

Who's the boss?

A case study that explores the course of the music therapeutic relationship, between client and music therapist, in improvisational music therapy.

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Dansk Abstract

Konteksten for denne afhandling var det musikterapeutiske forløb med en 4-årig dreng med autisme spektrum forstyrrelse. Specialet blev udført som et single-case-studie, der søgte at udvide eksisterende viden om den musik terapeutiske relation og forholdemåde.

For at få ny viden om dette fagområde, anvendte jeg kvalitative metoder baseret på hermeneutik og fænomenologi. En litteratur præsentation om børn med autisme spektrum forstyrrelse og nyere interventionsmetoder, der går ind for et en child-led (med udgangspunkt i barnets udtryk) tilgang, blev præsenteret. Derudover har jeg ekspliciteret mit syn på min egen modifikation af denne musikterapeutiske forholdemåde i den improvisatoriske musikterapi som læner sig op ad litteratur om en "moving along" i psykoterapi, der bliver kaldt negotiation.

Gennem mikroanalyser blev det illustreret, hvordan forløbet mellem child-led og negotiation udspillede sig i musikterapien. Jeg konstaterede at jeg hele tiden skiftede mellem en child-led og negotiation tilgang.

Desuden tilføjede analysen og fortolkningen nye forforståelser om klientens kommunikative og sociale evner, og transskriptioner illustrerede, hvordan selv meget små interaktioner og fragmentariske møder kan tilføje mening til den musikterapeutiske relation.

English Abstract

The context and case of this thesis was the music therapeutic course with a 4-year-old boy with autism spectrum disorder. It is a single-case-study, seeking to extend existing knowledge about the music therapeutic relationship.

To gain new knowledge of this field of study qualitative approaches based on hermeneutics and phenomenology were chosen. A literature presentation about children with autism spectrum disorder and newer intervention methods that advocates a child-led approach were presented. In addition, I explicated my view on my own alteration of the child-led approach in improvisational music therapy leaning on literature about a theory of “moving along” in psychotherapy, called negotiation.

Through microanalyses, I found how the progress between child-led and negotiation was playing out in the music therapy in this particular case. I found that I was continuously shifting between a child-led and negotiation approach.

Moreover, the analysis and interpretation added to my preconceptions on the client’s communicative and social abilities, and the transcriptions illustrated how even very small interactions and fragmental meetings can add meaning to the music therapeutic relationship.

A very special and sunny thank you to all the staff and precious children at Eersterust Care and Training Centre – a piece of my heart will always be with you.

Thank you Carol and Ulla for being brilliant supervisors and inspirational power women.

Thank you to my chinese sister's, Anna Jean, Olga, and Reggie – for making the stay in South Africa feel like home.

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...And of course coffee, cheese and music.

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1 Introduction

This project is a final Master's thesis at the education of Music Therapy, Aalborg University, Denmark. The thesis' subject and focus is selected from and is a product of my 9th semester obligatory practical experience, which took place at a community clinic in Eersterust, a township outside of Pretoria, South Africa, during the Fall semester of 2014. It is an empirical study that discusses the *music therapeutic approach* in a specific case with a 4-year-old boy diagnosed with Autism Spectrum Disorder.

1.1. Motivation

During my studies I have always been fascinated by the quality of a "meeting" between people and especially the client-therapist relationship. Previously I have amongst other read Martin Buber's "I & Thou" (Buber 2007) and Daniel Stern's "moment of meeting" (Stern 2005). As preparation for my practical experience I wrote, on my 8th semester, a literature review (Andersen 2014) on music therapy with children with Autism Spectrum Disorder (ASD), which investigated music therapeutic approaches and joint attention in music therapy. The articles and a Cochrane Review showed that a child-led approach was preferable and that it showed positive effects on children with ASD's communication skills (Kim 2006; Kim, Wigram & Gold 2008;2009 and Geretsegger, Elefant, Mössler & Gold 2014). I therefore chose to work with a child-led approach with my clients with ASD.

1.2. Wonderment

In the specific case with the 4-year-old boy I started out working with a purely child-led approach. During session 5-6 I started wondering where we were headed together in the therapy. The child was interested in music and active in the sessions, but he was also very disruptive and fidgety and rarely made contact with me. I felt an urge to change my approach. I had a sense or counter-transference that I was a cat chasing a mouse, and as if I needed to change my strategy. This sense appeared to me because we had a few glimpses of meeting, which subsequently quickly slipped through my fingers. After changing my ap-

proach – or more accurately my presence and attentiveness – the client's communications skills started to develop rapidly and he even started to acquire beginning language skills. The therapy became more meaningful to me, and maybe also the client? The sudden change made me wonder what the cause to it was. Therefore this thesis explores the relationship between the boy and I in the first sessions of change.

Field of Study

1.3. Focus of subject

In my sense, or counter-transference, I especially felt the need for the contact between the client and I to be meaningful to both him and I – in any way it could possibly be. That was the actual cause that made me change my approach to an approach where I was more authentic to myself. This approach is further described in part 1.6.2. *View on Humanities and Therapeutic Stance*. As a graduating music therapist the clinical practice and the therapist role are still new to me and I want to explore this *field of common meaning* and *the music therapist's role* in this to become more aware of the relational processes within music therapy. From an inductive process, which will be further explained in the *methodology* and *method* descriptions (part 1.6. and 1.7.), I found that there were two approaches or manners of contact present: *child-led* and an approach/contact I have named *negotiation* after Stern's (2004a; 2004b; Stern et al. 1998) description, which will be further explained in part 2.7. Negotiation. These two terms make it out for the field of study and my problem statement and research questions are as follows:

1.4. Problem statement & Research questions

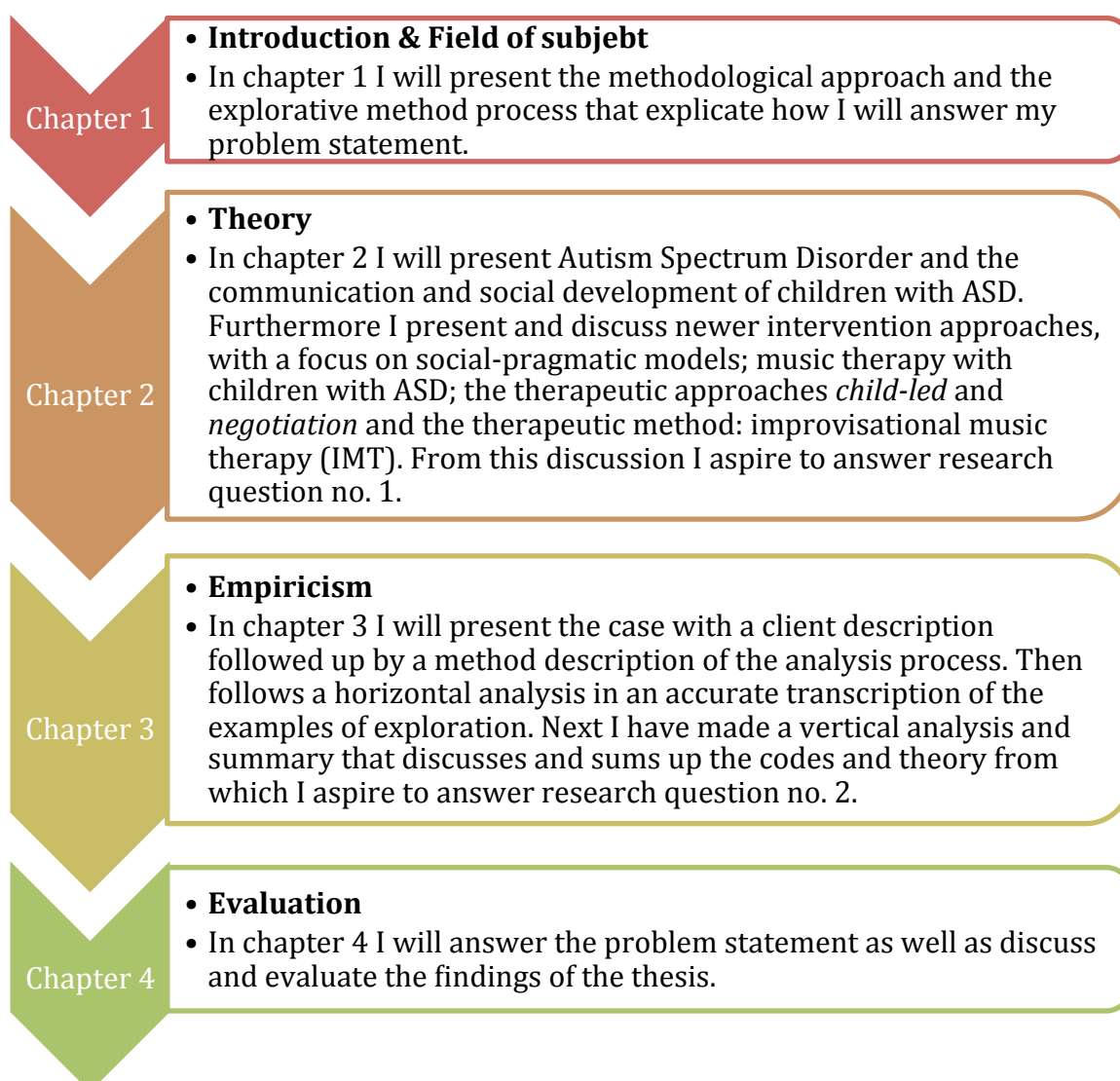
With a starting point from a rapid progress in showing communication skills of a child with Autism Spectrum Disorder in a course of Improvisational Music Therapy I want to explore what occurred preceding in the therapeutic relationship between the client and music therapist.

To be able to explore what happened, I need to answer following research questions along the way:

1. **How are the terms child-led and negotiation described in newer autism and music therapy literature?**
2. **How is the progress between child-led and negotiation playing out in the music therapy in this particular case study – and what does it mean for the therapeutic relationship?**

The thesis consists of four general chapters – that makes out the process of which I aspire to answer the problem statement - presented in the disposition as follows.

1.5. Disposition



1.6. Methodology: A Qualitative Approach

In this part I will explain how I will answer my problem statement. I will describe the methodical stance in a general manner and how it is conducted in this specific thesis. Furthermore I will explicate my preconceptions in form of my view on humanities and music in music therapy as well as my therapeutic stance – which all have had a substantial say in my way of interpreting and selecting data. Following this part, I will present my exploration process in the part about my method and how it is carried out (part 1.7.).

My overall methodical approach in this thesis is qualitative. Qualitative research rests on the belief that not all that is important can be reduced to measurements, “it is essential to take into account the interaction between the researcher and the participant(s) being studied” (Wheeler 2005, p. 13). The findings cannot be generalized beyond the context in which they are discovered, and also values are essential in any investigation (ibid.). This thesis seeks to explore the relational aspect, specifically the relationship between the client and music therapist, in a specific case (Ridder & Bonde 2014, p. 409). The overall goal is the discovery of meaning, and the qualitative research act is an intensely human act, where the researcher is an instrument of the research her or himself (Wheeler & Kenny 2005, p. 59). Another goal is also to modify the way that things are done or thought about (Wheeler 2005, p. 3). In this specific thesis I am intending to unfold the aspects within the *child-led* and *negotiation* therapeutic approaches in music therapy. To do so I am using two different but related disciplines within the qualitative paradigm: a hermeneutic and phenomenological approach – with emphasis on the hermeneutics.

1.6.1. *Hermeneutics and Phenomenology*

According to Thurén (2008) the hermeneutics wants to deeply comprehend not only grasp. Hermeneutic interpretation is important when you seek to understand people, the actions of people and the result of peoples' actions. But when you interpret within the hermeneutics you rest on an uncertain basis, because it is affected by the interpreter's judgments, preconceptions and the context (Thurén 2008, p. 116).

According to Forinash and Grocke (2005) phenomenology concentrates an intense examination upon experience in its multifaceted, complex, and essential forms. It is essential that the researcher is able to suspend or bracket his or her beliefs about the phenomenon being studied. This is called *bracketing* or *epoché* (preconception). The researcher must let go of preconceived notions and beliefs and be fully present with the experience as it is being revealed. Another concept is the search for the essential structure or essence of experience, which implies that there is a fundamental structure within an experience that allows us to recognise it for what it is. (Forinash & Grocke 2005, p. 321). The *lived experiences* being studied can relate to *emotions* such as grief, love, or anger; *existential concepts* such as aloneness or being effective as a therapist; and other human experiences such as intuition, listening to music, or improvising music. (ibid.).

Preconceptions relates to ones view on humanity and our *being in the world*, (Thurén 2008) and since I am a part of the object being explored, I find it necessary to unfold my view on humanities (part 1.6.2.) with this in mind to explicit the bias of the thesis further. I believe that preconceptions involves those experiences that we get through our entire life, also in every day activities, and how the consequences of those experiences affect us when we make conscious and unconscious decisions. The preconception is the filter that we look through, understand through and interact through with the world and culture surrounding us.

A central term within the *hermeneutics* is the *hermeneutic circle*, see figure 1 (which here is illustrated as a path). Seeking new understanding is a continuous motion between preconceptions or understanding and interpreting the new preconception – between part and whole. It shows that knowledge and preconception is dependant on each other and shows that more experience creates a deeper understanding that furthermore affects the way you interpret in a more nuanced manner. The preconception is often unconscious and as a researcher you should aspire to make it explicit to have more reliable results. (Thurén 2008, p. 69-70).

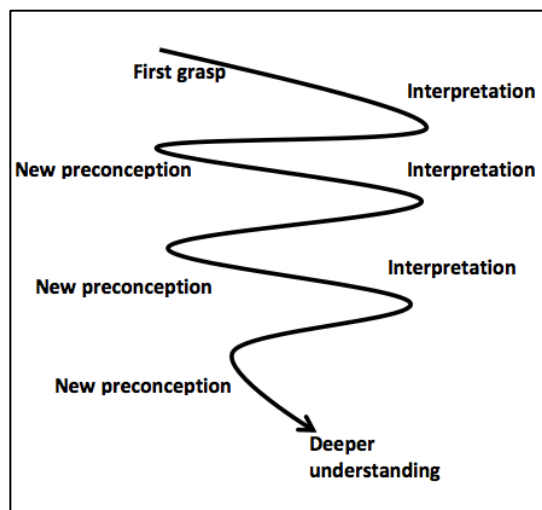


Figure 1: The Hermeneutic Circle

In perspective to this thesis I will explore my field of subject and answer my problem statement with the hermeneutic method. In Chapter 2, I will present literature that are relevant in understanding and expanding the preconceptions and knowledge of my music therapeutic approaches: child-led and negotiation. Part of the methodical approach is also phenomenological because I, in my horizontal descriptive analysis, have tried to put my preconceptions aside and focused on describing and coding the events in an inductive manner. This process was done before writing chapter 2 and therefore also became a part of a new preconception and a way of choosing relevant theory that will be discussed with the analytical findings in chapter 3 and 4. I would also argue that my data selection was partly phenomenological, since I did not know exactly what I was looking for except some kind of essence or structure. Following I will present my view on humanities and therapeutic stance, which are a part of my bias.

1.6.2. View on Humanities and Therapeutic Stance

My view on humanities is both affected by my personal and professional life. My personal background made me who I am and gave me certain values and perspectives on life. Overall I have a holistic view on humanity, which comprises that whole is greater than the sum of its parts. The parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood without reference to the whole (Oxford Dictionary, 2015). My educations particularly affected my way of viewing and interpreting the world and are what I try to base my professionalism upon. Entering a new professional field or a new music therapeutic process I am very much aware of my way of entering and meeting it. This is an awareness that was induced in me at my Master study in Ethnomusicology¹. Stige (2005) says that:

“To study music therapy practice, where two or more people interact and communicate, is to study a social practice. Since humans are cultural by nature, a social practice is necessarily also a cultural practice. This suggests that there is a relationship between music therapy research and ethnography.”

(Stige, 2005, p. 392)

I recognise this point of view from myself, and the way I look at music therapy practice. The meeting of life worlds with this perspective concerns terms called *etic* and *emic* perspectives. The etic perspective is the *outsider view* that the researcher brings, and the emic perspective is the *insider view* and way of understanding (Stige 2005, p. 395). A music therapist (outsider) should be able to see things from both the client's (insider's) and his or her own professional stance, see figure 2:

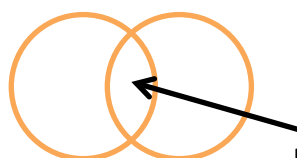


Figure 2:
The “in between”
etic and emic.

¹ www.glomas.net

But what then defines my own stance and professional way of viewing things? I believe that my therapeutic competence relies on me being authentic and genuine towards myself. My change of approach in the specific case being explored in this thesis was, as explained previously, because I felt an urge to be more authentic to myself. By being authentic I mean being present or aware of my private self in the therapeutic relationship. In humanistic psychology it is called congruence. The congruent therapist is present as him or herself. This will support the client's feeling of trust to the therapist (Jørgensen 2007, p. 60). It also implies that the therapist is genuine in touch with her own inner experience, and is able to share it when appropriate, and that the therapist should reject defensive facades and professional jargon, and maintain an openness to the experience (Ewen 2003, p. 205). I am also very influenced by Pedersen's (2000) psychodynamic way of thinking. Pedersen talks about the music therapist's presence and attentiveness. She states that therapeutic attentiveness; presence and professional empathy should be based on perceptions that are linked to the deep layers of the inner psychodynamic (personal centre/listening attitude) - which from there should resonate in the flow and interaction between the client and the music therapist (Pedersen 2000, p. 107). This is a discipline that demands awareness to transferences and counter transferences – a so-called disciplined subjectivity (Pedersen 2000).

Viewing all this in a perspective to the specific case, I was very aware of counter-transferences, and it was a counter-transference that made me re-evaluate my therapeutic approach and be more authentic to myself. Moreover I attracted and chose, in the beginning, to have a child-led approach, which you could claim is a way of entering the culture of the child on his premises as an outsider trying to meet the world of the insider.

1.6.4. View on Music in Music Therapy

My view on music in Music Therapy is influenced by my views mentioned above and the overall definitions on music therapy (World Federation of Music Therapy 2011), where the use of music in a professional context and its elements is used as an intervention to promote life quality and improve different aspects of life. Bruscia (1998) defines music therapy as “...a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change.” (ibid., p. 20). My view on music in this specific case is closely related to my view on humanity, and I believe that your perception of music changes according to context. Ruud (in Bonde 2009, p. 19), in accordance with Stige (2005), believes that the meaning of music always is determined by the context: social, cultural, therapeutic etc. - Music is “communication and acting together” and the music’s meaning becomes complex communication processes, which are local and concrete. I view the music in this specific case on a pragmatic and a syntactic level. The pragmatic level comprises the music as a social and interactive phenomenon (the music’s role in the social context or in the therapeutic process). An analysis on this level is interested in music as interaction and communication between, in this case, client and therapist, and the function in the social process and role in the therapeutic process (Bonde 2011 p. 23-24). - This refers to my interpretation. The syntactic level comprises music as an aesthetic phenomenon. An analysis on this level seeks an accurate description and interpretation of the musical parts and their role in the meaning of the whole. In this specific case their role in the therapeutic interaction (ibid., p. 23). - This refers to my analysis.

Following I will present my exploration process towards a new conception of my field of subject.

1.7. Method

In this part I will present the process from raw data, consisting of video recordings from 15 music therapy sessions, to the final product of which this thesis consists.

1.7.1. Case study

The context and case of this thesis is the music therapeutic course with a 4-year-old boy with ASD. It is a single-case-study, seeking to extend existing knowledge (Neergaard 2007, p. 21) – in this case my preconceptions about the therapeutic relationship – and to understand the profundity of a specific phenomenon. My raw data consists of video-recordings from all the sessions (1-15) I had with the boy. The data to be analysed has been selected in a *purposeful manner* (Neergaard 2007, p. 11): first by choosing certain sections from two sessions I found relevant; then making macro transcriptions (see Appendix no. 2) of the sections; and finally choosing certain examples from these sections. The process of the data selection will be further described in the *data selection* description in part 3.2.1. In total 7 examples were selected and are to be analysed with a qualitative descriptive approach (Holck 2007) with emphasis on verbal, musical and gestural expressions made by the music therapist and client, to be able to show and answer how the progress between approaches child-led and negotiation is played out in the music therapy.

1.7.2. Analysis approach

My data material available were video recordings, so to explore the field of study and to answer my research question I have chosen to use elements from Holck's (2007) *Ethnographic Descriptive Approach to Video Microanalysis* to analyse the examples. The descriptive approach is suitable to portray what actually happens between client and music therapist and can be used to put awareness on the interactions taking place partly or fully outside of the therapist's awareness (Holck 2007, p. 29). Specifically, the method can give the

clinician knowledge about what actually influences the interaction, and whether or not this is desirable, and in addition also to give a specific direction towards the client's next zone of development (ibid., p. 39). Video recordings make it possible to enlarge and expand parts of the whole, so you recognise new elements that you did not see. I have transcribed the examples in a similar manner to Holck's and divided different interactions in the Horizontal analysis into *child-led* and *negotiation*. In the Vertical Analysis these divisions and codes will be discussed with the literature presentation, chapter 2, and the precise process of the analysis will be further described in the *data presentation*, part 3.2.

1.7.3. Ways of concluding

Two common ways to make conclusions are via *induction* and *deduction*. Induction builds upon empiricism and deduction on logic. (Thurén 2008). In induction you conclude in a general manner from empirical data. Related to the phenomenological way of thinking the researcher lets the unfolding of the phenomenon itself guide the logic of his inquiry (Forinash & Grocke 2005, p. 321). I selected data on the basis of my wonderment experience, and I would argue that I narrowed down the field of subject in an inductive manner. I found, from looking at the video recordings; process description; and macro analysis, that my wonderment arose from a shift in my therapeutic approach. Then, to unfold and investigate the terms further I made a literature search and presentation, which was based on deduction. In my Vertical Analysis I then use a third way of concluding: *Abduction*. In abduction you explore an unknown or unspecific phenomena and aspire to understand it in a scientific manner (Karpatschhof, 2007). Holck (2002) recommends, in her PhD, *abduction* as a way of exploring a small data size in a comprehensive way. The abduction has been done simultaneously with the literature presentation. In that way the data material have affected and added new knowledge (preconceptions) to the choice of literature and vice versa, which makes out a circular process between data and literature, where both put new perspectives on the field of subject and final interpretation (ibid, p. 169). In that way the abduction process resembles

or follow the example of the hermeneutic circle. Below, the explorative process is illustrated in correspondence with the hermeneutic circle, but here exemplified as a “path”/process, see figure 3:

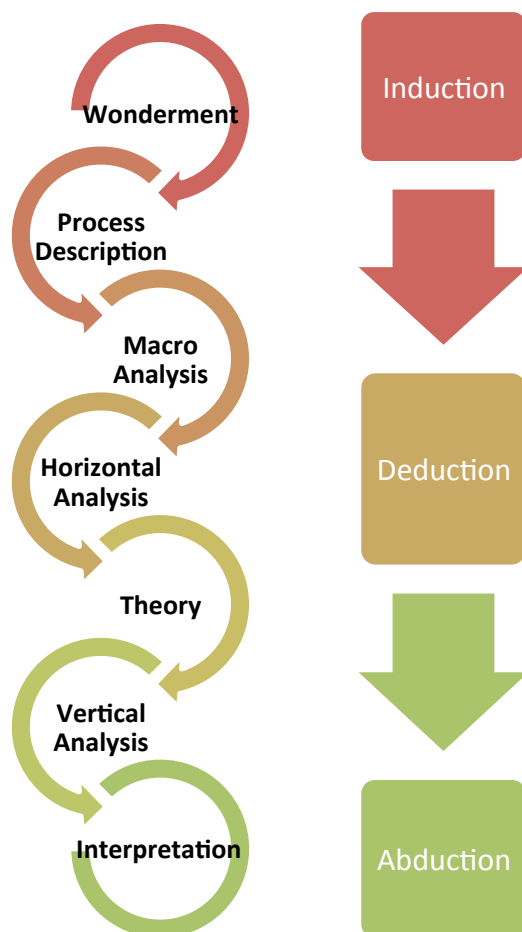


Figure 3: The Explorative Process

In addition to the method descriptions I will shortly explicate my ethical considerations in connection with the use of data material. Before moving on to chapter 2 and the literature presentation, I will also make a suggestion to a possible target group that would find interest in reading this thesis.

1.8. Ethics

To protect my client's anonymity I have given him a pseudonym. I call him Noel. Moreover, I have received written consent from the parent that allowed my to video record the sessions and use the data for educational purposes including material for this thesis (view the consent form in Appendix No. 3). In the appendix there is a DVD² (see Appendix No. 4) with extracts from the music therapy sessions. I kindly ask to hand me over the DVD, after the examination, so it can be destroyed.

1.9. Target group

I find this thesis relevant for those who are interested in client-therapist relationships and therapeutic approaches. Especially, connected to children with ASD. I have aspired to explain the common terms in music therapy that I use, in a manner that makes it available for those who are not familiar with music therapy. Furthermore I find it relevant music therapy student and clinicians with an interest in the subject.

² Exclusively for the supervisor and censor.

2 Theory

In the following chapter I will present how *child-led* and *negotiation* are described in newer literature on children with ASD. First I present the diagnosis Autism Spectrum Disorder with a focus on deficits in communication and social skills. Next, I present the “new wave” interventions that emphasise child-led approaches: both conventional treatments and music therapy treatments. Then I will present negotiation as presented by Stern (2005; Stern et al., 1998) and last, I will present my therapeutic method Improvisational Music Therapy (IMT). In a summary I will discuss the different parts of chapter 2. From this discussion I aspire to answer research question no. 1., and moreover how I make use of my reflections on chapter 2 in my analysis.

The literature presented in this chapter has been selected by evaluating literature that has been offered to me on my education in music therapy. Especially, the literature review (Andersen, 2014) has been used for a chaining search to a more comprehensive description of the child-led approach. A search on the university library's database, Primo, led me to literature about negotiation. Furthermore I was fortunate to have a supervisor who is an expert on therapy and music therapy with children with ASD, who suggested that I should look into the social-pragmatic interventions and provided me new literature on the field of subject. I chose not to do a new systematic search and review, since I estimated that the quantity of literature found in these three ways were sufficient. Because the thesis is data driven, the data and analysis assisted to narrow down the topics within the parts of this chapter.

2.1. Autism Spectrum Disorder

Autism is not a single condition – but a spectrum of disorders with huge variety in how it appears. For diagnostic purposes two systems can be used: ICD-10 (WHO 2015) or DSM-5 (APA 2015). South Africa, as well of Denmark, makes use of ICD-10, which is currently being revised. My client was still under assessment for a proper diagnosis during my practical experience and therefore I find it relevant to make use of the DSM-5 because it was revised in 2013 and therefore the newest edition of the two, but also because the diagnosis within the Autistic Spectrum has been joined under one term. As shown in table 1, as follows, the DSM-4 edition corresponds with the ICD-10:

DSM-5	DSM-4	ICD-10
299.00 Autism Spectrum Disorder	299.00 Autistic Disorder	F84.0 Childhood Autism
	299.80 Asperger Disorder	F84.5 Asperger Syndrome
		F84.1 Atypical Autism
		F84.8 Other pervasive developmental disorders
	299.80 Pervasive Developmental Disorder not otherwise specified (PDD-NOS) (including Atypical Autism)	F84.9 Pervasive developmental disorders, unspecified
		F84.4 Overactive disorder associated with mental retardation and stereotyped movements
	299.80 Rett Disorder	F84.2 Rett Syndrome
	299.10 Childhood Disintegrative Disorder	F84.3 Other Childhood Disintegrative Disorder

Table 1 (Dsm-5-Codes 2015 and WHO 2015)

In the new version of DSM-5, the diagnosis within the Autistic Spectrum is joined under one term: *Autism Spectrum Disorder*. The American Psychiatric Association believes that a single umbrella disorder will improve the diagnosis of ASD without limiting the sensitivity of the criteria, or changing the number of children being diagnosed (APA 2015). Under the DSM-5 criteria, individuals

must show symptoms of ASD from early childhood, even if they are not recognised until later. Moreover the term is now defined under the umbrella of neuro-developmental disorders (ibid.). The Diagnostic Criteria put emphasis on two different symptomatic areas:

A.) Persistent deficits in social communication skills and social interaction

across multiple contexts, e.g. failure of normal back and forth conversation, deficits in nonverbal communicative behaviours, abnormalities in eye contact and body language, deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication, difficulties in sharing imaginative play, and absence in interest of peers etc.

B.) Restricted, repetitive patterns of behaviour, interest, or activities, e.g.

stereotype or repetitive motor movement, use of objects or speech, insistence of sameness, inflexible adherence to routines, highly restricted, fixated interests that are abnormal in intensity or focus, hyper- or hypo-activity to sensory input or unusual interests in sensory aspects of the environment etc.

Furthermore, A and B can and should be divided into three different groups of severity - specified in the manual.

(DSM-5 2015)

As shown above people with ASD tend to have communicative deficits, such as responding inappropriately in conversations, misreading nonverbal interactions, or having difficulties building friendships appropriate to their age. In addition, people with ASD may be overly dependent on routines, highly sensitive to changes in their environment, or intensely focused on inappropriate items (APA 2015).

2.2. Social and Communication Development of Children with ASD

Early social and communication development are according to Landa (2007) intimately intertwined. Signs of disruption in this development may be present in children with ASD already at first year of life. It may be seen in de-synchronisation of vocal patterns with the caregiver; early sharing of affective expression; delayed onset babbling, use of gestures and responsiveness to communicative bids of others (Landa 2007, p. 17). By the third year of life, communication development in autism is generally characterized by reduced frequency and diversity of communicative forms (complex babbling, consonants in syllables, words etc.). Gestures tend to be isolated acts and less often integrated with vocalisation and initiation of social communicative acts (e.g. "showing" and joint attention) is impaired (ibid.).

Landa (2007) states that early intervention for communication impairment in ASD is important, since the social communication deficits in ASD are a major stressor for parents, and since gains in communication skills are related to prevention and reduction of maladaptive behaviours (Landa 2007, p. 18). Through early intervention: communication and social development may be improved.

2.3. Newer approach to treatment intervention

Traditionally one of the biggest tendencies in therapeutic interventions for children with ASD have been that the therapist led and maintained control over the activities in therapy, whereas some contemporary approaches are centred on the child's interests and activities (Landa, 2007). Newer approaches (Developmental Social-Pragmatic Interventions) emphasises on increasing children's motivation to communicate where the focus is on *the intention of the child's communicative attempts*, regardless the mode of expression, and where the goal is that it should be *meaningful for the child to participate*, and is especially relevant for younger children with ASD or children and adolescents with a severe condition of ASD (Holck, 2015; Ingersoll, Dvortcsak, Whalen & Sikora, 2005). Studies with this approach (e.g. Casenhiser, Shanker & Stieben, 2013; Mahoney & Perales, 2003) show positive results in the communication and social skills of children with ASD. Following is a presentation of some of the strategies with special emphasis on Ingersoll and colleagues' (2005) social-pragmatic model.

The developmental, social-pragmatic model (DSP) is a naturalistic strategy for teaching social-communication skills to young at-risk children and children with disabilities. It has also been referred to as the interactive model or the child-oriented approach and derived from research on typical child development that indicates a relationship between caregivers' responsiveness and their child's level of social-communication development (Ingersoll et al., 2005, p. 213). The therapist follows the child's lead or interest, which means that he or she

engages in the child's initiated interactions that are based on the child's interest and attention. The therapist also arranges the environment to encourage initiations from the child (ibid.). Common strategies include:

- 1. Playful obstruction** (i.e., briefly interrupting an activity the child is doing)
- 2. Sabotage** (i.e., omitting necessary items needed for an activity)
- 3. Violating familiar routines** (i.e., changing the way a child likes to do things)
- 4. In sight-out of reach** (i.e., displaying desired items so that the child cannot access them himself)
- 5. All communicative attempts, including unconventional** (e.g., jargon, echolalia, hand leading, nonverbal protests) **and preintentional** (e.g., reaching and grabbing eye gaze, crying, facial expressions, body postures) **communication are responded to as if they were purposeful**
- 6. The adult emphasizes emotional expressions and affect sharing**
- 7. The adult exaggerates his or her affective gestures and facial expressions and labels the child's emotional response**
- 8. Language and social input are adjusted to facilitate communicative growth** (the adult uses simplified language around the child's attention focus)
- 9. Common indirect language stimulation strategies include: imitation, descriptive modelling, self-talk, parallel talk, and expansion.**

(Ingersoll et al., 2005, p. 213-214)

Ingersoll and colleagues (2005) demonstrated a significant increase in spontaneous language over baseline following the beginning of the described treatment program. Results from a study by Casenhiser, Shanker & Stieben (2013) in a social-communication based intervention with children with ASD suggested that children who received this intervention type made significantly greater gains in social interaction skills in comparison to the other group (a community treatment group) (ibid., p. 220). A quasi-experimental study by Mahoney & Perales (2003) investigated the effectiveness of relationship-focused intervention on the social and emotional wellbeing of children with ASD. The relationship-focused intervention encouraged parents to use responsive

interactive strategies (e.g. take turns, follow the child's lead) during routine interactions with their children. The study showed that increases in mother's responsiveness were associated with significant improvements in children's social interaction (Mahoney & Perales 2003). According to Holck (2015) joy is an important motivation for all children also children with ASD, and mentions joy as a motivational factor - corresponding with the Social-Pragmatic stance. If the child shows increased vitality in an interaction it indicates that the child finds the interaction meaningful and therefore finds reason to stay in the interaction. From thereon the child might feel an urge to share something with the other person or see a purpose in understanding the other person's intention to make the interaction even more fun and interesting (Holck 2015). Following I will present and go in to further detail with *imitation* and *joint attention*, with a perspective on children with ASD, since those abilities are especially associated with communication learning (Landa 2007).

2.4. Imitation

Imitation is related to communication learning and provides a vehicle for communicative reciprocity. An imitation of another's behavior serves to acknowledge their act, confirming attention and responsivity in a reciprocal, meaningfully contingent way. The imitation also "invites" a response from the other person, and therefore initiates an interactive exchange. - A "teachable moment" has arisen. (Landa 2007, p. 20). Imitation is an impaired feature in children with ASD. Children with autism rarely show spontaneous, meaningful, and socially engaged imitation of others' actions on objects, vocalizations, and body movements (ibid.). Such impairment is shown to be related to language functioning later in the preschool years and is also related to aspects of development, like joint attention and play (ibid.). Children with ASD have a tendency to seek direct and accurate response (Hart 2006, p. 34), and when children with ASD do imitate they are more likely to "photograph" the action and then do it in the exact same way, whereas normal children do the imitation from the other person's point of view (Hart 2006, p. 58-59 and Stern 2004a, p. 93-94). Landa (2007) states that targeting imitation in intervention for ASD is a longstanding

practice. She suggests that since imitation is a powerful tool for communication and interactions with others, the movement patterns that children are taught to imitate should incorporate the movement patterns needed for targeted communicative gestures and for actions on objects within meaningful play sequences. Then as the skills improve, mapping language onto the production of the imitated movement will strengthen the link between motor and language modalities for communicative purposes (ibid., p 20).

In addition to imitation it is worth mentioning *affect attunement*. Hart (2006) states that Stern introduced affect attunement as a further development of imitation (Hart, 2006, p. 36). Affect attunement is a special form of behavior in response to the communicative affective behavior of another. Stern (2004a) states that: It is a way of imitating, from the inside, what an experience feels like, not how it was expressed in action. Like imitation refers to the other's overt actions, affect attunement refers of what the others must have felt like in the moment of action (Stern, 2004a). This requires that the attunement only imitate temporal dynamics of the intensity, form or rhythm, that refers to *forms of vitality* (Stern, 2010b) of the other's behavior, however in a different modality (Stern, 2004a).

2.5. Joint Attention

Joint attention is a behaviour, or ability, that attends to the orientations of other persons, to determine what is interesting them, or what they are intending to do. Joint attention involves a tripartite organisation of attention between the self, another person, and an object or event (Mundy, Gwaltney & Hendersen 2010). Joint attention is also a necessary ability for a child to begin learning the meaning of words (Trevarthen et al. 1998, p. 322; Landa 2007, p. 17). Children with ASD seem to be characteristically impaired in terms of use of joint attention or shared focus (Trevarthen et al. 1998, p. 123-124; Mundy et al. 2010). According to Mundy and his colleagues (2010) early interventions that increase joint attention have cascading effects on subsequent social learning (ibid., p. 410) and it is found that children that begin imitating spontaneously are more likely to develop joint attention (Holck 2015; Landa 2007).

Following this general part about children with ASD, their deficits in communication and social behaviour and newer intervention approaches, I will now in a similar manner describe how children with ASD are described in music therapy literature. My focus will be on music therapy with the group in general; on the approaches child-led and negotiation; and on the intervention improvisational music therapy (IMT).

2.6. ASD and Child Centred Approaches in Music Therapy

ASD has been and still is a major arena for practice in music therapy, and people with autism often show a significant interest in music and its components, e.g. rhythm, pitch, harmony etc. (Dimitriadis & Smeijsters 2011). According to Trevarthen and his colleagues (1998) especially improvisational music therapy can draw out and develop the talents of a child with ASD to sympathise with the expressive impulses and awareness of other persons. Rhythmic games, group play, music, dance and dramatic play can engage the interest and pleasure of autistic children, and can, in some cases, aid language acquisition (ibid., p. 123).

In the 1940s early pioneers of music therapy likely worked with children with ASD in various institutions (Reschke-Hernández 2011, p. 172). In the 1960s Nordoff and Robbins, who were pioneers in improvisational music therapy for children with autism, proposed that children with autism experienced music as a non-threatening medium and therefore were more likely to become engaged in a musical experience than other environments, particularly in child-directed improvised music. From this proposal the Creative Music Therapy technique arose. (ibid., p. 173). Several other authors followed and reported that child-directed techniques encouraged expressive language and social skills (ibid.). The first article to address a music therapy treatment for children with autism was published in 1969 by Juliette Alvin (ibid., 174) arguing that establishing communication should be the primary goal. Alvin ditto advocated a child-directed approach. Then in the 1990s many of the strategies were based on therapeutic approaches from psychology and special education (e.g. the com-

mon known TEACCH³ method was suggested useful in music therapy) (p. 179). A recent Cochrane Review (2014) states that music therapy may help children with ASD: to improve skills in areas such as social interaction and communication: to increase social adaptation skills and to promote the quality of parent-child relationships (Gerretsegger, Elefant, Mössler, & Gold 2014). The Review also states that processes that occur within musical improvisation may help people with ASD to develop communicative skills and their capacity for social interaction. The musical interaction within music therapy and particularly improvisation enables non-verbal people to interact communicatively without words (ibid.).

2.6.1. Child led

As described above child-centred approaches began to appear in literature in the late 1960s/1970s (Reschke-Hernández 2011). Most recent, an international study by Geretsegger, Holck, Carpenté, Elefant, Kim, & Gold, 2015 in press), which aimed to develop treatment guidelines with children with ASD, the authors advocates for a child-led approach. Following is a presentation of the newest research within child-centred approaches in music therapy.

Kim (2006) talks in her PhD dissertation about *structured* and *unstructured play* within the child-led approach. She divided her sessions in two sections. All sessions were started with a welcoming ritual and ended with a goodbye song. The primary task of the therapist was in the first section to engage the children at their level and interest, and then in the next section expand the children's experience, by introducing some structure such as modelling and turn-taking activities. (Kim 2006, p. 86)

The first half (approx. 15 min.), the therapist was instructed to allow the child to lead the interaction between following the child's behavioural cues and interests, and attending to the child's focus of attention. The therapist would try to

³ TEACCH: Treatment in Education of Autistic and Related Communication Handicapped Children.

share the object of the child's choice and the experience of that object with the child (ibid.). This might be done by *imitating, matching, reflecting, or verbally commenting* on what the child did in that moment. The therapist should carefully monitor the child's reaction and react to the child accordingly, but should always be careful not to insist on something against the child's will (ibid., p. 84). In the second half (approx. 15 min.) the therapist offered in a gently manner some structure in their interaction such as *turn-taking* and *modelling* within focus of attention, interest and tolerance of the child. When guiding the child to certain activities, the therapist should try to maintain his or her sensitivity and attentive attitude to the state of the child, and facilitate the child's own motivation, enjoyment and attention. (ibid., p 83).

The study by Kim was conducted as a RCT study and showed that a child-centred approach involving predictability and contingent adult responses to the child's focus of attention and interests would lead to increase joint attention and social engagement in children with autism (Kim, Wigram, & Gold 2008; 2009). In a mixed methods design study Vaiouli, Grimmet and Ruich (2015) showed improvement in joint attention and actions of social engagement with children with ASD elicited by a child-centred, improvisational music therapy intervention. The improvisational music therapy was defined as the use of music activities that varied from specific, age-appropriate songs, to instrumental music, and/or to short improvised rhymes designed to promote engagement and communication between the researcher and the child (Vaiouli, Grimmet, & Ruich 2015, p. 78). Another RCT study on relational music therapy (RMT) by Gattino, Riesgo, Longo, Leite, & Faccini (2011) also describes a child-centred intervention, where the musical activities arise from the child's initiative, behaviour, expression and interest, and their study showed some results in favour over a controlled condition. In connection with the approach, they mention that it focuses on some psychodynamic principles (e.g. free association, unconscious conflicts, drive component, transference and counter-transference) (ibid.).

The music in the child-led approach in music therapy serves as an essential emotional, relational and motivational medium, and music therapists seek to establish a meaningful relationship with the client through shared music making process (the joint clinical improvisation) (Kim et al., 2009, p. 390). This is done with the therapeutic approach 'musical attunement' – a term adapted from Stern's affect attunement – requiring various musical and emphatic techniques geared towards the child's responsiveness, characteristics and needs. In this intervention, the music therapists identify musical elements (e.g. temporal beat, rhythmic pattern, pitch range, melodic contour, dynamics of expression etc.) in the child's musical and non-musical behaviour. The attunement of these musical elements, or *forms of vitality*, should provide a predictable, emphatic and supportive musical structure to attract and engage the child. In this context, the children then often appear to experience the therapist's music as related to their own expression, which may motivate them to respond, join in or initiate further interactions (Kim et al., 2009).

2.7. Negotiation

In my macro transcription (see Appendix no. 2) I gave titles to the interactions taking place. This was done in an inductive manner. One of those titles was *negotiation*, which I thought would be an appropriate title to my experience in the interactions altering from child-led.

The term *negotiation* is a theory of "moving along" in psychotherapy, described by Stern (2004a; 2004b; Stern et al., 1998), which involves spontaneity and authenticity. It involves two people (client and therapist) who are trying to arrive at a goal, but where the goal cannot be precisely known in advance (ibid.).

"Sometimes the goal is clear and the dyad can move along briskly, as when hunger requires feeding. Sometimes an unclear goal must be discovered or uncovered in the moving along process, as in free play or most play with objects."

(Stern et al., 1998, p. 907)

The approach is based on ideas from developmental studies of mother-infant interaction and from studies of non-linear dynamic systems, and their relation to mental events (where past experience is re-contextualised in the present such that a person operates from within a different mental landscape, resulting in new behaviours and experiences in the present and future) (Stern et al., 1998). This process of mutual regulation moving towards a goal demand a constant *negotiating* and missing and repairing in order to remain in or return to a range of balance. This requires both persistence and tolerance of failures on both partners' part (ibid.). Stern states that in any event intersubjective sharing is a primary goal, which occurs verbally and non-verbally. The units of interaction at this level are called *relational moves*. In relational moves the purpose is to adjust or regulate the intersubjective field (the shared mental/feeling landscape). These moves can consist of: a spoken phrase; a silence; a gesture; or shift in posture or a facial expression – which all makes up a negotiation. The process of arriving at these goals is called “moving along”. “Moving along” should be understood as a forward movement – *relational move* by *relational move* – as well as its frequent wanderings, wrong turns and surprising shifts in direction. These shifts of direction in the forward movement are called “sloppiness”, which results from the interaction of two or more minds working in a hit-miss-repair-elaborate manner to co-create and share similar worlds (2004b). Sloppiness is an inherent feature of interactions, often unexpected and messy, but can be used to create new possibilities (Stern, 2004a). “Moving along” can lead to sudden dramatic therapeutic change – or shift in negotiation – by way of ‘now moments’ or ‘now meetings’. Stern states that awareness of these processes can help the therapist gain a different perspective that makes him or her more ready to identify, and even expect, key moments of change in an ongoing process (Stern 2004b). What makes the moving along special is the scale in which we look at this dialogue: it is the therapeutic process seen through a micro-analytic lens, where the units are of several seconds' duration (Stern 2004a).

In the sessions I had with the boy I felt I tuned away from the pure child-led approach and felt instead, as described by Stern, we were in a process of mutual

regulation moving towards an undetermined goal. Several times I acted against the interest of the child, but the “wrong turn” then gave options for new activities that we could both agree on. Evaluating the use of music and its role in negotiation, in the same way as in the part on child-led, you could argue that the affect attunements, when regulating, could be a way of *re-attuning* (or *purposeful misattune*), as described by Stern (2005). Hart (2006) mentions that this sometimes happens spontaneously when the caregiver is guessing the child's needs. Sometimes her guess is right and other times she misses – and there is a mismatch (cf. negotiation). This leads her to ideas on what is effective, and a sense of knowing the child's needs and how to meet them (ibid., p. 42). The mismatches are purposeful in this way, but in order to be, the repair is crucial. Otherwise, the child might feel frustrated and be harmed (ibid., p. 43).

In music therapy literature a quantitative descriptive example analysis by Raglio, Traficante and Oasi (2011), describe their intervention style as cooperative (in a dialogue with the child). They mention and use affect attunement through the use of music and instruments to regulate (via timbre, dynamics etc.) emotional components through music-making. This approach description resembles negotiation. Stern call it co-create – whereas Raglio and his colleagues call it co-operation. Holck (2002; 2004) also describe a cooperative approach where the therapist both supports and challenges the child in the music and interaction, and where they in cooperation creates interaction themes. An interaction theme is build up around a specific musical figure that is repeated and varied. Often a particular movement, gesture or facial expression is connected to the theme and is just as fundamental to the theme as the musical figure (Holck 2004). The interaction themes create expectations towards the themes, which make it easy for the child to act socially in a manner that makes it easy for the music therapist to react to. Essentially, the interaction themes make it easier for both to understand the other's actions as meaningful (ibid.). Kim and her colleagues (2008) also mention how Holck described how the child and therapist exchanged roles in being initiator and imitator and suggests in connection with this that improvisational music therapy has the potential to

facilitate skills fundamental to social interaction, especially nonverbal interaction in children with ASD (ibid., p. 1764).

2.8. Context: Improvisational Music Therapy

I will now present the context of which the music therapy takes place. It is the clinical method improvisational music therapy (IMT).

Improvisation methods in Music Therapy arose in various ways and within different Music Therapy movements. A joined condition in all these is a focus on the here-and-now interaction with the client, where the clients' individual needs, characteristics, backgrounds and values are playing an active role (Jacobsen & Bonde 2014, p. 207). Wigram (2004) defines clinical improvisation as the "use of musical improvisation in an environment of trust and support established to meet the needs of clients." (Wigram 2004, p. 37). Supporting the client can be done through techniques such as *mirroring*, *imitation* or *copying* (Jacobsen & Bonde 2014, p. 207). A more flexible way to offer support is *matching*. In *matching* the music therapist's music has the same style or quality as the client's, but it is still possible to separate the two from one another (ibid. p. 208). Stern describes *matching* in music therapy as a kind of affect attunement, which is at the base of so much of the relationship and the transmission and communication between therapist and client (Stern 2010, p. 94). Other mentionable techniques within the method are: *grounding*, *dialoguing*, *holding*, *reflecting*, *framing*, *limbo* and *containment* (Wigram 2004).

In clinical practice music therapists try to balance and use musical elements such as accents, volume and tempo etc. that can evoke and lower arousal. Clients with ASD need to develop skills that make them capable to face the world's unpredictability. This ability could begin with the clients slowly adapting to the changes, surprises and unpredictability in the music in music therapy. (Bonde 2009, p. 69-70). The application of improvisation in clinical context can according to Wigram (2004) be understood as a process that involves different

functions. Wigram has defined the functions of improvisation as follows, (ibid., p. 42-43):

Motivation

Here one looks for the motivation for the music making. (e.g. Why should we do this? What do we need to do?)

Understanding

Refers to the music therapist's responsibility to understand the implications of the music and body language, taking into consideration the client's background, needs and problems.

Sensitivity

Refers to the sensitivity to the intentionality of the sounds the client is making, which should be based on knowledge and intuition and relies on the listening perspective and skill of the music therapist.

Integration

Refers to how the improvised music and the therapeutic process integrate and develop. The music therapist is becoming aware of how the client's specific problems and personality are evident in his or her music making and actively influencing the experience of mutual engagement through music.

Containment

The music therapist has to allow herself to be open to all the transferred and projected feelings of the client and accept and contain them.

In an international study, on its way to be published (Geretsegger et al., 2015, in press) on developing treatment guidelines in improvisational music therapy addressing children with ASD, Gerretsegger and her colleagues found principles/guidelines in IMT that are unique and essential to such an intervention, they are:

- 1. Musical and emotional attunement:** As described in child-led part, the music played or sung by the therapist is closely attuned to the child's immediate display of (musical or other) behavior, focus of attention, and/or emotional expression, which may develop into affective and emotional attunement and emotional sharing that increases opportunities for the child to improve his/her awareness of self, to experience shared attention and social reciprocity, and to engage in communication. In a case of high arousal states or disruptive behavior's subsequent regulation might serve to promote the child's ability of emotional self-regulation.

Improvisational techniques may involve imitation, mirroring, variation, elaboration, regulation, support, responding, or contextualization.

- 2. Scaffold the flow of interaction musically:** The therapist should meet the child's behavior and initiatives as having meaning and as being related to assumed intentions. The music therapist increases opportunities and uses supportive techniques, for the child to comprehend, engage in, and initiate interaction. In order to do so the therapist uses musical means such as matching volume, timbre, rhythm etc. I interpret this also in the context to interaction themes (Holck 2002; 2004).

Improvisational techniques may include rhythmic grounding, extemporizing or frameworking as a way of using musical elements or styles to structure musical interactions.

- 3. Tap into history of musical interaction:** Within the shared context, a shared musical repertoire and interaction themes may develop, that is, musical movement-based forms of interplay that arise from joint improvisation between play partners. The therapist should act as a playful and reliable interaction partner.

Improvisational techniques that tap into the shared history of musical interaction between child and music therapist include building up and drawing upon joint repertoire of interaction themes, variation, and playing with musical expectations.

Essential principles/guidelines, though not unique, to such an intervention form are:

- a. **Build and maintain a positive therapeutic relationship:** Building a positive therapeutic relationship is essential for therapy. Within improvisational music therapy, the therapeutic relationship is the sphere within which musical, emotional, and intersubjective experiences may be shared, developed and built upon. The general attitude of the therapist is to present with interest, respect, and confidence.
- b. **Provide a secure environment:** As any other intervention, it is important to conduct improvisational music therapy within a safe environment.
- c. **Follow the child's lead:** the general approach is to follow the child's focus of attention, behaviours and interest as described previously.
- d. **Set treatment goals and evaluate progress:** by assessing the child's competences, emerging abilities and needs, individual goals can be derived and related intervention strategies and techniques can be tailored to the need assessed (this should be done in cooperation with the family and caregivers).
- e. **Facilitate enjoyment:** Incorporating the child's interests and meeting his/her preferences and initiatives with an attitude of positive affect, acceptance, and affection facilitates opportunities for mutual joy. In turn, it enables the child to experience affect sharing as pleasurable, rewarding and motivating.

(Geretsegger et al., 2015 in press)

Following I am going to sum up chapter 2 and reflect on the content in order to answer research question no. 1. I will relate the different terms to my interpretation and explain how I will discuss them in my analysis in order to answer research question no. 2.

2.9. Summary: Reflections on Chapter 2

The overall therapeutic interventions: the developmental social pragmatic model (DSP) (Ingersoll et al., 2005) and the guidelines for improvisational music therapy (IMT) (Geretsegger et al., 2015 in press) both, in recent studies, show positive results in children with ASD's communication and social development. Both interventions emphasise on increasing children's motivation to communicate, where the focus is on the intention of the child's communicative attempts, and they both mention that it should be a meaningful experience for the child to participate in interactions. DSP and IMT both have an attitude towards emphasizing emotional expressions and affect sharing derived from ideas on developmental theories in the mother-infant communication.

They seem alike in the overall stance, and both emphasises on a child-led approach. However, digging into these approaches you see that DSP differ from the IMT guidelines in form of: (10) playful obstruction; (11) sabotage; (12) violating familiar routines; (13) in sight-out of reach; and (14) the adult exaggerates his or her affective gestures and facial expressions and labels the child's emotional response. Point 1, 2, and 3 in the IMT guidelines all emphasise that change within the therapy should happen in a playful or cooperative manner derived from the child's motivation and needs. Negotiation, however, has things in common with the points that differ in DSP. In negotiation the shifts of direction, "sloppiness", which results from the interaction of the client and therapist working in a hit-miss-repair-elaborate manner could be a way of viewing obstruction, sabotage etc. There is still a focus on the affect sharing, but here the therapist purposefully mis-attune (re-attune). However, it is essential that a repair follow the mis-attunement. Moreover, there is also a resemblance in the child-led perspective on cooperation that resembles Sterns co-creation, although cooperation has an implicit sense of knowing the goal, whereas co-creation has an unknown goal. Since this is my interpretive view on the terms and how they correspond I would like to check how my definitions and thoughts on the terms is played out in the music therapy in the specific case. In my vertical analysis I will therefore present a table that show the relation between child-led, negotiation, DSP and IMT, for further discussion.

3 Empiricism

Chapter 3 is divided in 4 major parts. First follows a case presentation of the 4-year-old boy, whom is the subject of this thesis. Secondly I present the data. In details I explain the data selection process and next my transcription method in connection with a reading guide for the horizontal analysis. In the third part the horizontal analysis is presented, which, together with the literature, will make up the subject of discussion and interpretation in the vertical analysis. Before moving in to the next chapter, I will sum up the findings of chapter 3, and answer research question 2.

3.1. Case presentation

On my 8th semester I wrote a report on Music Therapy with children with ASD as a preparation to my practical experience. I selected clients on the basis of wishes from the staff for children they thought could benefit from extra attention. One of these children suggested to me was Noel, who is the central person of this thesis.

The institution, which Noel attended, Eersterust Care and Training Centre, is situated in a township outside of Pretoria in South Africa. The Care and Training Centre is a Community Clinic driven as a non-profit organisation and aims to serve and uplift the historically disadvantaged areas of Eersterust, East Lynne, Mamelodi and Nellmapius⁴ by providing basic job skills and social services to children, youth, abused, disabled and uneducated (Eersterust 2015). In 2013 the Community Clinic incorporated an Autism Class.

⁴ All 'coloured' or 'black' neighbourhoods.

Noel is a 4-year-old boy diagnosed with autism (not specified). He is diagnosed by the Department of Health in South Africa but is still under assessment. He just started in the Community Clinic's "Autism Class" with 19 other children and young adults with ASD. He is the only child of a young single mother and his home language is Afrikaans. At the Community Clinic he was both exposed to Afrikaans and English speaking.

He was described to me by the staff and in a report as follows:

- fully awake, restless, fidgety and disruptive.
- able to take instructions but rarely does.
- has episodes of anger outbursts and may have speech impairment.
- able to make some needs known through non-verbal communication, but has no verbal communication.
- very dependent and needs supervision in most activities.
- is incontinent.

Once a week all the classes receive Group Music Therapy (GMT). According to the music therapist Noel will start to spontaneously play the guitar and sing. He thrives on attention and wants to be the centre of attention in GMT. The music therapist suggests that he does this because he may feel frustrated, and that he needs individual space to express himself.

From this information and also by observing the children for 2 weeks I chose to select Noel for individual music therapy. I observed him in the classroom to become more aware of his needs and to make therapeutic goals. In the classroom I observed that he was very uneasy and did not take part in any joint activities. Sometimes he sought contact and attention with the adults, including me. He enjoyed looking at himself in the mirror and made funny faces and movements in front of it.

During the first music therapy sessions Noel showed signs of potential in developing communication and social skills. I initiated a game of peek-a-boo that he picked up immediately and then began conducting. He babbled, imitated musical phrases and spontaneously hummed "Happy Birthday" (his favourite melody). This indicated to me that he might be able to acquire language skills. At the end of a session I said: "Bye-bye" to him and he responded by waving and saying: "Bye-bye". He was clear in his non-verbal communication e.g. he would take my hand to show me what he wanted me to do. By the third session he was able to stay in a drum activity for more than 10 minutes, but was highly aroused and peed his pants. He made eye contact when he changed pattern as if making sure that I would follow his lead. In spite these promising abilities that he showed me he was still very uneasy, not able to focus for very long and seemed most interested in objects.

From these observations I made my goals for the therapy, which continued unedited during all 15 sessions. Primarily I wanted to assess his abilities in joint attention since it would clarify his potential in developing more communication and social skills. I also wanted to make grounding activities that would strengthen his body awareness and lower his high state of arousal. Last I would stimulate, match and imitate his verbal expressions aspiring to develop language skills. I chose to have a child-led approach on the basis on my knowledge on its effectiveness.

3.1.1. Wonderment experience: Session 13

In session 13 Noel babbled a lot! At one point he approached me as if he wanted to tell me something and then showed me a burn mark on his arm. He then sat down on my lap, and I gave him comfort. We had eye contact and both looked at the burn mark saying "Uuh." in an aching manner. He responded to the musical activities with joy, he clapped, cheered and played along in pulse and rhythm on the mini guitar. In the musical activities there were several events of turn-taking and imitation. Noel also used words that corresponded with the musical and playful activities like: singing along songs with a few words; pointing at the

hammock and trying to sing the song *Row your boat*⁵ with words and saying: "Gomorming" and "Night" in an activity where we switched on and off the light and together said "Goodmorning" and "Goodnight". He reached me objects and said: "Ayioo goo" (here you go) and responded "Dankie" (meaning "thank you" in Afrikaans) when I reached him something. He also drew with crayons together with me. Extracts from session 13 can be viewed on the DVD (see Appendix No. 4).

Outside of the music therapy the staff could tell that he started potty training and when he sat on the toilet he would clap his hands and shriek "Pee-pee" (meaning "pee" in Afrikaans). He was more affectionate towards the staff than before and started engaging in joint activities in the classroom - especially copying or wanting to join in in the caregiver's activities.

The difference between the child first described to me and the child now unfolding his talents both in music therapy and in the classroom was vast. I wondered: what happened in the music therapy, which made a difference? Thinking back on the process I came to realise the relationship between me and Noel changed and he started engaging more in joint activities when I became more aware of my therapeutic approach. Following, I will present my data and the process of my data selection.

3.2. Data Presentation

Before presenting the horizontal analysis, here follows: a detailed description of the data selection process; setting of the therapy room; inductive codes; and transcription and reading guide, to explicate the context from which the horizontal analysis emerged.

⁵ A song we always sing, when Noel is laying in the hammock.

3.2.1. Data Selection

I made a process description of all the therapy sessions 1-15 (see Appendix No. 1). In session 13, as described above, the child showed significant change in his social engagement in the music therapy. Therefore, I felt a need to explore the events before session 13, to discover what encouraged the client's development. The process description made it clear that something changed in the therapeutic relationship in session 07-09, which corresponded to my personal notes on my counter-transference and change of approach – which also was a topic brought up in supervision. I had a feeling that the child-led approach made the therapy's development stand still – or me stand still. I therefore chose to be more inattentive to my fixed approach and rather follow my basic therapeutic stance as described in part 1.4.3 *View on Humanity*. By looking back on this, it became clear that this might be the field of exploration. I then made a macro transcription of the last 10 minutes of session 07 and the first 10 minutes of session 08 (see Appendix No. 2). I chose the last 10 minutes of session 07 because that was where the client and I had clear events of interaction. I chose the first 10 minutes of session 09 of the same reasons. Session 08 is left out because a caregiver assisted me in the therapy, which I consider an exclusion criterion. The macro transcriptions are transcribed using graphic notations of the sound events and narrative descriptions linked to the graphic notation. I framed and gave numbers and titles to sections that seemed most intensive in contact or made me curious. This was an inductive and creative process, but later the selection of video clips (data) has been selected in a purposive manner, which in this specific thesis means that the clips should show the approach and interaction clearly (Neergaard 2007, p. 11), and therefore the actual analysis/transcription was adjusted. The term that arose from the macro transcription, that made me aware of the field of subject, was negotiation.

3.2.1.1 Coding

I became aware of negotiation and looked at my titles and framings in the macro transcriptions with a focus on identifying negotiation. It became clear that negotiation could be the change or altering from child-led that I had felt. After choosing examples from the macro-transcriptions and video extracts, that I found purposeful for exploration, I made the micro-transcriptions. Naturally I coded sections with child-led and negotiation. But I also coded direct/initiative contact and times when the mirror in the room was being used. How, will be further explained in part 3.2.3. I coded direct/initiative contact because I transcribed both gestures and sound, and contact might be initiated in one and not in another. I coded the mirror, because I became aware, during session 7, which the child used to mirror to look at the events and me. The mirror, in that sense, became an active part of the interaction.

3.2.2. Setting

The room where the music therapy took place were consistent. On a daily basis it is used by the physio- and occupational therapist. The room is squared and the wall from where you enter there is a desk and a small sink and mirror. There are windows on the right and left wall, and I always covered the windows with the curtains before starting the session. The back wall consists of one big mirror. In the room therapeutic/gym balls in different sizes, a therapeutic tunnel, a trampoline, a small three-wheel bicycle and a hammock were accessible. Instruments and objects I brought to the room were: shaker eggs, mini tambourines, a mini guitar, a classical guitar, a triangle, two mini djembe drums, one conga, three juggling balls, and two pom-poms. The small instruments were always placed in a bag in the middle of the room, from where you could take them out.

3.2.3. Transcription & Reading Guide

Because I have an open analysis approach, I have made an effort to transcribe the events as descriptive and precise as possible. I have been inspired by Holck's (2007) way of transcribing: a timeline with time marks according to the time in the session(s) is drawn first; music/sound and gestures are then placed in relation to the line. It is a mixed classical and graphical transcription of the music/sounds. The **client's** expressions are notated over the timeline (in green) and the **music therapist's** expressions are notated under the timeline (in orange).

MP	Voice and gestures
Client	Voice and gestures

Times when the client is looking in the **mirror** has been marked with a bright turquoise and times when the client and music therapists approaches each other or look at one another in a **direct manner** are marked with a bright yellow.

	Mirror	→ The mirror plays an active part in the session
	Direct contact	→ When the client/MT approaches one another - or eye contact

Number codes (1, 2, 3, etc.) have been used to define and divide a shift in the sequenced events, and the numbered events have been coded with either *child-led* or *negotiation*, which will be discussed and argued for in the vertical analysis. The **vocal sounds** have been notated with classical notations, but should be interpreted as approximately accurate (see figure 4).




Voice	
Approximate tone of voice	
Whispering	
Rhythmic tone of voice	

Figure 4: Voice

A **guitar** and a mini guitar are notated in both a classical and graphical manner and are coded with a red colour. Strums on the guitar in coordination with the voice are notated in two ways. 1.) is when the strum follows the rhythm of the voice and 2.) is when the strum is played as a tremolo. Melodic play on the guitar is notated in a classical way and strums in pulse with the music are notated on a percussion line. Strums without a sense or intention of pulse are notated in a graphical manner (a dotted line), where the size and relation of dots define the tempo and texture of the strums. See figure 5.





Guitar/mini guitar				
Strums – with voice	1.) Ex. //// and	1.) Strums that follows the voice.	2.) 	2.) Tremolo
Strums – in pulse				
Strums – without pulse		Dotted red line. The size of the dots defines the tempo/texture		
Melodic play				

Figure 5: Guitar(s)

Similarly the **mini tambourines** being used have been with a purple colour. When played in pulse they have been notated with standard notation and when they are being played without pulse or making significant noise they have been notated with purple dots. See figure 6.



Mini tambourine		
In pulse		
Without pulse (+noise)		The purple dots define the texture/intensity of the noise.

Figure 6: Mini Tambourines

Shaker eggs have been coded with blue in the same manner as the mini tambourine, only with a straight line of dots. See figure 7.

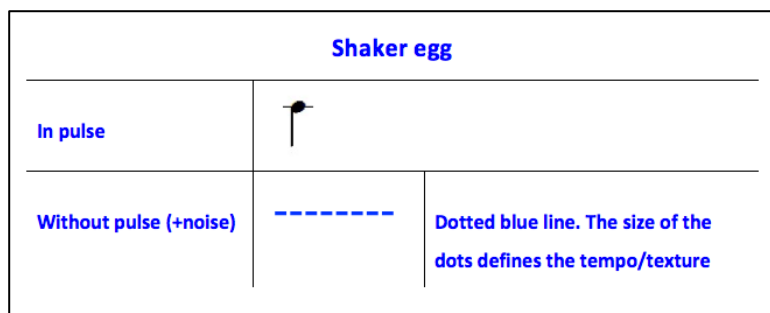


Figure 7: Shaker Egg

Other instruments, such as a conga and djembe drums, that are not used frequently have been titled and explained in the transcription. The horizontal analysis shifts between transcriptions and narratives. The narrative examples have not been transcribed in the detailed manner because the interaction does not make use of musical elements. Moreover I also, below a separate line at the bottom, transcribed something called actions, which tells the actions from a macro and observation perspective.

3.3. Horizontal analysis

Clip from the horizontal analysis can be watched on the DVD in Appendix no. 4⁶. There are seven different examples, divided with Roman numbers (I, II, III etc.). The analysis will be presented from page 42, since it should be read in pairs.

⁶ Only for examination.

3.4. Vertical Analysis

In this part I will present the vertical analysis. In the table (see table 2) below, I have shown how the different approaches and intervention techniques are played out in the music therapy according to my interpretation. No., child-led and negotiation refer to the codes in the horizontal analysis. IMT and DSP refer to the points of guidelines in improvisational music therapy and developmental social-pragmatic model.

Table 2:

No.	Child-led	Negotiation	IMT	DSP	Example No.	Session No.
1	X		2	5	I	7
2	X		2	5		
3	X		2	5		
4	X		2	5		
5	X		1	6		
6	X		1	6	II	
7	X		2	5		
8		X		2+4		
9		X	1	1		
10	X	X	1+2 +e.	5+7		
11	X		2	5	III	
12		X		1+3		
13		X		1	IV	
14		X	1+3	5		
15	X		1+2		V	
16		X	2+3			
17		X	2+3			
18	X		1	5		
19	X		2+3 +e.	5		
20	X		2+3 +e.	5	VI	
21		X	1	5+6 +7		
22		X	1+e.	5+7	VII	9

I will now explain how I have made those interpretations and after discuss these with my literature to conclude on my analysis.

3.4.1. Example 1: child-led

1 The client makes a calling sound - the Mp answers and is inspired to do a peek-a-boo game.

IMT: 2 (Scaffold the flow of interaction musically)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

Noel makes a sound "Oouu Wii-ih" that sounds like a call, as he crawls into the gymnastic play tunnel. I respond to this as if he has initiated a peek-a-boo game, in a way to add meaning to what he is doing.

2 The Mp builds up the arousal with her actions and voice and hereby catches the client's attention.

IMT: 2 (Scaffold the flow of interaction musically)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

I then build up the arousal by both verbally and with my actions. He reacts to this by walking towards me and pointing. It could be that he is imitating my forms of vitality. A consequence of this is, that I got his attention.

3 The client imitates the Mp and looks at himself in the mirror doing it.

IMT: 2 (Scaffold the flow of interaction musically)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

Noel then uses the mirror to see what he is doing. He copies me and hides his face in his hands. He may imitate me because of pure function, or he may be imitating me because he is trying to put himself in my place, to find out why I am hiding my face. The first three sections show how the child-led approach catches the child's attention, and how he starts imitating.

4 The client invites the Mp to play on a drum.

IMT: 2 (Scaffold the flow of interaction musically)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

Noel may be aroused by my actions – he jumps up and down – and he initiates a drum activity.

3.4.2. Example II: child-led & negotiation

5 The Mp catches the client's attention by playing the tambourine and then giving it to him.

IMT: 1 (Musical and emotional attunement)

DSP: 6 (The adult emphasizes emotional expressions and affect sharing)

Child-led

Noel and I are exploring the tambourine together(?). I attune vocally, “Uuh”, as if saying: that is nice. Noel again uses the mirror to look at himself.

6 It seems like the tambourine arouses the client - the Mp supports his vocal and body expressions.

IMT: 1 (Musical and emotional attunement)

DSP: 6 (The adult emphasizes emotional expressions and affect sharing)

Child-led

Noel then becomes aroused and jumps up and down. I improvise a small “playful” musical phrase in accordance to what I think he might be feeling.

7 The client babbles a melody similar to “Skud die klokkie” – the Mp then hums this melody.

IMT: 2 (Scaffold the flow of interaction musically)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

Noel babbles a melody that resembles a well-known melody to him. I therefore start to sing that melody, as if he has initiated it.

← Child-led
Negotiation →

8 The client wants to do an activity in the hammock (The Mp and client have used the hammock several times before in a peek-a-boo game)

DSP: 2+4 (Sabotage and In sight-out of reach)

Negotiation

Noel shows me that he wants to go in the hammock that is out of reach to him. I refuse him this activity, because I am ending the session. You could argue that I here enter the negotiation approach. I refuse him, or mis-attune him, but I am open to something else.

9 The Mp plays the 6 first tones on the guitar initiating their "Goodbye-song". The client grabs the mini tambourine in an impulsive (refractory) manner. After exploring the tambourine that the Mp puts on his arm he gets aroused. The Mp matches his energy/noises/movements with her voice.

IMT: 1 (Musical and emotional attunement)

DSP: 1 (Playful Obstruction)

Negotiation

I initiate the ending of the session. Noel grabs the mini-tambourine in a manner as if he is telling me: "No, take this". You could state that he is being the playful obstructer. He wants to continue interaction, but on other terms. Henceforward I follow and attune and match to his verbal and bodily expressions.

← Child-led

Negotiation →

10 The client uses the mirror to look at himself imitating what the Mp is doing. The Mp becomes aware of the client's use of the mirror (for the first time).

IMT: 1+2+e. (Musical and emotional attunement; Scaffold the flow of interaction musically; and Facilitate joy)

DSP: 5+7 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful; The adult exaggerates his or her affective gestures and facial expressions and label's the child's emotional response.)

Child-led+Negotiation

I approach Noel and extemporise his vocal expression with a short improvisation, in which we synchronise rhythmically. I become aware of his use of the mirror for the first time, and I try to meet his gaze in the mirror, and explore the tambourines together with him in the mirror. With the song I tried to facilitate joy and playfulness, in which I sensed corresponded with him exploring the

tambourines. In a way I labelled Noel's vocal sounds. I am definitely following Noel's initiative, but you could also interpret that we together – in the rhythmic synchronization and exploration of the tambourines – were moving along together to an unknown goal (cf. negotiation).

11 The client is aroused.

IMT: 2 (Scaffold the flow of interaction musically)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

I match musically to the actions and sounds of Noel, trying to frame his actions.

12 The Mp makes a calling sound "Aah^{aa} aah" and picks up the guitar. But the client shows that he does not want this and sits down next to her and starts to play the conga.

DSP: 1+3 (Playful obstruction; violating familiar routines)

Negotiation

Again Noel is playing the obstructing part, he does not want me to play the guitar. I hesitate and try to seduce or retune (cf. negotiation) him with my verbal expression.

3.4.3. Example III: negotiation

13 This narrative shows that the client does not want the session to end – or Mp to play the guitar. It also shows how they negotiate to find a way to end the session. They always shut off the camera together.

DSP: 1 (Playful obstruction)

Negotiation

We are both obstructing each other's activities. I state that this example is a good example of a "pure" negotiation. It is demanding for both of us, but somehow in the back-and-forth interaction we move along together and end up co-creating a goal we can agree on. In contact the whole time.

3.4.4. Example IV: negotiation

14 This narrative shows how the Mp uses a familiar musical pattern to engage the client in communicating with her.

IMT: 1+3 (Musical attunement; Tap into history of musical interaction)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Negotiation

This is an example of a clear interaction theme. Where I also try to attune the song to Noel's attention. It is although clear that I initiate and conduct the song, in which Noel engages in. I consider it negotiation because he turns his back to me, and then turns around again. We are also moving along together in the forms of vitality.

3.4.5. Example V: child-led & negotiation

15 The Mp builds up the arousal. The client then starts the melody "Happy Birthday/Play song" and the Mp continues it. The client plays along on the mini guitar.

IMT: 1+2 (Musical and emotional attunement; Scaffold the flow of interaction musically)

Child-led

I build up an arousal and Noel responds with a vocal expression. In the expression I hear the song from before and extemporize to it as if that was what he wanted me to do.

← Child-led

Negotiation →

16 The Mp improvises a melody inspired by the client's babbling sounds (Extemporisation). The client strums along in pulse. She builds up the arousal and there is a break. The client imitates the sound.

IMT: 2+3 (Scaffold the flow of interaction musically; Tap into history of musical interaction)

Negotiation

I view this musical interaction as a moving along process, where we are co-creating.

17 The Mp whispers the melody and lowers the arousal.

IMT: 2+3 (Scaffold the flow of interaction musically; Tap into history of musical interaction)

Negotiation

I view this musical interaction as a moving along process, where we are co-creating. Furthermore, I am “playing” with the arousal and Noel follows.

← Negotiation

Child-led →

18 The Mp and client play together in pulse after a small break without sound. Then the client builds up the arousal.

IMT: 1 (Musical and emotional attunement)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

I am following and attuning musically to Noel's rhythm and musical expressions.

19 The client improvises (babbles) a new melody. The Mp responds by extemporizing the melody (using babble sounds).

IMT: 2+3+e. (Scaffold the flow of interaction musically; Tap into history of musical interaction; Facilitate enjoyment)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

I extemporise Noel's musical initiation.

20 The client takes initiative to turn-taking.

IMT: 2+3+e. (Scaffold the flow of interaction musically; Tap into history of musical interaction; Facilitate enjoyment)

DSP: 5 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful)

Child-led

We have a clear turn-taking event, where it is clear, that I am responding Noel. It sounds like a “call-and-response” musical improvisation.

3.4.6. Example VI: negotiation

21 The narrative shows social interaction between the client and Mp.

IMT: 1 (musical and emotional attunement)

DSP: 5+6+7 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful; The adult emphasizes emotional expressions and affect sharing; The adult exaggerates his or her affective gestures and facial expressions and labels the child's emotional response)

Negotiation

The interaction consists of a moving along, but with obstacles on its way. We do not agree on how to interact, even though we *do* interact. It is a moving along towards an unknown goal.

Furthermore, when Noel tosses over the chair, we stare at each other, and it seemed like Noel was anticipating a reaction from me, before we returned to play the drums.

3.4.7. Example VII: negotiation

22 The narrative shows how the Mp joins an activity created by the client (he notices and accepts it.)

IMT: 1+e. (musical and emotional attunement; Facilitate enjoyment)

DSP: 5+7 (All communicative attempts, including unconventional and preintentional communication are responded to as if they were purposeful; The adult exaggerates his or her affective gestures and facial expressions and labels the child's emotional response)

Negotiation

This is an example on how a new interaction theme arose. Noel went to switch off the light and I responded to it as if it was purposeful. This led to excitement and he went to do it again. I then exaggerated the expression in order to facilitate enjoyment and excitement, but also to label the experience. We co-created an interaction theme.

3.4. Discussion of the codes and progress between child-led and negotiation

The balance

The order of the examples corresponds with the natural progression in the music therapy. It shows that the first examples consist of mainly child-led approaches, but soon after, they begin to alternate one another. There is a continuous rotation in the approaches.

Assessment of Social and Communicative Development

Noel imitates, e.g. in the first example (I); he imitates by hiding his face in his hands in the same manner as me. The mirror may have had an enhancing effect on his spontaneous imitations (cf. everything is mirrored in the mirror); also because he in general enjoys looking at himself in the mirror; and since the analysis indicates that he uses the mirror actively in all of the music therapy sections except 1-2 (where he is inside the therapeutic play tunnel), 7 (where is playing guitar not facing the mirror) and 8 (where we are negotiating about the hammock activity). His spontaneous imitation suggests that he has a basis for abilities in joint attention and acquiring language skills, which was proven in session 13. I, responding to his communicative attempts in a purposeful or extemporising way, activated these spontaneous imitations. There were several times in negotiation where we were attuned with each other in a process of moving along. This required that also he could follow and tune in - on my dynamics and me. Several times he looked at me directly, also straight in the eyes for several seconds, which indicates to me, that he is able to share an experience. Especially the shared moments where we explored the tambourines together show promising abilities in joint attention.

IMT, DSP, Child-led and Negotiation

I find that I persistently have had a child-led attitude towards Noel although I make variations that I call and interpret as negotiation. These variations have elements that show a correspondence to the DSP model, and differ from the guidelines suggested in the IMT treatment guide in their more direct manner of e.g. obstructing. It is mentioned within the IMT that a change of role do occur (Kim et al. 2008), and Raglio and his colleagues (2011) and Holck (2002;2004) also describes a cooperative approach, that alters from an idea of a pure child-led approach. Kim (2006) states that especially in the beginning of the sessions it is important to be very focused on following the behavioural cues of the child. After that, you can then gradually introduce e.g. turn-taking, but in a gentle form, which does not correspond with the DSP model's more direct manner.

3.5. Reflections on chapter 3

Times when I refused Noel the hammock activity or negotiated how to end was a consequence of me wanting the music therapy to make sense to me as well as it should make sense to Noel. Me being able to do that and still keep contact indicate a secure therapeutic relationship and persistence and tolerance from both Noel and I. It also show a wish from him to be in an interaction, which means that the music therapy must have been enjoyable and rewarding in spite of me frustrating him from time to time. Moreover the negotiation approach may have forced him to find alternative ways of communicating his wish to me. From this point of view, I interpret that our relationship and the development in his social and communication skills was modelled after the normal interaction between caregiver and child – and that the music therapy serves as a rehearsing room. Him being able to develop so rapidly could indicate that he might have a mild form of ASD, and he had some innate abilities that just needed help and support to show and develop.

4 Evaluation

4.1. Discussion of Methodology

"...man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretative in search of meaning "

**Clifford Geertz
The interpretation of cultures
1973, p. 5**

Given that I am both the researcher and an active part in the phenomenon being researched I am indeed suspended in the webs of significance that I, myself, have spun. I am both the emic and the etic observer, which of course can be considered as a positive thing, because it gives me expert and implicit knowledge on the field of exploration, but it is also knowledge shadowed by my preconceptions about it. With this thesis I did not pursue to find new knowledge about a universal subject, I was more interested in digging into my own approach and therapeutic stance to become more aware of my motivation behind certain behaviours (cf. negotiation) and add new meaning to the field of subject.

My overall methodical approach in this thesis was qualitative. One of the qualitative beliefs that I stated was that findings cannot be generalized beyond the context in which they are discovered, and also values are essential in any investigation (Wheeler 2005, p. 13). Given that I explored the therapeutic relationship in a course of improvisational music therapy with a child with autism spectrum disorder, my findings cannot be generalized beyond this case. What I did find that I would make use of in other contexts was that I have a more broad understanding and way of conducting the child-led approach than I thought initially. I also now not only grasp the idea of child-led approaches but also comprehend (cf. hermeneutics) more deeply the interplay going on in the therapeutic relationship, based on looking into the literature; digging into my video material and seeing the process with a new perspective. I also now see

that the client made many communicative attempts that I followed, and that he also imitated me in a manner I was not aware of before.

My wonderment was based on my awareness of the client's progress in communication skills, which first appeared to me to be a sudden change. I felt an urge to become more authentic and congruent to myself, which made me take this feeling in to the therapy. I now see in the analysis that the client makes many communicative attempts, which I respond to in a child-led and negotiation manner. It appears to me now, that these sessions might be the sessions of change in the therapeutic relationship because I became more attentive to my inner psychodynamics (Pedersen, 2000), and not something that e.g. evoked in the client. Therefore it would have been interesting to look into the raw video recordings again to see how my therapeutic approach changes from the very beginning, and how the client responds to it, especially to see what evokes the counter-transference in me, that served as a reason for changing my approach, since that might have been the proper way to answer my problem statement.

4.2. Discussion of Method

As just stated above my data selection made out the most crucial and determining part concerning the results and validity of this thesis (Thurén 2008, p. 30). It could have been interesting to look through the whole video material once again with my new knowledge about the relationship and its start of progression. I could also have chosen to make other therapists look through the material and select data – but that is a very comprehensive task. Moreover I could have made some deductive criteria for selecting data, based on literature. I chose not to include session 8, which is in between the two sessions I have presented, because I had a caregiver to assist me in the music therapy. She assisted me in some exercises on the therapeutic balls, and in the hammock. Doing so might have excluded important knowledge about the progress in the therapeutic relationship. I have made an effort to explicit the way I have conducted the research and analysis method. I cannot say that my way of coding

and analysing have not been affected by implicit knowledge and preconceptions, but I have made an effort to explicit my preconceptions beforehand. Indeed the process was circular and hermeneutic, so my choice of literature contributed to the findings. As the data could have been different, the field of subject could have been to, even if my wonderment was the same. Seeing things in a new perspective, my field of subject could have been on counter-transferences instead of therapeutic approaches, since they are both related to the wonderment experience, and both could help explore what happened preceding. My findings and conclusion could have been made more reliable if I had made use of peer-debriefing on my findings, or if I have made other music therapists code or transcribe my data (Thurén, 2008., p. 28). I could also have included alternative methods to explicate my preconceptions or data, e.g. music therapy methods presented to me in intuitive analysis methods, like Lawrence Ferrara's music analysis, open music listening, more graphic notations etc. In my analysis I thought of music on a syntactic level and sought to describe the events as accurate as possible, so I could extract their part in the meaning of the whole. Moreover, I did not choose to do a systematic literature review, which could have provided me with even more background knowledge on the terms.

4.3. Results

The results comprise my new preconceptions about the field of subject, which I acquired through writing this thesis.

I found that the two overall therapeutic interventions: the developmental social pragmatic model (Ingersoll et al., 2005) and (Geretsegger et al., 2015 in press) show positive results in children with ASD's communication and social behaviour, which advocates for an intervention like these two targeted to children with autism spectrum disorder. Both interventions emphasise a focus on the intention of the child's motivation to communicate, child-lead, and seek to create meaningful experiences for the child in the therapy. Both methods also emphasize emotional expressions and affect sharing derived from ideas on developmental theories in mother-infant communication.

I interpreted that the relationship between the client and me was modelled after a normal interaction between caregiver and child, and that the music therapy serves as a rehearsing room of social and communicative learning.

The relationship was naturally affected by my approach, which I found was continuously shifting between a child-led and negotiation approach to the child. The negotiation approach was understood to be the client and therapist working in a hit-miss-repair-elaborate manner, where the therapist should purposefully mis- or re-attune the client, which ultimately would lead the therapist to ideas on the best way to serve the child's needs (Stern 2005; et al. 1998). The hit-miss-repair, or sloppiness, was understood as excerpts from Ingersoll's social pragmatic model that differed from a pure-led approach. In that way I added to my comprehension of the child-led approach. Me obviously being able to frustrate the client, without him drawing himself back, told me that I had facilitated a secure environment, in which such an obstruction served as an addition and learning platform for his further social and communication development.

Through the analysis I also became aware of the client's abilities to imitate and to joint attention. His spontaneous imitations and eye contact suggested that he has a basis for abilities in joint attention and acquiring language skills and several times we shared moments of synchronization in the music making. This all expanded my view of his capabilities.

4.2. Conclusion

The context and case of this thesis was the music therapeutic course with a 4-year-old boy with autism spectrum disorder. It is a single-case-study, seeking to extend existing knowledge.

In the process of writing this thesis I sought to add to my knowledge and preconceptions of the therapeutic relationship. As a graduating music therapist the clinical practice and the therapist role are still new to me and I wanted to explore the approaches in the course with the 4-year-old boy to become more aware of the relational processes within improvisational music therapy.

I presented newer literature on child-led interventions for children with autism spectrum disorder, and explicated my view on my alteration of the child-led approach in improvisational music therapy, negotiation, as described by Stern (2005; Stern et al., 1998)

Through microanalyses, I wanted to find out how the progress between child-led and negotiation was playing out in the music therapy in this particular case. I found that I was continuously shifting between a child-led and negotiation approach, but always with an emphasis on tuning in according to the child. My interpretation and way of conduction the negotiation approach in the music therapy setting differed from the similar approaches of cooperation in improvisational music therapy. Instead, my negotiation approach resembled a social-pragmatic intervention, which in addition to being child-led, also advocates on challenging the client.

Moreover, the analysis and interpretation added to my preconceptions on the client's communicative and social abilities, and the transcriptions illustrated how even very small interactions and fragmental meetings can add meaning to the music therapeutic relationship.

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