussed with me. I would have to pick up on their intentions and follow their lead, which was good for developing my observational

skills, but I'd still sometimes have trouble understanding. While my co-therapist was always happy to discuss goals, I had to make sure to ask. Our collaborative goal-setting required ongoing communication about participant goals. With this communication we would have more information with which to form more appropriate goals for the participants' needs.

**As my co-therapist and I each had a different cultural heritage, we brought diverse cultural perspectives to the work.**

My co-therapist was Māori and could speak te Reo Māori as well as play various Māori instruments. These instruments were often used in sessions and were particularly valuable in sessions with Māori participants. One of our participants had Māori spoken in his home and so my co-therapist could often converse in Māori with him. I learnt many useful Māori phrases in these sessions which I was then also able to use in sessions. However, despite having learnt a few phrases I found myself quite envious of my co-therapist's ability to speak Māori, and the special avenue of communication it gave them with participants. This encouraged me to carry on trying to learn more Māori, which I would use alongside them in sessions. Additionally to this, my co-therapist utilised Te Whare Tapa Wha, the Māori health model, in their work (Kahui, 2009) ("Māori health models – Te Whare Tapa Whā," n.d.). Because of this different approach, we could often share unique cultural perspectives on our outcomes.

This aspect of our collaboration was perhaps more beneficial for me than my co-therapist. As New Zealand culture is predominantly European, many Pākehā (New Zealanders of non-Māori heritage), including myself, are not very exposed to Māori culture, whereas European culture is hard to avoid. As such, my co-therapist would presumably be very familiar with European culture and have very little to learn from me. Conversely, my co-therapist had many new and interesting cultural practices for me to observe and learn from. While I had learnt much about Māori culture in school, through books and media, I come from the south of New Zealand where the Māori population is very sparse, and so had experienced very little participation in

Māori cultural practices. Due to my co-therapist's cultural heritage our participants, as well as myself, enjoyed participating in various cultural activities, which as well as being musically engaging, were culturally educational for all of us. Due to our collaboration, in my future practice, I will now be more aware of the Māori perspective in music therapy, as well as a variety of culturally influenced music and activities.

**My co-worker and I each had a variety of professional skills which we could share with one another.**

Often in sessions I would observe my co-therapist's practices and learn from them. I would then try and implement the observed skills and techniques in my own work. I would not only observe skills used in practice, but also skills used working with and alongside teachers in a school-setting. I would pay close attention to the way my co-therapist would share progress with teachers and gather important information. Teachers were often stressed because they were frequently dealing with the difficult behaviours of students who were unable to manage, and my co-therapist was very supportive of them and would reassure them. This inter-personal communication with staff was an important professional skill I grew to replicate from my co-therapist. Sometimes we would share professional skills more overtly, taking the time to discuss our practices and what we had learned in previous facilities. The skills we would share with each other were sometimes more relevant to our previous practices but still valuable to our on-going development as music therapists.

**The student-teacher dynamic of our collaboration meant that there was a power differential in our collaborative relationship.**

Due to this, I sometimes didn't say the things I wanted to. As my co-therapist was also my practicum facilitator I wanted to maintain a positive relationship so as to not jeopardise either my practice or the security of my placement. As such, I was hesitant to mention anything I disagreed with. While I am confident my co-therapist would have been very good-natured about me challenging him, having the confidence to do this as a student is very difficult. To overcome this, difficult

messages must be communicated in a positive way. Disagreeing is not always negative, and it is important for music therapists to be able to deliver alternative views in ways that ensure they are well received.

Even in my journal, I found that I attributed anything I disagreed with as something I need change about myself. When I felt my co-therapist didn't discuss goals with me enough, I wrote that I needed to ask him about them more, rather than asking him to make sure to share them.

**Working with another therapist opened our work up to the possibility of judgement by peers.**

Due to my lack of experience as a music therapist I was initially very self-conscious in practicing music therapy with my co-therapist present. This was manifest as fear of both the therapist's judgement of my musical abilities and therapeutic rapport with participants. I noted that in our first few weeks working together, my guitar playing was very "show-offy". While this helped me feel more confident about what my co-therapist may have thought of my musical abilities it was not necessarily therapeutically beneficial for participants.

**Our collaboration gave us access to a greater range of musical instruments and accessories than we would have otherwise.**

My co-therapist and I each possessed a different range of musical instruments and accessories. Our collaboration and the nature of our relationship meant that we would bring multiple instruments for one another to use in sessions. This gave us access to a far greater variety of instruments than would otherwise be available to our participants. Sometimes one of us would bring an instrument that the other would be unfamiliar with and so we would get the opportunity to practice on them and expand our repertoire. One of the challenges I found with sharing resources is that I sometimes planned on using instruments of my co-therapists only to find that they weren't there on the given day. An additional benefit was that the instruments were given more care than usual. I would keep tools and cleaning products with and

whenever I had the opportunity I would perform basic maintenance on both my and my co-worker's instruments.

## Chapter Eight

### Vignette

In this chapter I will present a vignette of the work I was doing with one of my participants. This particular participant was having both individual music therapy with myself and group sessions facilitated in collaboration with my co-therapist. It is my hope that the details of our work with this participant will illustrate some of my findings in a way that is both interesting and perhaps clarifying for the reader.

One of the students I had been having sessions with is a 14-year-old boy named Lewis. Lewis is very friendly, physically healthy and has been diagnosed with Down syndrome. I had two sessions a week with him; a half-hour individual session, and an hour-long group session with 2 of his classmates and the resident music therapist. When I first met Lewis in his class he greeted me with a big smile and a handshake. However when he introduced himself I couldn't understand what he had said. I politely asked him if he could repeat himself, but once again struggled to understand what he had said. Lewis furrowed his brow in concentration when he spoke and so I felt quite embarrassed for not understanding his efforts. His teacher then intervened and told me Lewis' name and some more about him. I was told that he was a huge fan of Michael Jackson and would probably only want to play that in our sessions. His teacher then took me aside and suggested that we may want to focus on his speech in our sessions. I was also told that I should discourage him from singing or dancing like Michael Jackson in class as he is quite obsessed with it, and that I should probably discourage it in sessions.

As our sessions began I learned that Lewis was a born performer and loved an audience. While he would enthusiastically participate in reciprocal musical play and activities on a range of different instruments, whenever he would get an opportunity he would jump up and begin singing and dancing like Michael Jackson. Lewis would always be pleased at my accompaniment while he did this and began to

make requests of me by pointing to the piano or drum and indicating he would like to dance. His performance was almost always the song “Thriller” (M. Jackson, 1984). He knew the entire dance and would execute it brilliantly. His singing was perhaps reinforcing difficulties in his speech. He would pronounce “thriller” with a degree of clarity but would then string the rest together as a string of approximate noises. I attempted slowing the song down and going over it line by line with him to see if we could practice each part for a range of consonant sounds. Lewis wasn’t very pleased with this though and would just take off on his own performance again.

In Lewis’ group sessions my co-therapist and two of Lewis’ classmates joined us. While my co-therapist had worked extensively with one of the participants in the group, the therapist had not worked with Lewis before. Because of this Lewis would often come to these sessions wanting to repeat the activities we had done in his individual sessions. If we were to repeat his individual sessions it would exclude his classmates and my co-therapist. I was able to use this constructively in helping Lewis build rapport with my co-therapist by asking him if he could show them what music we had been working on, so they might join in. He would be able to start singing or dancing for the group and they would draw off his energy and excitedly play percussion for him. In this way I was able to utilise my established rapport with Lewis to aid him in building relationships with others. Lewis was one of the few participants with whom I established a therapeutic rapport before my co-therapist, and this gave me particular insight into aspects of the collaborative experience.

Due to Lewis’s teacher suggesting we avoid Michael Jackson, the prevalence of “Thriller” in our sessions was something of a dilemma for me. While I wanted Lewis to feel free to creatively indulge and express himself however he pleased, I also knew I had obligations to the school in respecting their goals and wishes. Because of this I tried to present Lewis with choices so he’d know we wouldn’t only be doing “Thriller”. Lewis would perform that song all session if allowed and so I generally tried to make it a reward later in the session. I explained this to each teacher and was pleased to learn that Michael Jackson had ceased to be a disruptive issue for

Lewis in class. He was still hugely passionate and excited about Michael Jackson but had already distinguished music therapy as a place where he could freely express that without getting in trouble. With his new avenue of expression in music therapy Lewis didn't need to perform in class.

Within our sessions I continued to focus on speech development, using many call-and-response songs and that practice consonant sounds. Lewis would always happily participate in music with me but would still struggle to enunciate many consonants and would grow quite frustrated if we focussed on it too much. I tried to balance our speech practice with activities that just allowed Lewis to communicate with me without the pressure of speech. He was a fantastic dramatist and we would act out little musicals together where I would play guitar. Due to his love of "Thriller", Lewis also had a fascination with zombies and the macabre. Because of this, our musicals would often be horror or fantasy-themed. We would run around the room playing our respective characters and I would sing about what was happening. Lewis would always act with gusto, singing back my parts and waving his arms like an opera singer. I feel that these opportunities to interact with each other playfully without any communicative pressures were very valuable for Lewis and he would often not want to end sessions after them.

I eventually enquired with Lewis' teacher as to whether there were any speech therapy opportunities for Lewis. I was disappointed to learn that Lewis had had funding secured for speech therapy in the past but his family didn't want him to participate. It wasn't explained to me why they did this but I told was told there were quite a few issues at home for Lewis.

In the time I spent with Lewis I did not observe any improvement in his speech. In fact, any focus on his speech upset him rather than helped. I reached the point where I didn't believe that trying to improve his speech was a good use of our time together. I discussed this feeling with his teacher, the resident music therapist and my supervisor and we agreed that there was more value in providing Lewis with the



opportunity for expression and interaction. With his speech difficulties such an opportunity was rare and valuable for him.

Another issue I have encountered in my sessions with Lewis is that some days he will come to sessions quiet and with his head hanging low. Sometimes when he is feeling low he will begin crying but cannot tell me why due to his speech. This is quite upsetting, and so I just did what I could to improve his day. These low moods culminated in one of the group sessions with my co-therapist. Lewis arrived at the session looking quite glum so we quickly began making music together. I sat at the piano with Lewis improvising while the other participants and my co-therapist loudly played percussion with me. While the rest of the group were enthusiastically participating, Lewis began self-harming in a variety of ways. He bit his hands and began head-butting the edge of the piano. Although I managed to remain calm and casual towards Lewis, inside I felt very scared and concerned for his safety. I suddenly felt very unsure of myself and didn't know what to do. As I continued playing piano for the rest of the group I spoke reassuringly to Lewis trying to sooth him. Despite trying very hard to not appear panicked my co-therapist recognised my hesitation and quickly came to the aid of Lewis. I felt relieved that the other therapist was able to focus on Lewis and cheer him up while I led the rest of the group. My co-therapist placed his hand on Lewis's shoulder and Lewis embraced him in a hug and began crying. My co-therapist spoke softly to him, reassuring him that he was ok. He then told him he would feel better with some of the music he loved and encouraged him to show off his "Michael Jackson moves" to the other participants. Lewis slowly began dancing and singing with his classmates and his mood appeared to slowly perk up. At the end of the session he approached me and said "sorry". I felt terrible about him apologising to me as he was the one really hurting.

Within that session, I felt so lucky to have the guidance and help of a more experienced therapist. Lewis' self-harm was quite shocking for me and I felt quite unprepared at the time. While Lewis exhibited these behaviours in future sessions, I

was glad that the first time he did so I had the safety net of my co-therapist. In future sessions when this behaviour was exhibited I was no longer as unsure of myself and could respond without hesitation. I was able to emulate the actions of my co-therapist from then on.

Lewis had a very frustrating and difficult time in his daily social endeavours. I regularly had to apologise for not understanding him when he wanted to tell me something. Sometimes I felt frustrated that I could not understand him, but this cannot even come close to his own frustration. Lewis is a beautiful person who has so much he wants to share with the world but is often unable to due to his disability. I hope that our sessions offered Lewis a place where he could interact and share with others in a safe environment, and I hope he carries on using music as a conduit for his expression.

## Chapter Nine

### Discussion

Within the findings of this research there were many points of interest which deserve further discussion. A particular aspect of the findings that intrigued me was my consistent perspective that a session was being led by whoever was currently leading the music. There were many instances where I presumed that whoever had the guitar was currently leading the session. This presumption was perhaps a result of my inexperience as a music therapist, and was not as true as I thought at the time. A comparable dynamic of note would be that of Paul Nordoff and Clive Robbins. Within their approach to music therapy, Nordoff would play the music; the “musician”; while Robbins would facilitate the participant the “special-educator” (Kim, 2004). Despite the fact that Nordoff filled the role of “musician” in their collaboration, it would be difficult to call him the leader. The concept of a “leader” in collaborative music therapy is perhaps moot, as the planning and sum of the session is the collaborative effort of both parties (Twyford, 2007). Each member fills a different, but equally important role. In the case of Nordoff and Robbins, each of these men brought separate skills to a session; the collaboration was the sum of these skills. Through successful collaboration we bring our own skills together in a way that they complement one another to the benefit of both therapists and participant.

Another possible reason that I presumed that sessions were led by whoever was creating music was a misattribution of power to the guitar. Within our sessions we often used a guitar as it is the primary instrument of both therapists. Because of this being my primary instrument I feel comfortable playing it and will choose to play it if given the opportunity. As a student where I am still building my confidence as a music therapist I would want to use the instrument I am most confident with. Because of this I possibly viewed the guitar as a more “important” instrument. This quality of “importance” would mean that whoever had the instrument at the time had more power in the situation and would be the leader. However, such a

perception is somewhat revealing of my naivete as a student. Even though I may not be utilising my most competent instrument does not mean I'm not doing significant work. I think it's important to distinguish that I mistook the guitar's importance to me, as a nervous and learning therapist, with its importance to the session. Of course the confidence the guitar gave me was important for my work, but not having one does not mean that I cannot still provide meaningful music for participants.

Nervousness was common a trend amongst my findings. From the nervousness of beginning new practice, to opening yourself up to a colleague's judgement scrutiny and judgement, to addressing disagreements with somebody more experienced than you, there are many aspects of collaboration which can make a person nervous. This nervousness in collaboration is not unique to student's either, with professionals with many years experience reporting the same thing (Rickson & Twyford, 2011; Twyford, 2007). Rather than being an overt on-going challenge of collaboration, nervousness could instead be regarded as an important hurdle to manage in achieving successful collaboration.

One of the features of my findings which I had not anticipated was the way I was often dependant on my co-therapist's abilities. It was so easy to rely upon the "safety net" which my co-therapist's abilities provided me, that I must question the extent to which the collaboration was beneficial for my growth as a music therapist. While having a co-therapist allowed me to learn from and emulate an experienced colleague, it also allowed me to withdraw from challenges. Challenges are an essential part of learning, and I may have avoided challenges that would have been beneficial for my growth. Of course this is speculative; I cannot know what might have happened without my co-therapist, and I don't know what challenges I may have unconsciously avoided. I would have to surmise that dependence was not a critical challenge of the collaboration as I was still able to grow and learn, and continue to practice independently of my co-therapist. Rather, dependance highlights an aspect of collaboration that for students could prove challenging in the long-term if not considered.

## Limitations

Both a strength and limitation of this study would be its qualitative design. While this design provides the study with rich and descriptive data, it means that its findings cannot be generalised. As such it would be difficult to cite this study to support the benefits of collaborative music therapy, but rather to provide examples of how it can be beneficial.

## Chapter Ten

### Conclusion

When beginning my practicum in a special education facility I had not anticipated that there would already be a music therapist working there. We soon decided we would collaborate when we could. I was immediately curious about the effects such collaboration would have on my practice as I was growing and learning and so I set out to study them.

Through the process of secondary analysis of my clinical notes and journal I was able to explore the benefits and challenges of the many aspects of interaction that collaboration enables. These benefits and challenges were diverse, with many elucidating the processes, which enable successful collaboration. Communication was repeatedly stressed as both one of the beneficial aspects of collaboration, as well as an important process necessary in maintaining it. As this research took place while I was learning and growing as a student, my understanding of collaboration changed through the research, and I came to better understand successful collaboration as the complementary nature of the diverse skills different people provide. As a student, the collaboration provided many beneficial opportunities for me to learn from and emulate a more experienced therapist. As I was a student, our collaboration had a power differential with my co-therapist being my facilitator. This meant that I was initially hesitant in communicating my contrary thoughts with my colleagues for fear of causing distress. As such, this helped me develop my skills in disagreeing in a respectful manner so as not to harm the collaboration.

Despite the many challenges in maintaining a successful collaboration, it provided my co-therapist and me with many extra opportunities for our participants, as well as a flexible learning environment for myself. Due to this, collaboration appears to be a largely beneficial under-taking for student music therapists.

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## Appendix

### A1: Example of Analysis Procedures

#### A1.1: Initial clinical notes.

The following is an excerpt taken from my clinical notes. From these I was able to generate my raw data. In the interests of confidentiality I have redacted the names of participants and replaced my co-therapist's name with "my co-therapist".

"This week was quite different from the week beforehand as my co-therapist gave me a few opportunities to lead. We also had another student in the class. [REDACTED] wasn't very interested in joining the group and sat at his chair watching everyone else. He walked over a couple times but wouldn't join. As we only brought one guitar, whoever had it was the de-facto group leader it seemed. So when my co-therapist passed me the guitar I tried a few children's song like "Old Macdonald" and went around the group getting everyone to contribute in their own way. While I led my co-therapist took on the role I had been previously doing, and would facilitate students with physical disabilities or encourage those not engaging."

### A1.2: Initial Codings

From my notes, I extracted all parts that were the result of our collaboration. All interactions between my co-therapist and I, all co-operation, separate student facilitation and reflections on our collaboration were extracted for the purpose of initial codings. The following is an example of the extracted information and the initial codings I gave them. Many of the extracts had multiple codings.

so I played the guitar and sang while my co-therapist helped the students to dance	Flexibility
I... ...could focus on facilitating [REDACTED] for the rest of the session	Individual
we only brought one guitar, whoever had it was the de-facto group leader it seemed	Leading
Today me and my co-therapist brought 4 guitars to the session which turned out to be a big mistake	Shared responsibility
...my co-therapist introduced many different funny voices to sing in which kept the session fresh and exciting.	Sharing professional skills
which made it necessary for me and my co-therapist to play loudly	Strengthened
my co-therapist and the TA knew the song as well and we all sang it	Strengthened
The class did a call-and-response which my co-therapist helped encourage	Supported

### A1.3: Compiled Codings

My next step of analysis was compiling all like codings together. For each coding I compiled all of the extracts that had been coded such. I could then analyse and compare each of these compilations for themes.

#### **Strengthened –**

- I played along with him on guitar and he was often able to put down his guitar and carry on singing
- While my co-therapist sang “I love you”, [REDACTED] and I sang high vocalisations alongside it
- My co-therapist helped [REDACTED] to play along on percussion and loudly sang along with me
- The best my co-therapist and I could do was to sing really loudly in unison
- My co-therapist and the TA knew the song as well and we all sang it
- Supporting my co-therapist’ music was particularly necessary due to the volume of [REDACTED]
- My co-therapist did a call-and-response with each of my lyrics and facilitated [REDACTED] to play some percussion
- I began vocalising, hoping [REDACTED] would join in. [REDACTED] didn’t join in until Dennis did as well
- Fortunately my co-therapist can sing higher than I can and doubled me up an octave, and that really cut through
- My co-therapist and I played together and sang loudly to give the group something to play to
- [REDACTED]’s guitar playing was very loud and raucous but it was fine thanks to me and my co-therapist’s combined volume
- My co-therapist facilitated [REDACTED] to play percussion while I did this and did a call-and-response with me
- The session was like a silly opera which [REDACTED] watched in fascination while Dennis vocally supported as he helped [REDACTED] play percussion
- My co-therapist played the guitar and sang while I vocalised along and offered a drum for [REDACTED]
- My co-therapist and I played a simple chord progression and played little lead parts back and forth
- My co-therapist played a repeating chord progression while I played a melody on xylophone
- My co-therapist sang along with me and stood by [REDACTED] placing his hand on his shoulder
- Me and my co-therapist began singing a Waiata together
- My co-therapist began playing guitar and singing and I played on the drums
- My co-therapist sang with me as I played it with him and told me [REDACTED]’s Grandma used to do it with him a lot

- My co-therapist supported me with a harmony

## A2: Information Sheets and Consent Forms

### A2.1: Information Sheet for Facility and Co-Therapist



#### *Collaborative music therapy; Determining the benefits and challenges of collaborative work from a student's perspective*

##### INFORMATION SHEET

My name is Jamie Macdonald and I am currently studying the second year of my Master of Music Therapy at the New Zealand School of Music. As part of the degree requirements I am currently working as a music therapist at [REDACTED] where I am required to conduct research into my work and complete an exegesis about it.

An important factor about this clinical placement is that my facilitator is a music therapist who has worked at the school for two years. I have three days of clinical practice each week and we have decided to work collaboratively for two days of that. This will give me a mixture of both collaborative and independent work, which is likely to contribute significantly to my developing music therapy practice. However the process of collaboration is complex especially when collaborating parties have differing roles that potentially create power differentials. Within this study I will examine the benefits and challenges of collaborating with another music therapist as a student music therapist. This will be an observational study as my data will be generated from secondary analysis of the clinical notes and reflections I record as part of my usual clinical practice. The secondary analysis will involve me analysing my notes and reflections for themes, which will be used to answer my research question.

I am writing to you because I would like to use data that was collected as part of my clinical practice, and which relates to you, in my research project. The data will be analysed along with data from other sources, to answer my research question. All data will be stored in my password-protected laptop. Upon project completion I will return the data to the facility or to the New Zealand School of Music where they will be stored for a period of five years before they're destroyed.

All possible precautions will be taken to ensure anonymity of both my facility and the students I work with. All names and locations will be removed and replaced with



pseudonyms to ensure privacy, however due to the small size of the New Zealand music therapy community it is possible you might be identified.

You are under no obligation to give your permission for your data to be used for research purposes. If you decide to allow it to be used, you have the right to:

- ask any questions about the study at any time until it is completed;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

This project has been reviewed and approved by the New Zealand School of Music Postgraduate committee. The VUW Human Ethics Committee has given generic approval for music therapy students to conduct studies of this type. The music therapy projects have been judged to be low risk and, consequently, are not separately reviewed by any Human Ethics Committees. The supervisor named below is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research, please contact the supervisor or, if you wish to raise an issue with someone other than the student or supervisor, please contact the Victoria University of Wellington Human Ethics Convenor; AProf Susan Corbett, email [susan.corbett@vuw.ac.nz](mailto:susan.corbett@vuw.ac.nz), telephone +64-4-463 5480)

Thank you for your consideration,

Jamie Macdonald  
Lead Researcher

### **Project Contacts**

Lead researcher:

Name: Jamie Macdonald  
Phone: 0277424142  
Email: [jamiealexanderm@gmail.com](mailto:jamiealexanderm@gmail.com)

Research supervisor:

Name: Dr. Daphne Rickson  
Organisation: Te Kōkī New Zealand School of Music  
Email: [daphne.rickson@nzsm.ac.nz](mailto:daphne.rickson@nzsm.ac.nz)

## A2.2: Information Sheet for Vignette Participant



New Zealand School of Music, Victoria University of Wellington, P.O. Box 600, Wellington 6140

Music Therapy Dept., Tel: 04 463-5233 x 35807/35808

Dear .....,

As you probably know, my name is Jamie and I am a music therapist. I like to do all kinds of music with students at school to help them to do and learn things. Throughout the year, I have gotten to know you, and we have created lots of wonderful music together.

I am going to write a story about doing music with students. Teachers, mums and dads, and other music people will read my story, and it will help them to understand what fun music is and how it helps us to learn and do things. I am writing to you to ask if I can write about the music things we did together. The story would not have your real name in it.

You are not the only student who I am writing to. I am going to ask some of the other students I have worked with if they would like to be in my story too, so it's ok if you don't want to be in it. Your caregivers or school helpers will help you decide what the best thing to do is. It is also a good idea to ask lots of questions until you are sure you know what this is all about.

If you do want to be in my story you need to say "OK" to your principal or teacher, and if you can, write your name on the paper behind this one. Someone will write your name for you if it is too hard.

If you say "OK" I will be happy. If you do not say OK, I will still be happy. Thank you for reading or listening to my letter.

Best wishes,

*Jamie Macdonald,*

*Music Therapist.*

## A2.3: Consent Form for Use of Facility Clinical Notes for Research



New Zealand School of Music, Victoria University of Wellington, P.O. Box 600, Wellington 6140

Music Therapy Dept., Tel: 04 463-5233 x 35807/35808

### **Collaborative music therapy; Determining the benefits and challenges of collaborative work from a student's perspective**

#### **PARTICIPANT CONSENT FORM - INDIVIDUAL**

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/do not agree to the researcher's clinical notes produced at Sara Cohen School being used for reflection and analysis for research purposes

I agree/do not agree to the researcher's notes from meetings and/or discussions being used for reflection and analysis for research purposes

I understand I can withdraw my information from the research up till the end of the data analysis

I agree to my data being used in this study under the conditions set out in the Information Sheet.

**Signature:** ..... **Date:** .....

**Full Name - printed** .....

## A2.4: Consent Form for Co-Therapist



New Zealand School of Music, Victoria University of Wellington, P.O. Box 600, Wellington 6140

Music Therapy Dept., Tel: 04 463-5233 x 35807/35808

### **Collaborative music therapy; Determining the benefits and challenges of collaborative work from a student's perspective**

#### **PARTICIPANT CONSENT FORM - INDIVIDUAL**

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/do not agree to the researcher's clinical notes about our sessions being used for reflection and analysis for research purposes

I agree/do not agree to audio recordings of music from my music therapy sessions being used for reflection and analysis for research purposes

I agree/do not agree to audio recordings of meetings and/or discussions being used for reflection and analysis for research purposes

I agree/do not agree to the researcher's notes from meetings and/or discussions being used for reflection and analysis for research purposes

I agree/do not agree to video recordings of music from my music therapy sessions being used for reflection and analysis for research purposes

I understand I can withdraw my information from the research up till the end of the data analysis

I agree to my data being used in this study under the conditions set out in the Information Sheet.

**Signature:**

.....

**Date:**

.....

**Full Name - printed**

.....

## A2.5: Consent Form for Vignette Participant



New Zealand School of Music, Victoria University of Wellington, P.O. Box 600, Wellington 6140

Music Therapy Dept., Tel: 04 463-5233 x 35807/35808

### **Collaborative music therapy; Determining the benefits and challenges of collaborative work from a student's perspective**

#### **PARTICIPANT CONSENT FORM - INDIVIDUAL**

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/do not agree to my clinical notes being used for reflection and analysis for research purposes

I agree/do not agree to audio recordings of music from my music therapy sessions being used for reflection and analysis for research purposes

I agree/do not agree to video recordings of music from my music therapy sessions being used for reflection and analysis for research purposes

I understand I can withdraw my information from the research up till the end of the data analysis

I agree to my data being used in this study under the conditions set out in the Information Sheet.

**Signature:** ..... **Date:** .....

**Full Name - printed** .....

