Music Therapy with Children and Parents:
Toward an Ecological Attitude

Claire Flower

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Declaration

I certify that the work presented in the thesis is my own. All material which is not my own work has been identified and acknowledged as such. No material has previously been submitted and approved for the award of a degree by this or any other University.

Abstract

Since 2000 there has been significant growth in music therapy with children and parents. Empirical studies have primarily investigated outcomes associated with parental participation. Less literature addresses the processes through which therapy is enacted.

The practice-led study is situated in a Child Development Service within the UK state-funded healthcare system. Within the music therapy service, and more widely across the profession, parental attendance has increased in recent years, challenging conventional frames of practice and theory. This study investigates the enactment of music therapy with a child and parent in relation to everyday practice, organisational and professional structures.

The research consists of two interlinked, phenomenologically-informed studies. A preliminary study explores a single case of child, parent, and therapist, investigating experiences of those within it and musical-social processes. It uses a hybrid methodology of interviews and video microanalysis. The second main study, investigates the broader meshwork of people, places, events, and expertise through which music therapy with a child and parent is enacted. It employs focus groups with parents, music therapists, and healthcare staff. Methods drawn respectively from Interpretative Phenomenological Analysis and Grounded Theory are used.

The findings of the preliminary study suggest that music therapy with a child and parent appears through emergent, complex activity and interactivity between participants. It is characterised by a permeability of traditional music therapy boundaries. The main study further reveals the musicing of child and parent in everyday life and the various forms of expertise through which this appears.

The thesis argues for a radical realignment of practice, away from a conventional dyadic perception of music therapy. It proposes an ecological attitude by which music therapy is understood as a meshwork of interweaving lines of musicing, expertise, and emergence, within and beyond the therapy room. Implications for practice, theory, and research are drawn from this realignment.

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Chapter 1 : Introduction

1.1 Tracing Personal and Professional Roots

It is thirty years since I began my music therapy training. For the last twenty-five years I have spent part of every working day sitting on the floor, or at the piano, with a child. For the last fifteen of those years, a child's parent has sat with me too, in music therapy with their child. This is the distinctive music therapy scenario that forms the basis of my work as a music therapy practitioner and in which lies the driving impetus for this qualitative, practice-led study.

Training and Emerging Practice

I trained as a music therapist at the Guildhall School of Music and Drama in London. At the time this was a course known for offering an eclectic approach. It combined a strong psychodynamic base with a clear focus on musical-therapeutic skills and thinking. I emerged from the training with an appreciation of and familiarity with a range of theoretical frames, along with an understanding of the centrality of music and music making, in therapeutic practice.

In setting out in practice, I sought supervision and support from music therapists who themselves balanced a keen music-focused approach to practice with interest in a range of theoretical frameworks. These included Sandra Brown, whose practice and writing offered what I felt to be a trustworthy frame through which to navigate the potential tensions of such a broad approach (1999, 2002). Brown (1999, p. 184) positioned herself firmly in stating that 'a belief in the musical process itself as an instrument of change in its own right is central to my own work', while also acknowledging the developmental and psychotherapeutic frameworks available to her in clinical work. Inspired by Brown and others, the bringing together of music, health-based, and psychotherapeutic domains became, and continued to be, significant in my practice and thinking over the years (Flower, 1999, 2005; Flower and Sutton, 2002).

Working with Sandra Brown coincided with the move into working with children. Prompted by changes in my own circumstances, I began to work in schools

with children with additional needs.[1] Albeit unknown at the time, I can see, looking back, that the seeds of this study were sown at that point. The nature of everyday music therapy practice with children in a school sparked as yet unformed questions about the nature of the relationship between parent and music therapist.

In the school environment, parents did not attend music therapy sessions with their child, and I often only met parents once or twice a year. The Annual Review, a formal meeting convened with parents, school staff, and other professionals to discuss a child's progress in the past year, was the forum for such meetings. It was at this meeting that goals for a child's continuing development were agreed between educational and health staff and parent. While there was occasional telephone contact during the year, and informal contact at school events, the ongoing relationships I had with parents were often intermittent. Certainly, a parent's knowledge of their child's activity and experiences in music therapy was sparse, as was mine of the child and family's everyday life.

The insularity of this approach is evidenced in my own writing at the time (Flower, 1999). The emphasis lies firmly on the detail of the activity within the music therapy room between therapist and child, with little reference to parent, family, or the wider school context. Such an approach both to practice and writing was, perhaps, 'of its time', and its exclusivity may appear jarring when read through the lens of current perspectives. I include it here not to defend it, but merely to note it as an approach that influenced my practice and thinking at the time.

Moving from work in education, I was subsequently employed in two organisations that demanded a re-evaluation of my understanding of the relationships between parent and therapist in a child's music therapy. In one, a parent-funded and -run centre for children with additional needs, the convention was for parents to attend all therapy sessions with their child. This was in sharp contrast to my experiences in schools, and prompted a significant change in my approach that I have described more fully elsewhere (Flower, 2008).

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[1] I use the term 'additional needs' to mean 'any child or young person with a physical, sensory, communication, behavioural or learning disability, or a long-term or life-limiting condition. This may also include children with emotional health and wellbeing needs where there is an impact on their daily life, including those with more significant mental health problems' (2013, www.education.gov.uk/vocabularies/educationtermsandtags/6326)

A key trigger for those changes, and ultimately for this research journey, was a simple comment made by one parent. In correspondence, following the unexpected death of her young daughter, the parent said this:

> I cannot emphasise enough the importance of music therapy for me and Alice....I had spent so much time talking about what Alice couldn't do, it was so refreshing to come and have her able to do something and enjoy it. (Flower, 2008, p. 179)

Her words suggested that music therapy, while ostensibly serving her daughter's needs, also offered something of value to her as a parent. At the time, this was revelatory for me. Rather than only being of relevance to the child, she suggested that music therapy sessions might carry significant value for parents themselves, not least in witnessing a child as enjoying and participating as fully as they were able. This sparked a shift of thinking in me which found further expression in subsequent clinical work within a children's hospice.

Within the setting of the children's hospice, a family-centred model of care prevailed. This ethos privileged the quality of the relationship between the child and family, and permeated every aspect of the organisation, including music therapy (Widdas et al, 2013). My previous emphasis on regular, individual sessions lessened, and my focus as a practitioner shifted towards enabling and supporting the opportunities for music making between child, family, and others in more flexible ways (Flower, 2005, 2008). Now, in contrast to my approach in the educational context, parents were often an integral part of sessions. Not only were they present, but my focus as therapist tilted away from a primary concern with the child-therapist relationship towards finding ways to support and sustain connections between child, parent and wider family. At times, this challenged the notion of sessions as being inevitably private events, separate from the everyday life and places of the hospice. It also raised questions for me personally about the nature of the relationship between therapist, child, and parent in such a setting: what did my role involve, what did I and music therapy offer families, and how? Practice, and the ways in which I conceptualised it, needed to shift in response to perceptions of the needs of the child, the parent, and the contexts in which music therapy took place (Cubitt, 2005, Flower, 2005).

In part, this shift emerged from questioning the notion of 'context'. Aasgaard, describing music therapy within a paediatric hospital, comments that:

> Context, here, is not just the external frame or background for
> music therapy interventions, but constitutes tightly interwoven
> relationships where foreground and background change
> according to changing perspectives. (Aasgaard, 2004, p. 160)

Context takes on multiple levels. It is the physical location in which music therapy takes place, but it is also relational. Context emerges as an interconnecting of people, place, and events, and it is through such interconnecting that music therapy finds form. This was the case in the hospice, where the conventional dyadic shape of the music therapy encounter altered to fit the physical and relational contexts.

The demand to expand practice to better fit the context of the hospice signalled a shift in my thinking about music in music therapy. Christopher Small (1998, p. 2) wrote of music that 'it is not a thing at all but an activity'. This became an apposite way to understand music in the hospice. Small used the expression 'musicking' to signify music not as an object, but as something that people do (p. 9). As he describes it:

> To music is to take part, in any capacity, in a musical
> performance, whether by performing, by listening, by
> rehearsing or practicing, by providing material for performance
> (what is called composing), or by dancing. (Small, 1998, p. 9)

'The term 'musicing'[2] is widely used within community music therapy discourse (Ansdell, 2004, 2014; Pavlicevic and Ansdell, 2009; Stige and Aarø, 2012; Wood, 2015, 2016). It enables a way of looking (or listening) which considers the relationships between 'those who make sounds and those who make sounds possible' (Stige and Aarø, 2012, p. 7). The activity, they suggest, does not all lie with the performers. Rather, musicing, in music therapy, is enacted through a complex web of relationships: between sounds, people, and situational contexts (Stige and Aarø, 2012; Ansdell, 2014). These ideas reflect the evolving nature of family-centred, communal music therapy practice within the context of the hospice. They have offered me a way of understanding the involvement of parent, sibling, staff and others in a child's music therapy, and continue to offer me a way of understanding and describing the activities

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[2] Small's original spelling of the term is 'musicking' (1998). Throughout this thesis I use the alternative spelling, 'musicing', in keeping with that predominantly used by music therapists writing in the UK (Ansdell, 2004; Pavlicevic and Ansdell, 2009; Procter, 2014)

of music therapy in my current practice within an NHS Trust. It is the practice in this specific site that acts as the arena for this study.

1.2 Contextualising Practice and Research

An NHS Context

Chelsea and Westminster Hospital NHS Foundation Trust is a large central London teaching hospital situated in the Royal Borough of Kensington and Chelsea. This is an area of broad socio-economic variation, serving a population in which just under half of its residents were born in the UK.[3] The Trust offers a full range of inpatient and outpatient services, and is a leading provider of specialised services in neonatal and paediatric surgery, and burns care within the region.

The Child Development Service (CDS) forms part of the Trust's community services. It is described in the current patient information leaflet as providing 'specialist assessment and healthcare therapy for children with significant developmental needs, including those who are likely to have difficulty learning.' The leaflet (Appendix 1) details referral criteria to the service and outlines the multi-disciplinary assessment process offered. This consists of a medical and developmental assessment by a consultant paediatrician, to which designated members of the CDS team may contribute. It is after this assessment that a child may be referred to music therapy.[4]

Music Therapy in Context

Music therapy has been part of therapeutic provision within the CDS for over twenty years (Fearn and O'Connor, 2003; Wood et al, 2016). The music therapy service has expanded over the last ten years and is now offered over three different CDS sites. It has also, in that period, developed community provision, working within the local network of children's centres and nurseries, as well as offering in-patient, ward-based

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[3] 2011 Census:
https://www.rbkc.gov.uk/pdf/Census%202011%20%20December%20Release%20Summary.pdf

[4] In consultation with the Trust Research department I have decided to identify the location of the study. This pragmatic decision is based on two factors: the location is identifiable as it is the only UK hospital Trust with such a large music therapy service, and also, within professional circles, the Trust is widely known as being my workplace.

initiatives. Information about the music therapy service is clearly available on the Trust's website, the CDS page referring to music therapy in its opening statement:

> The Cheyne Child Development Service is a family-centred service based at Chelsea and Westminster dedicated to supporting children with special education and developmental needs. We have been running for many years and are one of the few services to provide music therapy. (2017, www.chelwest.nhs.uk/services/childrens-services/community-services/cheyne-child-development-service)

The music therapy service (which I refer to as 'the service' from here on, unless otherwise specified), accepts referrals from the multi-disciplinary team for children from birth to the age of five years, eleven months. Prior to submitting a formal referral form (Appendix 2), the referrer talks about music therapy with a family and discusses whether they would like their child to be referred. In having those discussions, a parent may be directed to the Trust website, which offers a description of music therapy written by therapists within the team:

> Music is a powerful tool for expression. It can touch our emotions and allows a freedom of communication which needs no words. Music therapy uses shared music-making to help children cope more effectively with their lives and difficulties, and allows them to show their potential. It is based on the understanding that all human beings are able to respond to music irrespective of ability or disability, and is supported by a growing evidence base and child development psychological theory. In our sessions the therapist and the child make music together – it is shared and spontaneous – through this the two establish a musical relationship in which emotions can be expressed, explored and worked through in a safe environment. (2017, www.chelwest.nhs.uk/services/therapy-services/childrens-therapy/music-therapy)

Starting work within this service demanded a significant reorientation of my practice from the previous setting of the hospice. The informality of the hospice setting, with its communal spaces and comfortable furnishings, was replaced by clinical spaces and wipeable chairs. The day's timetable, moulded in the hospice to a child or family's needs, was compressed into fixed appointment slots. The explicit focus of therapy, in this setting, was the child and their developmental needs. The child as an individual, as suggested in the description above, was the focal point of therapy, which was itself conducted through the singular relationship between therapist and child. Music therapy became dyadic again.

A dichotomy became apparent, however, between discourse and practice. The statement on music therapy above makes no reference to parents. No mention is made of their involvement in bringing children to music therapy, their frequent attendance in sessions themselves, the nature of their role in sessions, or the possibility of shared music making with their child.   In joining the service, however, I realised that therapists clearly emphasised establishing and nurturing relationships with parents. My experience was that working closely with parents, sharing information, discussing expectations, and considering their active participation in sessions, was a usual part of everyday practice within the service. The work of parents, the parent-child pair, and the relationship between parent and therapist underpinned everyday practice, but seemed all but invisible in the ways practice was discussed. This began to prompt questions for me as to how therapists and parents understood the relationships between themselves, and what their experiences of working together might be.

In the following years, the numbers of children whose parents attended sessions with them grew steadily. The rise was attributable, in part, to changing commissioning patterns for the service. Currently, music therapy is offered to children from a younger age than previously, and extended input is available for children with particularly complex needs. Parental attendance and direct involvement in music therapy is often perceived as crucial now, particularly in terms of optimising a child's communications or movement in sessions (Wood et al, 2016).

The everyday realities of families mean that it is usually one parent who brings their child to sessions, most frequently the mother. It is also not always the parent who brings the child.   Frequently they are brought by another adult, whether that is another family member or a paid carer. While the weekly work of therapy sessions may be carried out without a parent, meetings prior to and on ending a course of therapy will still be held with parents, and regular contact is maintained in the interim. For the majority of work within the service, it will, however, be parents who attend with their child.

Thinking Musically

As I began to work, week by week, with children and parents together in the music therapy room, I became increasingly aware of the practical musical challenges involved. I found my attention being pulled variously between the child, whose therapy

this was intended to be, and the parent, whose role in sessions I found easier to identify at some times than others. Threading through these tensions were the strands of my prior experiences working with parents. These felt more fluid, less formal than the experiences here.

At times the tension that I experienced in responding to both parent and child was enacted musically. If, for instance, a child drew a parent into drumming together, I found myself shifting in my playing, retreating musically to accompany their pairing. On the other hand, if a parent seemed at ease sitting back in the comfy chair, watching their child play with me, my own musical activity increased, settling more solidly into dyadic play. Considering the fluctuations of the three in music therapy as musical opened an avenue of inquiry for me. Could the shifting, fluid activities of child, parent, and therapist be understood by borrowing the idea of the musical trio?

At the time, prior to this study beginning, I was playing and immersing myself in Mendelssohn's 1839 D Minor Piano trio, Opus 49 (Fig. 1:1).

Figure 1:1 Opening Page of Mendelssohn Piano Trio No. 1 in D Minor, Opus 49

My familiarity with it allowed me to ask questions of it in relation to music therapy with a child and parent. How, for example, did Mendelssohn write for three voices, how did individual lines or pairings emerge and recede, which instruments did what, and how? Did this mirror in some ways the interweaving voices of the child, parent, and therapist as they improvised together? Was it possible to understand music therapy in this context not in the usual terms of the duo between child and therapist, but rather as a trio comprising parent, child, and therapist?

Underlying this questioning was my growing sense that this work presented particular challenges. Personally, it seemed to be a combination of all my previous practice experience. It had the regularity and consistency of time and place of the dyadic work in education, but could not be considered wholly dyadic because of the parent's presence. Yet, while I was familiar with working with children and parents together in the fluid, unpredictable setting of the hospice, CDS practice did not allow for the same flexibility. It also held the child as an individual, rather than parent-child and wider family relationships, as its focus. Moreover, in terms of the detail of sessions, I found myself balancing what I understood to be the needs of the child, the parent, and the parent-child pair in constant flux in what I offered musically.

As a practitioner, my need to ground my practice and resolve these tensions became urgent. The heuristic of the music therapy trio of child, parent, and therapist offered a starting point, raising questions particularly about the musical-social detail of activity within the room. These were questions of who did what, and how within the unfolding events of sessions. In asking such questions, I identified strongly as a practitioner. I wanted to know how I, as a music therapist, could meet what I perceived to be some of the technical challenges of working in the room with a child and parent. How, as I phrased it at the time, could I 'do it better'?

1.3 Uncovering the Research Problems
Problems of Practice

These questions formed the personal drive for embarking on this study. I was predominantly concerned with my own day-to-day practice in the music therapy room and how I understood events in it. Uncovering my own practice dilemmas, however, revealed further problems which presented themselves in working with parents. As

these came to light through my initial questioning, they raised issues which I realised were not mine alone.

Talking with colleagues in the music therapy team, I heard echoes of similar conundrums. For some therapists, working with parents in the room was entirely new. Nothing in their training had specifically equipped them for this work. I increasingly heard questions about what therapists were to do if a child wanted to play with a parent rather than with them, or if a parent seized the beaters to play the drum at what seemed, to the therapist, like an inopportune moment. This was felt to be challenging and even threatening ground, particularly for newly qualified therapists. How was a therapist to manage such shifting ground of action and interaction within a context in which the dominant focus purported to be on therapy offered to meet the specific developmental needs of the child?

Ambiguities in a Service

These dilemmas, voiced individually, began to coalesce in such a way as to suggest that the tensions were not only an issue of individual experience or competence. Rather, they could also be understood as a manifestation of tensions at a service level. Public statements about music therapy within the CDS present it largely as activity between therapist and child. Everyday practice, however, appeared also to be dependent not only on the presence but on the activity, knowledge, and skills of parents in being accomplished. The gap between discourse and practice began to seem increasingly problematic in terms of how the service was offered. What did therapists, CDS staff, children, and parents understand parental attendance at music therapy to entail; were there assumptions about parental participation, and if so, whose; and how might such participation be experienced by those in music therapy?

Questions of Congruence

In some respects, the mismatch between discourse and practice apparent at service level could be seen as resulting from the nesting of a music therapy service within the context of a NHS organisation. The CDS operates under an over-arching medical model. As such, the individual – in this context, the child – is understood to have particular difficulties which require assessment, diagnosis, and intervention (Stige and Aarø, 2012; Aigen, 2014). The prevailing medical model has distinct value in many ways. The complex medical and neurodevelopmental conditions which children attending the CDS may have clearly require skilled diagnosis and effective

treatment. The difficulty here lies in the extent to which a music therapy service identifies itself with such a model, adopting its language and approaches.

The prevailing medical discourse shapes the language used to describe the music therapy service. The child is clearly identified as the patient, and processes of referral, assessment, and treatment are emphasised. The language is congruent with the medical model of the umbrella organisation, suggesting an alignment which is either ideological or pragmatic (Procter, 2014). To some degree there is an element of pragmatism here. This congruence confers a degree of legitimacy to a discipline which may otherwise be hard to find in a NHS, or equivalent setting (Aigen, 2014). The dissonance sounds when music therapy, as a situated service, is compromised in the ways it is offered or described by seeking to fit into the shapes cast by the medical model (Rolvsjord, 2010).

While in describing the service I have already used the terminology of referral and assessment found in the service documentation, there is a tension for me in doing so. This speaks of the need to balance my own experiences as a practitioner working collaboratively with families, acknowledging their expertise and learning from them, with an organisational context in which a medical model is dominant, and in which parents may not perceive themselves to have expertise. While the CDS publicity announces it to be 'family-centred', it operates through a formal, clinic-based system of waiting times, appointments, and reports written by professionals and disseminated to parents. In some ways these institutional arrangements could be understood as more professional than family-centred. The music therapy service operates in many of the same ways listed above, but has as its core activity an improvisational, creative, participatory musicing.

It is, I would argue, the unpredictable, emergent nature of musicing that creates tension for practitioners, possibly for families, and also in the relationship between the music therapy service and the CDS. What, I wondered, could be learned about the events and experiences of music therapy with a child and parent that might challenge existing models or approaches to practice in the organisation, or that might inform a more robust understanding of the organisational frictions and opportunities afforded both by and for music therapy within a healthcare organisation such as the CDS? My perception was that in investigating music therapy practice in context, I would also find myself exposed to the constituent 'interwoven relationships' of the context itself (Aasgaard, 2004, p. 160).

Linking Practice to Training

There is one further contextual thread linked to the music therapy service, and that is one of professional training. The service has connections with a number of music therapy training courses in the UK, and it regularly offers training placements to students. Particular placements carry specific remits, such as, for instance, opportunities for group work or joint working with other professionals. One such request is for students to have experience of individual work with children. This has presented a dilemma. From the training institution's perspective, the presence of a parent has brought a complicating element to a student's clinical work with an individual child. At times, the institution has suggested asking a parent not to attend, in order to return the work to the supposed clarity of individual work. From the service perspective, however, there is an assumption that individual work with a child involves parental attendance. This is the nature of individual work in this setting. It raises two particular questions, though. Can music therapy when a parent is also present be considered as individual work, or might it need to be considered as a distinct configuration requiring a particular therapeutic approach? If the latter, this carries implications for music therapy training, given that working closely with parents and families more broadly has become a burgeoning area of practice and research in recent years.

Positioning Research in the Professional Community

Growing parental attendance in music therapy within the CDS has echoed a parallel rise in developing practice involving parents or families both in the UK and internationally. This has been evidenced in a general increase in publications in the field, outlining the variety of settings in which music therapy takes place and the range of therapeutic approaches employed (Oldfield and Flower, 2008; Edwards, 2011; Jacobsen and Thompson, 2017). Chapter 2 gives a comprehensive review of literature in and related to the field. In developing the study, however, my initial forays into the music therapy literature suggested a discrepancy between the research avenues being pursued in current literature and my own intentions.

There has been a clear emphasis in research literature on studies concerned with outcomes of parental involvement in a child's music therapy. Without distinguishing between specific contexts in which music therapy takes place, parental involvement in therapy has been broadly shown to offer three distinct areas of benefit: for the children themselves, in terms of developmental gains (Allgood, 2005; Chiang, 2008; Walworth,

2009); for parents, in terms of improved mental health (Williams et al, 2012); and for the parent-child relationship (Thompson, 2012a; Thompson and McFerran, 2013; Jacobsen et al, 2014).

The growing body of literature covers a wide spectrum of practices that require delineation. Broadly speaking, these span music therapy – as in this context, specifically with a child when a parent is present – to therapy in which attention is explicitly paid to the parent-child pair. The range of practice is large and potentially confusing both for practitioners and families. The concern voiced recently by Jacobsen and Thompson (2017, p. 322) as to whether, in attending music therapy, a family 'know what they are getting' is becoming a pressing one for the professional community. What do parents and children understand by their involvement together in music therapy, and in what ways are the intentions driving therapy made explicit? And, in order to probe further, what difference does knowing and not knowing intentions of therapy make to its enactment between child, parent, and therapist?

As practice grows in this field, there is an imperative for the music therapy research community to address not only outcomes but also the detailed processes of practice. The focus of this research is not on outcomes, although these have emerged as a side product of the research. Rather, the focus has remained on the processes through which such outcomes may be reached. My concern, arising from the specifically practice-led dilemmas at the heart of the study, has been to uncover and delve into the activities and experiences of people as they do music therapy together. This positions the study at a particular investigative point. I am not directly concerned with the question of why parents attend sessions with their child, and only indirectly concerned with what the outcomes of attending might be. My concern has been to accept existing context-specific music therapy practice with a child and parent as a phenomenon which warrants attention in its own right. In doing so, I have sought to uncover and question the activities and experiences of people as they do music therapy together.

1.4 Approaching Research
Theoretical Foundations

The impetus for the study arose from my lengthy experience as a music therapy practitioner. As my practice has evolved over the years, shaped by the needs and

constraints of the specific settings in which I have worked, so too have the theoretical foundations through which to understand practice. Aspects of my initial, music-focused training have combined, over time, with other key concepts, forming a sustaining orientation to clinical work. The ideas of Sandra Brown (1999, 2002), whose clear commitment to musical process, together with an acknowledgement of developmental and psychotherapeutic frameworks as available tools, have provided a strong, pragmatic anchor for my developing thinking.

While keeping music central, two distinctive areas of theory have guided my approach to practice. The first are the ideas concerning the detail and musicality of early parent-infant interaction emerging from the field of developmental psychology. The intricacies of disruption and repair of interactions in the early relationship (Beebe and Lachmann, 1994), notions of attunement and mis-attunement between parent and child (Stern, 1985, 2010), and the dynamic work of the pair articulated in the concept of 'communicative musicality' (Malloch, 1999; Malloch and Trevarthen, 2008), have been foundational in my practice with children. They have offered me ways of understanding the musical-relational ebb and flow between therapist and child (Flower, 1999, 2005). I return to these ideas in Chapter 2.

Yet my theoretical frame has also evolved in line with my practice. Working more closely with parents, and, in the hospice setting with other family members, has brought constellations other than the dyadic into focus (Flower, 2005). I have had to question the usefulness of models based primarily on the dyad when seeking to understand practice in relation to broader social, cultural, and musical worlds. Thinking emerging from Community Music Therapy has been instrumental then in broadening the theoretical frame (Amir, 2004; Stige, 2004; Pavlicevic and Ansdell, 2008). In holding a balance between theoretical positions, a resource-oriented approach (cf. p. 50) has become a further orienting frame through which I seek to work with the resources, musical, social, and otherwise, that a child and family bring to therapy (Rolvsjord, 2004, 2010).

These concepts serve as anchor points within my own clinical practice. In outlining them, however, it is important to say that this study is of music therapy as practiced within a team in which a theoretical consensus is not assumed. Therapists within the service work with the theoretical traditions of their trainings, experience, and particular interests. My own theoretical orientation then may differ or overlap with that of others

within the team, but is most usefully understood here as informing the ways of looking that I might bring to the study.

These theoretical positions ground my understanding of the clinical practice explored within the study. From a research perspective, I have also used sets of ideas from two key academics beyond the music therapy world which I introduce briefly here.

The first concerns ideas of emergence and collaborative emergence as proposed by the psychologist R.K Sawyer (2003, 2006). Sawyer's primary academic focus has been on creative processes within improvisational groups such as jazz ensembles. Using previous understandings of emergence, Sawyer proposes collaborative emergence as an explanatory concept for the unpredictable, highly contingent processes within such groups (2006). Described more fully in Chapter 2 (p. 63), the notion, together with associated concepts of ideation and evaluation, subsequently provided a theoretical lens through which to consider the music therapy trio in the first phase of this study.

In the study's second phase, I introduce a second theoretical perspective, drawing on the work of anthropologist, Tim Ingold (2007, 2008a, 2010). Ingold's commitment to understanding the interconnecting trails of people, places, and things in ecological terms gave rise to his notion of the meshwork (2008a). This he distinguishes from a network, where the emphasis may more often be on endpoints and destinations.   In broadening the scope of the study in its latter phase (Chapter 5), I have used the notions of the meshwork as a heuristic to guide my enquiry, subsequently discussing the study's findings in the light of the typology of lines proposed by Ingold (2007).

Ontological and Epistemological Considerations

Having grounded the study in clinical and academic theoretical foundations, it is important here to comment on further aspects of my research approach. Moses and Knutsen (2012) note that 'different ways of knowing' influence the ontological, epistemological, and methodological positions taken by researchers (p. 1). That is, respective positions taken on the nature of reality, a theory of knowledge, and how knowledge might be generated. The authors propose two key traditions in social science research through which such ways of knowing may be understood: naturalism and constructivism.

Within social science research, naturalism, perhaps more commonly known as positivism, is characterized by certain ontological and epistemological assumptions. It assumes a reality that exists independent of the researcher, but that might be known through observation, recording, and the analytic work of a neutral researcher (Alvesson and Sköldberg, 2010). Constructivism, on the other hand, is recognized through an ontological perspective of reality as being contextual, multiple, and continually constructed (Mol, 2002; Moses and Knutsen, 2012; DeNora, 2014). As such, it does not exist independent of the researcher, the research activity and researcher becoming instead part of the construction of a reality. This ontological position carries epistemological implications, demanding that knowledge also be considered as multiple, complex, and socially constructed. Constructivism, argue Moses and Knutsen (2012), thereby acknowledges a close relationship between knowledge and power, and consequently assumes a critical approach to questions of what can be known, and by whom.

Of the two traditions, this study assumes a constructivist approach. Such an approach finds congruence with my understanding of the nature of music in music therapy, and music therapy itself. In terms of music, within music therapy literature no singular consensus on the nature of music is to be found (Ruud, 1998: Aigen, 2014). Rather, the ways in which music itself is understood is in dynamic relationship with the theoretical frameworks that both shape, and are shaped by it. In my own music therapy practice, and in this study, my understanding of music is as process, and context, manifested relationally, through what people do together (Garred, 2001; Rolvsjord, 2010; Ansdell, 2014). The improvisational, interactive nature of music within the practices explored in this study can be understood then as constructed moment by moment, and, therefore understood and experienced differently by all those within and around it.

What then, do I understand of the nature of music therapy within the context of this study? Broadly speaking, music therapy is understood as both a discipline and profession (Bruscia, 1998; Pavlicevic, 2004; Barrington, 2005; Stige, 2010). As a discipline it functions through evolving knowledge and skill sets. As profession, it develops and maintains the educational, academic, and regulatory organization through which the discipline operates. Not only are the profession and discipline mutually influential, but both also operate in relation to wider forces of shifting political, cultural, health and education landscapes (Pavlicevic, 2004).

These combined forces, together with those at a local, institutional level, serve to shape the particular music therapy service at the heart of this study. In so doing, the ways in which the everyday routine of music therapy sessions takes place is also forged. It is at the level of music therapy as practices, enacted through people doing things together, that the focus of this study lies. Thus, while acknowledging music therapy as discipline, profession and service, the primary objects of my investigation are the everyday activities of music therapy. I use the term 'objects' intentionally, assuming an ontological perspective that considers such activities to be multiple, emerging and receding through 'common day-to-day sociomaterial practices' (Mol, 2002, p. 6).

Such a perspective shapes the epistemological and methodological choices within the study (Carter and Little, 2007). It does not assume that a singular truth, or truths, lie 'out there' to be discovered, but rather that there are multiple ways of understanding continually being constructed, with which those of the researcher combine, fresh understandings emerging in the process (Moses and Knutsen, 2012). The methodological approach taken then can be seen as both congruent with the constructivist orientation of the study, while also being sitting within a research tradition concerned with investigating everyday music therapy practices (Pink, 2012; Ansdell and DeNora, 2016).

On Methodology

The methodological grounding for the study is that of 'gentle empiricism' (Ansdell and Pavlicevic, 2010; Ansdell and DeNora, 2016). Characterised by a commitment to exploring a phenomenon as it appears within its natural setting and disturbing it as little as possible through research activity, the approach allows theory to emerge from an idiographic focus on the phenomenon itself. As a music therapy research approach it finds its roots in the attitude to practice developed by Paul Nordoff and Clive Robbins, most notably in a reverent, responsive attention to the ways in which instances of 'people-in-relationship' show themselves (Ansdell and Pavlicevic, 2010). While not trained within the Nordoff-Robbins tradition, this attitude mirrors my own approach to practice. An equivalent openness to what each child, musical gesture, or closing cadence might bring, is central to my understanding of improvisational music therapy. 'Gentle empiricism', as a methodological pillar, has allowed research and practice to

correspond in a way that has been appropriate given the practice-led nature of the study.

A further corresponding pillar rests in the phenomenological approach of Henri Bortoft (Bortoft, 1996, 2012). Phenomenology, Bortoft suggests, can be understood as essentially a 'shift of attention within experience' (2012, p. 19). That is, a shift from focusing on what is experienced, to the 'experiencing of what is experienced' (p. 19). As Bortoft notes:

> […] the position of attention is shifted from what occurs (downstream) into the occurring of what occurs (upstream). In particular, it is concerned with the happening of appearing.'
> (Bortoft, 2012, p. 95, italics author's own)

In line with 'gentle empiricism', retaining an 'upstream' perspective in the study signals a methodological intention to keep the phenomenon of music therapy with a child and parent central, and to keep an attentive alertness to the ways in which it might show itself.

Introducing Research Methods

The underpinning methodology informed decisions as to particular methods utilized within the study (Finlay, 2006). I consider these in greater detail in Chapters 3 and 5, but introduce them here in order to contextualize them within the broader discussion of ontology, (Edwards, 2012).

The first phase of the study, involving a single grouping of therapist, parent, and child, was concerned with understanding the ways in which music therapy was experienced. Given its focus on the detail and depth of experience, Interpretative Phenomenological Analysis (IPA) provided an appropriate frame for this phase (Smith, 2004; Smith et al, 2009). This is discussed more fully in Chapter 3 (section 3.6, p. 88). I chose to use the Video Elicitation Interview (VEI) framework rather than the more usual semi-structured interview used in IPA (Henry et al, 2011; Henry and Fetters, 2012). Discussed in Chapter 3 (section 3.4, p. 80), VEI is a method in which research participants watch and discuss a video recording of an event in which they have been involved. In the context of this study, the rationale for using VEI in the initial phase was that it enabled participants to guide the research encounter towards the events and experiences of particular significance to them.

The scope of the study broadened in the second phase from a focus on a singular trio to a wider exploration of people, places, and events through which music therapy with the child and parent appears. Grounded Theory (GT), as a flexible, open-ended method, modified to suit the broader range of emergent material, provided an appropriate framework at this stage (Charmaz, 2006, 2014). I offer a fuller rationale for the use of GT in Chapter 5 (section 5.4, p. 163), while also contextualizing its use in relation to wider music therapy research literature. In a further expansion of method, focus groups were used in the second phase (Chapter 5, section 5.5, currently p. 165). As a method of data collection, groups provided a means to both hear multiple voices, while allowing those voices to intermingle and complexify the emerging narratives (Bradbury-Jones et al, 2009).

While each of the methods outlined above offer more or less formal guidelines for use, they do not impose stringent or over-prescriptive rules. Indeed they remain open to a creative use of methods in the service of a study (Smith et al, 2009). Making use of the systematic frameworks of method, while allowing for flexibility offered a suitable balance given the emergent nature and design of the study.

Researching Practice

A key feature of this study has been its practice-led nature. It emerged from, and has tackled questions pertinent to everyday music therapy practice. As such it is positioned within a strong tradition of music therapy practitioner-led research, by which I mean research concerned with, and driven by, the problems and conundrums posed within practice for the practitioner and others (Thompson, 2012b; Strange, 2014; Gottfried, 2016; O'Neill and Crookes, 2018). It can be argued that practitioner-led research is strengthened by the researcher's knowledge and experience of the clinical area, and a relatively straightforward access to research participants (Thompson, 2012b). The practitioner's commitment to improving or expanding music therapy provision may also provide research impetus (Krantz, 2014). However it manifests itself, the relationship between the roles of practitioner and researcher becomes a constituent element in the research process (Pink, 2012).

This study has held a particular tension in terms of the practitioner-researcher roles, heightened by a change in my role within the workplace part way through the study. Assuming a managerial role brought new responsibilities for me in terms of maintaining and developing the music therapy service within the wider organization. In itself, this

had an impact on my working life as a practitioner researching practice within the service, further complexifying roles and relationships. A further facet of the practitioner-researcher role within this study was my decision not to research my own practice as a music therapist. Rather, I focused the study on clinical work as practiced within the service as a whole. This methodological decision enabled me to step back from my own practice, and avoid the potential ethical complexities for children and parents with whom I worked. Nonetheless, while not actively investigating my own practice, the study has clearly been shaped by own experience and knowledge as a long-standing practitioner.

On Positionality and Reflexivity

The clinical experience, knowledge and concomitant assumptions that I have brought to the research inevitably shaped my approach as researcher (Jack, 2008; Alvesson and Sköldberg, 2009). Placing under scrutiny the positions I have taken both on the research area and approaches to exploring it have been crucial in navigating the research process (Malacrida, 2007; Stige et al, 2009). That is, considering the assumptions and potential bias I may bring through my prior knowledge, and cultivating an alertness to questions of power relations within both practice and research (Finlay, 2002; Hadley, 2013; Muller and Gubrium, 2016). The latter has been particularly important given the weight of emotion frequently experienced by children, families, and staff within the particular healthcare context of the study. My position as both practitioner and manager has, I would argue, brought greater depth to my understanding of both the needs of children and families attending the service, and the wider institutional and policy demands that shape it. These, in turn, have shaped my understanding of my research position.

That position could be understood as that of an 'insider' researcher (Costley et al, 2010; Greene, 2014). The study investigates practice within my own workplace, enabling me to utilize existing knowledge, and affording a degree of ease in setting up and conducting the research. The notion of the 'insider/outsider' researcher has been critiqued however as an oversimplified binary, lacking the more nuanced realities of the research endeavor (Dwyer and Buckle, 2009; Bryant, 2015). This critique resonates with my own experience, which I explore further in Chapter 5 (section 5.3, p. 160). While I may crudely identify as an insider with music therapists in the study, being part of the same professional group, my position in relation to parents in the study is radically different, my understanding and experience of their everyday worlds

positioning me more clearly as an outsider. I have found it useful to understand my positioning in less fixed terms, my own research positions shifting in relation to those involved in the research (Bourke, 2014). As my roles within the workplace have changed over time, I have also become aware that my own ways of looking have been influenced by the evolving culture and values at an institutional level (Appleby, 2013). This creates a further axis around which my own positionality shifts.

Throughout the study I have become increasingly aware of the unequal power relations that underlie the research process and the potential impact of such inequalities for those participating (Warner, 2005; Procter, 2014; Muller and Gubrium, 2016). I have needed to consider the power relations with regard to the music therapists and other staff within the study, and the degree to which my role as service manager might interfere with their wish, or capacity, to participate freely in the research. Similarly, in inviting parents to take part, I needed to consider the extent to which my role might influence their decision to participate. Might I, for instance, be perceived as someone with influence as to whether, or for how long, their child might receive music therapy? I have responded directly to questions such as these when they have been voiced during the study. For the issues that remain unspoken, I have endeavoured to remain alert, as part of a reflexive approach to the study. .

Reflexivity can be understood as the researcher's awareness of the influence they may exert on what is being investigated, together with a continuing critical assessment of the ways in which the experience of research affects them (Stige et al, 2009; Finlay, 2014; Probst, 2015). Finlay argues that it has become a fundamental aspect of qualitative research, the need for which is broadly accepted to ensure the quality and ethical robustness of research.

I understand reflexivity as a stance, or attitude to research, bringing with it an expectation of researcher and the research area being mutually influential. This perspective corresponds with the epistemological foundations of the project, in which knowledge is understood as being co-created and context-dependent (Carter and Little, 2007). A reflexive stance, however, must be demonstrated in practical terms (Finlay, 2002). Within this study I have used specific practical ways to cultivate a reflexive position. These have included writing as an activity, both informally, in terms of personal reflective note keeping, and formally, in written preparatory sections discussed with supervisors. Ongoing presentation and discussion of the research process, both with fellow students and supervisors have also provided support in

considering and challenging my own ways of looking. Additionally, given its practice-led nature, the study has benefitted from opportunities for ongoing dialogue between myself and colleagues, families, and others with and through whom the research evolved. Throughout, my intention has been to hold a tension between pursuing the research work, with its inevitable pragmatic pressures of time and resources, with clarity and purpose, and being responsive to the shifting relationships, events and experiences of both practice and research during the course of the study. I reflect on this process throughout the course of this thesis, while moving on here to the specific details of the study and the questions raised within it.

1.5 Posing Research Questions and Outlining the Study

A single guiding question runs throughout the study:

How is music therapy with a child and parent enacted within a specific healthcare context?

I use the term 'enactment' here as defined by Law (2004, p. 56) who describes it as 'the continuous practice of crafting'. Enactment, he suggests, is not only the presentation of something already made, but also its coming into being. My interest in the study is to interrogate music therapy with a child and parent as dynamic crafting between people, places, and objects.

The study is a phenomenologically informed, practice-led investigation of music therapy practice. It consists of two discrete but linked studies: a Preliminary Study and Main Study.

Outlining the Preliminary Study

The Preliminary Study is a single case design exploration of the phenomenon of the music therapy trio. It uses two main research methods: separate Video Elicitation Interviews (Henry et al, 2011) with a parent and music therapist using a video of one of their recent sessions, and microanalysis of a short extract of the same video. Interpretative Phenomenological Analysis is used as the methodological and analytic frame (Smith et al, 2009), and five main themes emerge from the study material. These point to the emergent nature of the trio and to the permeable borders across which musicing travels between therapy room and the everyday life of the

family. The discussion of findings draws on Sawyer's notion of collaborative emergence as a key concept (2003).

The Preliminary Study's research questions are:

- How do a parent and therapist describe the experience of music therapy with a child in which a parent is also present?
- How might these descriptions inform an understanding of the phenomenon of the music therapy trio?
- How can an analysis of musical-social processes within the trio contribute to a greater understanding of the phenomenon?

Outlining the Main Study

Based on the findings of the Preliminary Study, the Main Study broadens the scope of the enquiry to investigate the enactment of music therapy across the interlinked contexts of the CDS and the everyday life of the family. It makes use of differentiated focus groups with parents, music therapists, and CDS staff, and it uses a Modified Grounded Theory approach to analyse the emerging material (Charmaz, 2006, 2014). The Main Study has a particular focus on the forms of expertise through which music therapy is enacted, and adopts a symmetrical focus on the expertise of all involved (DeNora, 2006). In following people, events, and objects, it makes use of Ingold's notion of the meshwork (2007, 2008a).

The Main Study's research questions are:

- What is the range of the meshwork within which music therapy takes place?
- What forms of expertise do different parties in the meshwork contribute?
- In what ways is expertise assembled across the meshwork and manifested in music therapy with a child when a parent is present?
    - In what ways might the musical-social activities of music therapy afford or preclude distinctive opportunities for the enactment and assembling of expertise?
    - What are the implications of an understanding of expertise in music therapy for child, family, the professional music therapy community, and for the wider healthcare network?

1.6 Navigating the Thesis

The thesis comprises eight chapters and is structured in such a way as to reflect the two phases of the study itself. This chapter and the final postlude serve as the bookends of the thesis. They frame the main body of the work with my own personal journey both into, and out of, the study. Chapter 2 is a review of literature relevant to the enquiry. This includes subject-specific literature within the field of music therapy with children and parents. It extends to include literature from other related therapeutic and academic fields.

In Chapters 3 and 5 I present the data work and findings of the preliminary and main studies, respectively. These two chapters are linked by a bridging section in Chapter 4, which serves to connect the two phases of data work.

The Discussion, Chapter 6, synthesises the findings of both studies, discussing them in the light of particular theoretical frames. I argue in this chapter for a shifting of the conceptual frame through which to understand the complexities of practice in this field. The implications of the study, at multiple levels, are discussed in Chapter 7. Woven into this chapter is consideration of the study's limitations and strengths, and recommendations for future areas of, and approaches to, research.

Chapter 2 : Reviewing the Literature

2.1 Introduction

This chapter grounds the study in a review of relevant literature. The practice-led nature of the study has shaped, to some extent, the approach I have taken to reviewing literature. While approaching the review systematically and in a strategic manner, I have wanted to retain a degree of flexibility in the approach. This has enabled me to gather material both formally, through purposive literature searches, and informally, as literature has emerged during the course of the study. Taking as its starting point literature from music therapy and neighbouring therapeutic disciplines, the chapter also samples a broader range of literature from related fields such as musicology and music psychology. The chapter concludes with a brief summary, bringing the review back to the practice-based issues which the literature raises.

2.2 Outlining a Search Strategy

A review of music therapy research and practice in the field of working with children and parents forms the largest part of the chapter. The review also includes literature from neighbouring therapeutic disciplines. This situates music therapy in a broader base of literature concerned with children and their parents, exploring commonalities and differences between them.

Given that the focus of this study rests on practice with a child, parent, and therapist in a specific healthcare context, the review is largely limited to literature concerning individual therapeutic practice with children and parents. In itself, this is not a single, clearly defined area but rather, a number of loosely overlapping areas. Within this scope, individual therapy with a focus on the child, although with a parent present, and practice attending specifically to the parent-child pair, although not including the wider family group, were included. I also intentionally limited the survey to practice and research most closely associated with the setting or the identified needs of children in this study; this brought into focus literature concerned with practice with children who had developmental disorders or disabilities. Given the focus on the child, parent, and therapist as a distinctive grouping within this study, a fuller review of group work or

practice involving larger family units was intentionally not included. In keeping with an express intention to approach literature flexibility, however, the review refers to pertinent aspects of group or systemic family therapy literature, particularly in specific relation to the parent, therapist, and child cluster.

In surveying music therapy literature I reviewed English language literature only. I searched the PubMed, PsychINFO, Embase, and CINAHL databases, using the terms 'music therapy', 'child*', and 'parent'. This search brought up 109 results across the four databases. These included peer reviewed papers, book chapters, and details of conference presentations. In order to keep the review within useful limits, literature which related to the following areas was excluded: music practices other than music therapy; parental mental health; clinical areas not addressed within the CDS; older age range of child or young person; and literature relating to medical contexts or approaches, such as music therapy during painful procedures. The remaining texts, thirty-five in total, are combined in this review with music therapy literature previously known to myself, or encountered through other means during the course of this study (Greenhalgh and Peacock, 2005).

The chapter also situates this investigation within a cross-disciplinary body of literature concerned with the musical-social processes of ensemble performance and improvisation. Following a manual search, literature from music therapy, music psychology, and music education is reviewed in terms of the conceptual frameworks it offers for understanding both the practice and the investigation of music therapy. While concentrating primarily on literature on small ensembles, in line with my formulation of the music therapy phenomenon as a trio, I have also, in reviewing jazz improvisation literature, considered material which deals with larger jazz groups. Given the stated intention not to explore literature on therapeutic groups, this discrepancy needs some explanation. The focus has been not on the size of the ensemble but rather on the improvisatory and interactive processes through which it emerges. It is these which are of interest as providing a further lens through which the activity of the music therapy 'ensemble' can be further understood. I begin, though, with music therapy literature, tracing the historical path of developing music therapy practice with children and parents.

2.3 An Emerging Practice

Music therapy practice with children and their parents has emerged as a distinct area of practice within the UK over the course of many decades. The earliest examples of which I am aware are those described by the pioneering music therapist, Juliette Alvin (1965, 1978). Alvin (1978) describes a mother who, having attended sessions with her child, comments on changes observed in her child over a course of sessions. Alvin, however, proposes a further perspective on the outcome of sessions:

> In reality, the mother had begun to accept the child as he was,
> to handle him better and to relate to him, because of what the
> music sessions had revealed to her. (Alvin, 1978, p. 115)

Alvin's writing not only provides early evidence of the music therapy trio but also hints at its inherent complexities. Who might benefit from music therapy: the child, the parent, or perhaps the child-parent pair? How might this be understood, and by whom? These issues were to become more prominent as practice developed across the profession.

In the last decade of the century, accounts of music therapy practice involving children and their parents appeared, variously suggesting its value for parent, child, and the parent-child pair (Müller and Warwick, 1993; Shoemark, 1996; Trolldalen, 1997; Jones and Oldfield, 1999). In an early study, Müller and Warwick (1993) investigated the experiences of mothers who participated in music therapy at home with children diagnosed with autistic spectrum disorder (ASD). Findings suggested that mothers described their child's skills more positively following a course of sessions, the implication being that participation in music therapy enabled parents to see their child differently. In their respective papers, Trolldalen (1997) and Shoemark (1996) report on groupwork with children and parents, perceived by Shoemark to afford opportunities for parents to gain 'valuable insights about their children' (p. 14). The 1999 paper by Jones and Oldfield suggested that a parent might not only gain insight, but that witnessing their child as an engaged musical partner carried emotional weight. As Jones, the co-authoring parent, commented, 'his enthusiasm and pleasure were so intense that it was impossible not to feel happy myself' (p. 168). Music therapy appeared to afford an affirming, reciprocally influencing experience for parent and child together.

At the turn of the century, Bunt and Hoskyns (2002, p. 82) described the music therapy practice of working with children together with their families as a 'steadily growing trend'. It is difficult to assess, however, whether it was the trend of practice or its representation which was growing (Fearn and O'Connor, 2003; Sobey, 2008). Fearn and O'Connor track a gradual development of parental involvement in music therapy over the course of a decade, emerging from a contextualised understanding within a specific healthcare setting (p. 67).[5] Sobey suggests this to be a common model in this period: practice developing at a local level, and being presented only gradually to the broader professional community.

Why might there have been a professional reticence in presenting emerging practice? Was the practice itself not legitimized sufficiently at this point to be deemed suitable for presentation? Oldfield (2017a) suggests this may have been the case, having experienced a questioning of the validity of her own developing practice with families years before. Involving parents in a child's music therapy may indeed have challenged contemporary practice paradigms. Ansdell (2002, no pagination) while not specifically discussing work with children, has argued that the prevailing music therapy model at the time favoured practice which was 'mostly private and behind closed doors', privileging the therapeutic relationship between therapist and client in either individual or group work.

It was not only within music therapy that this may have been the case. Novick and Novick (2005, p. 2) track a similar course within child psychotherapy, suggesting that 'parent work has a long and checkered history'. They suggest possible obstacles to the legitimization of parental involvement over the course of the profession's development and, at its roots, a political force. Pioneers of child psychotherapy such as Anna Freud and Melanie Klein were, they suggest, 'eager to demonstrate that child analysis followed the same principles as the most recent models of adult work' (p. 4), and as such turned attention away from the wider family. Even as the involvement of parents developed in practice, the profession was slow to address it either in literature or training (Hirschfield, 2001).

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[5] Fearn and O'Connor's 2003 paper is based on their innovative work in establishing the music therapy service in the same healthcare setting as this study. I began working in this service shortly after both authors had left.

Emerging theoretical frames which have anchored child psychotherapy theory and practice have also played an influential part in underpinning practice and thinking in music therapy. These have often found their roots in the dyad, as observed in the parent-child relationship. From the psychoanalytic tradition, for instance, Winnicott and Bowlby provided ways of conceptualising the early parent-child relationship on which music therapists have drawn extensively (Levinge, 1993, 1999, 2015; O'Callaghan and Jordan, 2011; Shoemark, 2011).

More recently, research within developmental psychology has furthered the understanding of the elegant and complex nature of the earliest interactions. Research into early parent-infant interaction has presented a picture of the infant as a communicative individual, primed to generate and engage in nuanced exchanges of sound, movement, and affect with parents (Tronick, 1989; Papousek, 1996; Trehub and Trainor, 1998; Nakata and Trehub, 2004; Ham and Tronick, 2009). The concepts of affect attunement and vitality affects, developed by Stern, offer a means to understand the intricate ways in which feeling states are shared between infants and parents, through which the infant comes to know themselves, others, and their world (1985, 2010). Elsewhere, the inherent musicality and highly social nature of dyadic parent-infant exchanges have found expression in the concept of 'communicative musicality' (Malloch, 1999; Malloch and Trevarthen, 2008). Described initially by Malloch (1999, p. 48) as 'the art of human companionable communication', communicative musicality captures the process by which pulse, quality, and narrative of sound, gesture, and expression interweave, enabling infant and parent to engage in closely attuned exchanges.

The conceptualising of the essentially musical activity of the parent-infant pair as described by Stern has long appeared appealing to music therapists (Pavlicevic, 1990, 1997, 2000; Hughes, 1995; Trolldalen, 1997; Robarts, 1998; Brown, 1999, Nöcker-Ribaupierre, 1999; Trondalen and Skårderud, 2007; Trondalen, 2016). It is perhaps through the emphasis on what Pavlicevic (2000, p. 274) describes as 'the musicality of a mother and newborn infant getting to know one another intimately', that therapists have made connections with the unfolding relationships created in practice through improvisation. Pavlicevic (1997, p. 121 author's own italics) notably developed the notion of 'dynamic form' as a theoretical construct, through which improvisation in music therapy offers 'an *inter-person* event, rather than only being a *musically* interactive event' .

In recent years, the notion of communicative musicality has been appropriated by music therapists describing practice with children and parents (Edwards, 2011; Shoemark, 2011). Within the medicalised setting of the neonatal intensive care unit (NICU), for example, Shoemark describes the use of infant-directed singing, through which 'an experience which offers companionship' may be offered to the infant (p. 172). The concept has also offered a theoretical framework for a cross-discipline, experimental study into infant social engagement within the NICU (Malloch et al, 2012).

The theoretical frames described here, centred as they are on the parent-infant pair, may have been a contributory factor in the situation described by Ansdell (2002), within which music therapy was largely perceived as preserving the therapist-client dyad as the core of both practice and the presentation of practice. While the growing understanding of the parent-infant dyad offered, and continues to offer, much in terms of understanding music therapy practice, practice which evolved to include a third, as in work with child and parent, could be seen to lack a conceptual model at the beginning of this century. To return to the anomaly raised by Sobey (2008), this dyadic focus, or even dogma, may have been a factor contributing to the time lag between emerging practice and the relatively recent public platform for the presentation of practice.

A further parallel development is of note at this point. Parent-infant psychotherapy, a response to what Stern (1995, p. 1) described as the encounter between established therapeutic approaches and 'new clinical populations', emerged during this period. As a therapeutic discipline, by definition it opened the traditional therapist-patient dyad to some complex configurations (Baradon, 2005a; Pozzi-Monzo and Tydeman, 2007). Moreover, the pragmatic model of 'psychotherapy in the kitchen' developed by Fraiberg (1987, p. 108), prompted further developments of practice beyond the conventional clinic setting into accessible community contexts (Woodhead and James, 2007; Barlow et al, 2015). It could be argued that the development and publication of models of practice within parent-infant psychotherapy legitimized and brought to light emerging practices of parental involvement in music therapy with children.

That said, literature on music therapy practice with children and parents continued to be sporadic in the first decade of this century (Woodward, 2004; Procter, 2005; Jacobsen and Wigram, 2007). In a review of contemporary literature at the time, Jacobsen and Wigram (p. 130) note that 'in music therapy literature there do not seem to be many who have written about music therapy with families'. It is since that point that there has been a sharp increase in the number of publications that describe,

investigate, and theorise a broad spectrum of practice both within the UK and internationally. The publication of a themed edition of the British Journal of Music Therapy, explicitly relating to music therapy with families, speaks of the growth in this field in recent years (Oldfield, 2017a). The recent publication of a text explicitly addressing the importance of 'significant others', aside from family, in music therapy also speaks of an expanded understanding of music therapy practice beyond the conventional therapist-client frame (Strange et al, 2017). It is to the spectrum of practice within the field of music therapy with children and parents that the explicit focus of this review now turns.

2.4 Putting Practice in Context

Music therapy with children and parents is practised in a wide range of settings to meet a variety of needs. Practice with children with developmental disorders and their parents, the population that is the focus of this study, is described as taking place in Child Developmental Services (Fearn and O'Connor, 2003; Oldfield, 2008, 2011; Wood et al, 2016; Loombe, 2017), music therapy centres or clinics (Woodward, 2004; Sorel, 2004; Procter, 2005; Horvat and O'Neill, 2008; Loth, 2017; Schwartzberg and Silverman, 2017) and educational contexts (Howden, 2008; Bull, 2008; Gilboa and Roginsky, 2010; Kaenampornpan, 2015). The home environment provides the setting for practice with children with ASD (Pasiali, 2004; Thompson, 2012a; Thompson and McFerran, 2013; Yang, 2016; Thompson, 2017), with adoptive families (Salkeld, 2008), and with children with life-threatening or life-limiting conditions (Flower, 2008; Lindenfelser et al, 2011; Mitchell, 2017). Community bases also offer the setting for music therapy more explicitly intended for child and parent as a unit (Jönsdottir, 2002; Loveszy, 2005; Warren and Nugent, 2010; Williams, 2010; Burrell, 2011; Williams et al, 2012; Krantz, 2016).

Music therapy with children who have particular medical needs and their parents takes place in a range of healthcare settings appropriate to their current needs.[6] These include neonatal units (O'Gorman, 2006; Shoemark and Dearn, 2008; Shoemark, 2011; Haslbeck, 2013a; Mondanaro et al, 2016; Ettenberger, 2017a, 2017b), in-patient paediatric wards (Aasgaard, 2004; Dun, 2007; O'Callaghan and Jordan, 2011; Baron,

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[6] While not strictly lying within the specific population of this study, it is the case that a proportion of children attending a CDS will have spent time within a NICU, or may use hospital or hospice services due to the complexity of their medical needs.

2017), and children's hospices (Rees, 2005; Flower, 2005, 2008: Lindenfelser et al, 2008). Within palliative care, Lindenfelser et al stress the geographic flexibility of practice, and the impact of this for parents. An evaluation of music therapy practice within UK children's hospices (Hodkinson et al, 2014) notes the range of means through which parents are involved in the most appropriate manner at any one time. Participation has been explored further by Mondanaro et al (2016) who consider the specific challenges for fathers in the NICU environment. Context shapes not only who participates in practice but where and how.

Describing Practice

Across such diverse practices it is perhaps unsurprising that the ways in which it is described or labelled also differ widely. Some authors stress the parent-child pair, such as dyadic music therapy treatment (Gilboa and Roginsky, 2010) or dyadic music therapy intervention (Jacobsen et al, 2014). Other descriptors foreground the family, such as family-based music therapy (Pasiali, 2013), a family-based music therapy approach (Nemesh, 2017), or family-centred music therapy (Thompson, 2012a, 2012b; Ettenberger, 2017b). Some terms sidestep specifics, as in the paper written by colleagues in the work setting of this study (Wood et al, 2016). The authors suggest a 'family model of working with an expanding theoretical base', allowing for a multiplicity of approaches (p. 45).

The shifts in terms used are often slight, but they are significant in appearing to suggest changes in meaning and intention. Oldfield (2017a, p. 8-9), within a single article, circles between the terms 'music therapy with families', 'family music therapy', and 'music therapy family work'. The shifting terms possibly denote the many differing ways in which families and music therapy meet. Loth (2017, p. 27) brings a clarifying voice to this potential confusion, suggesting that, in working with a parent and triplets, she offered a 'form of family music therapy', an approach which considered the complexity of the family's needs, while retaining a sense of one of the children as being a 'named patient'.

Clearly, balancing the individual family member, whole family, and music therapy is, in some ways, a linguistic challenge. In giving a historical perspective in the area, Jacobsen and Thompson comment that:

> To our knowledge, music therapy with families, or the mention
> of including parents […] has existed in the literature since 1976
> (Jacobsen and Thompson, 2017, p. 15)

In what ways might 'music therapy with families' differ from 'including parents'? Terms and practice appear to elide, becoming slippery in meaning. This is addressed, to some extent, by Jacobsen and Thompson (2017, p. 321) who, in an editorial summary, note the range of meanings ascribed to the term 'working with families' by authors. These, they suggest, range across practice terrain concerned with either the individual deemed to require music therapy, the parent or carer, or support for the wider family.

An ontological dilemma threads through this discussion. What music therapy with a child and parent is understood to be, and by whom, may well influence the terms in which it is described. It is also a dilemma that threads through this study. I have resisted describing it as a study of music therapy with child and parent, considering that to imply that both parent and child know themselves to be the 'named patient' (Loth, 2017, p. 27). Rather, I have talked of music therapy with a child when a parent is also present. The clumsy turn of phrase is necessary in order to remain as transparent as possible, but it also signifies the ambiguous nature of the phenomenon itself.

That said, the range of descriptors used across the literature denotes a spectrum of practices that are interdependent on factors such as setting, perceived need, and theoretical orientation. While the trio of child, parent, and therapist may be present within each, the rationale for practice and the focus of attention within it appear to differ widely across the spectrum. Where does the focus of attention lie, and how might it shape the way in which practice takes place within the trio?

2.5 Finding the Focus of Attention

Music therapy involving parents, such as in the CDS, is primarily focused on meeting a child's identified needs. In my own everyday practice, I draw heavily on the experience and knowledge of parents in working to meet those needs. Within music therapy literature, parental involvement is perceived to be of direct benefit not only for the therapist, but in supporting the child's ongoing development (Chiang, 2008; Standley et al 2009; Thompson and McFerran, 2013; Loombe, 2017). Thompson and McFerran (p. 17) argue, however, that if parental involvement is considered purely in terms of a child's developing skills, then only a 'limited portrayal' of its potential is given. In being

involved in music therapy sessions, they suggest, parents discover new ways through which they themselves can 'best promote and support their child's development' (p. 12). Their study of family-centred practice with children with ASD reported parents' perceptions of improved relationships between parent and child. Not only was this outcome highly valued by parents, but it could in turn, they suggest, contribute to the further development of a child's skills.

While the child's developing skills may be a central focus of attention, a further focus may be the relationship between parent and child. In particular contexts, music therapy is offered with an explicit intention to support parent-child relationships (Gilboa and Roginsky, 2010; Levinge, 2011; Pasiali, 2012; Edwards, 2014; Yang, 2016). Addressing the importance of early experiences of relationship between baby and parent, Edwards (p. 44) makes a strong case for music therapy in 'the promotion of parent-infant bonding in the first instance', while mindful of the various factors which might impede the developing relationship. Gilboa and Roginsky (2010), for instance, outline the potential emotional and communication difficulties encountered within the parent-child relationship when the child has cerebral palsy.[7] Music therapy, they suggest, enables increased communication between the pair through musical, gestural, and spoken means (p. 126). In a randomized controlled trial (RCT) which investigated 'dyadic music therapy intervention' in families with children experiencing emotional neglect, Jacobsen et al (2014) also suggest that parent-child communication and attunement improved following therapy. This finding is confirmed in the recently published longitudinal study by Thompson (2017c), in which benefits in relationships through the wider family are perceived by parents to be one benefit of music therapy.

The focus of practice is often expressed as being mobile, shifting between the child and the parent-child relationship during the course of a child's therapy (Horvat and O'Neill, 2008; Pasiali, 2013). Horvat and O'Neill, for example, outline particular musical activities used to engage the parent-child pair, which, in turn enabled a clearer attention by both parent and therapist to the particular needs of the child. Attention also swings, particularly within the context of NICU work, to the relationship between therapist and parent (Haslbeck, 2013a; Loewy, 2011, 2015). Loewy (2015) describes supporting parents in choosing and singing a familiar song to their baby, providing instruction to parents on aspects of the specific 'Song of Kin' intervention. Describing

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[7] 'Cerebral palsy is a condition that affects muscle control and movement. It's usually caused by an injury to the brain before, during or after birth.' (2014, www.scope.org.uk)

music therapy with the infant themselves as medical music therapy, and support for the parent as music psychotherapy, the two practices appear less as shifts of focus within the trio; but rather, they are separate practices situated in distinct theoretical frameworks.

The explicit distinction that Loewy (2015) makes between related practices appears to be unusual within the literature. In much of the literature outlined to this point, the focus of attention within practice shifts between individuals and the possible pairs within the music therapy trio of child, parent, and therapist. Such shifts happen in a dynamic moment-by-moment manner within sessions or across the course of therapy, being considered by authors as an integral part of the trio's functioning. The ways in which those shifts are understood or occur can be further illuminated by a consideration of literature from related therapeutic disciplines.

2.6 A View from Neighbouring Disciplines

In considering the trio of child, parent, and therapist, the discipline of parent-infant psychotherapy is perhaps most closely related to the music therapy practice investigated in this study. It takes place with the trio of infant, parent, and therapist in the room together, differing in this regard to some other child-focused therapeutic practices. Its aim is 'to promote the parent-infant relationship in order to facilitate infant development' (Baradon and Joyce, 2005, p. 25), giving primacy to the relationship with the ultimate intention of supporting the child's development. It has as a core tenet a shifting focus between infant, parent, and the parent-infant pair (Baradon, 2005a; Dowling, 2006; Dugmore 2014). Baradon describes this in pragmatic terms:

> While the parent-infant relationship is held in mind throughout,
> the focus of attention and intervention may also be with either
> parent or infant, for a period of the session as appropriate.
> (Baradon, 2005a, p. 45)

Baradon goes on to outline specific techniques through which 'the focus of attention and intervention' might shift as required between infant, parent, or the parent-infant as a pair. Dugmore (2014, p. 367) reflects on the demands on the therapist of what she terms the 'multirelational interventions' of this fluid practice. She suggests that the therapist is required to 'accommodate shifts' in the moment, given the emergent, unpredictable nature of sessions. Dugmore's particular interest is in the flexing of theoretical frames through which such accommodation might be understood.

The trio finds further form in the therapeutic disciplines of infant mental health and systemic therapy. The term 'triad' is frequently used to refer not to the child, parent, therapist grouping as in this study, but rather to denote interactions between three persons in the family (Byng-Hall, 1998; Dallos and Draper, 2010). While three possible relational dyads can be identified within each triad, individuals may also be drawn into the dynamic within any one dyad in what is commonly termed 'triangulation' (Dallos and Draper, 2010; Dallos and Vetere, 2012; Dallos et al, 2016).

Studying the interactions within the triad has been of particular concern over many years to key clinicians and researchers within the discipline of infant mental health (Corboz-Warnery et al, 1993; Byng-Hall, 1998; Frascarolo et al, 2004). The Lausanne Triadic Play (LTP) tool was developed primarily as a clinical tool through which the interactive resources of the mother, father, and infant could be evaluated and supported (Corboz-Warnery et al, 1993; Carneiro et al, 2006). Carneiro et al (p. 207) propose the use of the tool even in the antenatal period to consider, through role play with a doll, the strength of the 'co-parenting alliance'. The development of the LTP tool emerged first from an acknowledgement that the dyad had largely been the basic unit through which family interactions had been investigated, together with an understanding that studying the triad as a whole brought considerable methodological complexities (Frascarolo et al, 2004). A more recent publication from the same group of authors views the triad through the lens of co-parenting: parents working together in shared, rather than traditionally gendered, roles (Frascarolo and Favez, 2014). While the explicit focus on the family unit within such research and practice differs from that within this study, it is included here as an informing perspective on the notion of the trio.

Within child psychotherapy literature, a different picture of the trio emerges, given that, in general, parents do not attend a child's sessions. How, then, is the trio considered within this discipline? Sternberg (2006, p. 53) offers a particular perspective, suggesting that 'contact with the child's family is considered, to some extent, necessary, although the frequency and nature of this contact is a matter for debate'. While a number of authors suggest that developing good working relationships with parents is important in order to ensure a child's attendance at therapy (Sternberg, 2006; Baldwin, 2014), there is an increasing argument made in the literature for practice in which parents' needs are considered, and provision is made for meeting them (Sutton and Hughes, 2005; Jacobs, 2006; Naidu and Behari, 2010; Gvion and

Bar, 2014; Jeon and Myers, 2017). Outlining a model for 'parent-centred work', Jacobs (p. 238) describes offering 'a facilitating environment for the parents in which they could be understood and held and could then extend their capacities for empathic understanding of their child'. With support for the parent, parents in turn might support their child. Novick and Novick (2005, p. 2) suggest that 'the lack of a clear model for clinical work with parents' has inhibited developing practice in this area. While practice has developed significantly, gaps still appear both in terms of the theorising of therapeutic work with parents (Gvion and Bar, 2014) and the training of therapists in order to offer such support (Jeon and Myers, 2017). This echoes many aspects of the current picture within the music therapy profession.

A slightly different picture emerges, however, within current literature on play therapy. Historically, and dependent on context, parents have not usually attended sessions; therapists, as in child psychotherapy, met parents separately before, during, or after the course of therapy (Axline, 1990; Cates et al, 2006; Brumfield and Christensen, 2011). Cates et al, reviewing literature on consultation with parents, report on its crucial importance in terms of supporting the therapeutic process with the child. More recently, a range of practices have been documented that include play therapy specifically for parent and child, or the larger family group (O'Connor and Ammen, 2012; Prendiville and Howard, 2014). Working with the trio of parent, child, and therapist increasingly appears as one of a number of available therapeutic options.

The developing range of practice is also evident in the proliferation of therapeutic programmes that seek to enhance parenting skills for those with young children. Often framed as parent training, programmes such as the Triple P Positive Parenting Programme (Sanders et al, 2001) and Parent-Child Interaction Therapy (Thomas and Zimmer-Gembeck, 2007, 2012), focus on the parent-child relationship, with the therapist observing the pair and parents then being 'coached to attend' to the activity of the child (2012, p. 254). A further approach, Video Interaction Guidance, aims to enable parent and child to develop secure attachments, using video as a primary tool (Kennedy et al, 2010; Kennedy et al, 2011). The method aims to focus 'not on the behaviour of either the parent or the child, but on the relationship, or what happens between the two' (Kennedy et al, 2010, p. 59).

The range of therapeutic approaches outlined above provides an overview of the range of practices involving the trio of child, parent, and therapist within which the present study sits. The specific focus of practice varies, as does the particular shape which the

trio takes within each practice. This chapter's focus now moves towards a more detailed exploration of the nature of the music therapy trio itself, particularly in terms of the ways in which roles and relationships within it are negotiated, understood, and presented.

2.6 Understanding Roles and Relationships within the Trio

Within this study's healthcare setting, participants in the trio are generally referred to in terms that assign them particular identities and roles: therapist, child, and parent. These titles denote relationships both one to the other, and to some extent, to the particular NHS context in which the trio takes place. This section explores questions of roles within the trio. Who is in what role, or roles, and for what purpose? How might roles be assumed or negotiated, and how are questions of power considered, and by whom?

Within the NHS, the complex and evolving nature of roles and relationships between healthcare provider and patient has received particular attention over recent years (Coulter, 1999; PMETB,[8] 2008; HCPC,[9] 2014). As far back as 1999, Coulter (p. 719) commented that 'the concern to equalise relationships between health professionals and lay people is gathering momentum'. The 2008 report published by the General Medical Council could be said to demonstrate the outcome of that momentum, declaring that 'medical professionalism is now being framed in terms of how it can foster partnership in patient-doctor relationships' (p. 24). Moreover, the current emphasis within the NHS on user involvement in service and research design, as well as Care Quality Commission (CQC) inspections, suggests ongoing activity in bringing the principles of partnership into practice. Described as 'Experts by Experience', the CQC now works with approximately 500 individuals who have had experience of using care services across the UK as part of inspection teams.[10]

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[8] Postgraduate Medical Education and Training Board.

[9] Health and Care Professions Council. The HCPC is the regulatory body within the UK that monitors the practice of health and care professionals.

[10] http://www.cqc.org.uk/content/involving-people-who-use-services

Within music therapy, the frameworks of community music therapy (Pavlicevic and Ansdell, 2004; Stige et al, 2010) and resource-oriented music therapy practice (Rolvsjord, 2004, 2010), perhaps demonstrate most clearly a partnership-based approach to practice, (Rolvsjord, 2004, 2010; Sandford, 2016). The professional, Rolvsjord (2004, p. 105) suggests, 'works with participants rather than advocating for them', roles emerging from evolving relationships between people in context. Working in partnership carries with it the implicit commitment for dialogue, both between therapist and client, but also between client and a wider audience. Professional meetings and conferences should, Sandford (2016, p. 63) stresses, 'have service user perspectives as standard input'.[11]

Reviewing music therapy literature on roles in the child, parent, therapist trio suggests that the notion of partnership, in terms of an equalising of relationships between health professionals and patients, is not yet evident in the presentation of practice. Most publications have a concern with the role of the therapist rather than that of parent or child whose voices remain largely unheard. Given that the vast majority of literature is written by practitioners and researchers for a professional readership, this is perhaps understandable. The jointly authored article by Jones and Oldfield (1999) stands out as an early and perhaps solitary example of a parent-therapist partnership finding expression in print.

The discussion below focuses on the roles of individuals within the trio, initially of the therapist, and then parent. A discrete discussion of the child's role is not included, given the scarcity of available literature. In exploring the roles of individuals, there is a danger that the understanding of the trio as a whole becomes fragmented. This is not the intention of this discussion, nor of the study as a whole. Rather, the discussion is separated here simply in order to guide the reader and offer clarity.

The Roles of the Therapist

Within the trio, the therapist assumes multiple roles, shifting between them according to perceived need (Shoemark, 2011; Thompson, 2012a; Jacobsen et al, 2014; Haslbeck, 2017). Shoemark (p. 171), speaking of the parent-infant pair, suggests that she acts 'as a facilitator, container and witness to the contingent interaction of the dyad', while

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[11] The 2018 Conference of the British Association for Music Therapy made, in its Call for Papers, a specific invitation to those with 'lived experience of music therapy' to both attend and present at the event.

Haslbeck (p. 30) uses the term 'coach and collaborator'. The moment-by-moment reshaping of role occurs in response to unfolding events and relationships within the trio. Jacobsen et al (2017, p. 317) describe a further shifting of roles, with the therapist acting as 'a role model providing structure and guidelines and a facilitator for the parent-child relationship'. Roles are largely assumed and described in relation to the child and parent, but descriptions of practice also point to the assumption of outward-facing roles, such as advocates for the family (Baron, 2017; Mitchell, 2017). In such roles, therapists reach 'beyond the usual liaison with health-care and professionals', bringing a child or family's voice with strength to a wider audience (Mitchell, 2017, p. 42).

Within sessions, the finding of roles may mean the therapist relinquishes an overtly musical role within the trio (Shoemark, 2011; Thompson, 2012a; Oldfield, 2017a). The decision to 'hold back from singing' (Shoemark, 2011, p. 171), or to 'keep quiet' (Oldfield, 2017a, p. 7) arises from a privileging, in the moment, of the activity between child and parent or, in Shoemark's case, grandparent. Oldfield, in describing a father and son playing horns together, puts it this way:

> Dad plays his horn and looks expectantly at Charlie who eventually responds by playing. Chris responds again and they continue in this way until Chris then varies his sound by making it much longer. Charlie looks surprised and then tries a slightly longer sound himself. I keep quiet, not wanting to interfere with this intense, creative dialogue. (Oldfield, 2007a, p. 7)

While describing a brief moment in which the author sets aside a clearly musical role, other authors suggest that therapists should aspire to extend such periods, effectively seeking to become redundant in the trio (Archer, 2004; Drake, 2011). Describing practice with adoptive families, Drake (p. 38) suggests that such a shift would indicate that parent and child 'no longer need my role as enabler or holder'.

The shifting between the therapist's roles is often portrayed in dynamic terms, the language used being suggestive of physical movement (Jacquet, 2011; Levinge, 2011; Thompson, 2017b). The therapist 'leaves space' for the parent-child interaction (Jacquet, 2011, p. 96), or adopts a 'third and more distant position' (Levinge, 2011, p. 44). Of her own practice with children with ASD, Thompson comments:

> I regularly stop and reflect on how I will step forward and step back to both provide support to the parent and also get out of the way of the parent-child relationship. (Thompson, 2017b, p. 111)

Her comments convey a sense of movement in relation to others in the trio, although it is unclear what such stepping forward and back might entail, or how that might be negotiated with parent and child.

Towards Collaboration

In his foreword to a recently published text on music therapy with families (Jacobsen and Thompson, 2017), Stige (2017) himself tackles the question of the therapist's role. Many authors in the book, he comments, argue 'that it is relevant to replace the traditional role of being a professional expert with one of being a collaborator' (p. 10). He suggests that this move reflects a response to recent media portrayals of the expert as an intrusive, over-powerful figure in some health and social service scenarios. The notion of 'replacing' one role for another is problematic. Stige appears to create a false dichotomy, as though it were not possible for a therapist to be both expert and collaborator. Given the arguments he makes elsewhere for an ecological, complexified understanding of work with families (p. 8), it may be that his dichotomous suggestion is less about positioning and more about what he terms 'the challenges of developing professional discourse' in this field (p. 10).

Thompson (2017, p. 93) offers a balancing perspective to this difficulty, describing an ethos of partnership-based practice, in which 'the expertise of the therapist is not abandoned within this collaborative framework'. In resisting the designation of 'expert', Thompson's suggestion is that the therapist may draw on specific skills and knowledge in their work with child and family. A similar approach is outlined by Gottfried (2017, p. 125), who describes a collaborative relationship between herself and parents as 'combining the parents' priceless knowledge of their child with my professional experience and knowledge'. The practice Gottfried (2016, 2017) describes is highly specific. Defined as a 'Music-Oriented Counselling Model' for parents of children with ASD, it offers individual music therapy sessions with a child, and separate counselling sessions for parents. Collaboration in this context is qualitatively different therefore from that described when parents attend sessions with their child (Loombe, 2017; Schwartzberg and Silverman, 2017). Gottfried (2017, p. 131) herself notes that as parents are not actively involved in their child's therapy, 'this can be a barrier to grasping the essence of the musical interaction'. While Gottfried's argument appears to be that the parent's perception is of the therapist as having knowledge and experiences of a child which a parent does not have creates a tension in working collaboratively, the converse may also be true.

The Roles of the Parent

Discussion of the complex nature of the therapist's roles does not happen in isolation, but rather in response to a fluidity of roles for the parent, child, and the parent-child pair. How, though, do parental roles appear in the literature, and how might they be understood? The nature of the parent's roles within the trio may be dependent on context: the where, why, and who of music therapy.

Within children's palliative care, an understanding of the child within the context of the family unit guides practice (Aasgaard, 2004; Flower, 2008; Lindenfelser et al, 2011). Aasgaard's simple comment that 'family members may have different (and changing) roles in relation to the musical activities' expresses the flexibility inherent in this approach to practice (p. 158). The family-centred philosophy underpinning care in such contexts is often demonstrated in the therapist working with the resources and strengths of the family themselves (Rolvsjord, 2004).

In contrast, the particular complexities of working with 'looked-after' children[12] appears to bring a demand that roles are clearly delineated and understood (Hasler, 2008; Tuomi, 2017). Hasler (p. 170) stresses the importance of communicating to carers that they 'let the therapist be in charge in the session, setting boundaries and directing activities as appropriate'. The clarifying of roles is intended to mitigate against any potential behaviour difficulties and support the child's capacity to manage the experience of therapy.

In practice with children with developmental difficulties, emerging parental roles appear in relation to the child or child-therapist pair. The image of the parent as a bridge is used variously to suggest both connecting child and therapist (Oldfield, 2006; Kaenampornpan, 2017), and to support the child's explorations of their physical and social environment (Sorel, 2004; Loth, 2008). Sorel (p. 230) notes the 'evolutionary nature' of the parent's role, which emerges through the course of therapy. A therapist research participant is quoted as considering the parent's role in the following way; 'let's see what it is that it actually will be rather than defining it and losing her' (p. 230).

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[12] Children and young people who, for a variety of reasons, are unable to live with their birth families, are described as 'looked-after children'. According to the National Society for the Prevention of Cruelty to Children website, there were over 94,000 looked-after children in the UK in 2016. While the majority of children enter care due to abuse or neglect, the figures also include children and young people who are temporarily classed as looked-after when using short break or respite care services.

One such emerging role is expressed in the notion of partnership between parent and therapist.   The parent forms a 'creative partnership' with the therapist (Sorel, 2004, p. 110), becomes a 'working partner' (Oldfield, 2008, p. 20), or becomes the focus of the therapist's wish to 'promote a partnership' between the pair (Thompson, 2012b, p. 167).

There is a potential tension underlying these formulations. How might a parent understand themselves to be a 'working partner' if their role is emergent and evolves over time? Oldfield (2011) has worked to address this issue. While questioning whether she should 'say more to parents about what their role will be within the sessions' (p. 65), she acknowledges the practical difficulties of this:

> One reason why it may be difficult to spell out exactly what will happen before the sessions start is that parents' roles in sessions will vary from one family to another, depending on the needs of the child, and whether younger siblings join in. The needs of the parents will also vary greatly, and the progress of the session may depend on what a parent feels able to contribute. (Oldfield, 2011, p. 66)

Oldfield outlines the tension that may exist between the emergent nature of roles in improvisatory music therapy, and the need to manage parental anxiety and expectation at the start of therapy.

A View on Parental Roles from Neighbouring Disciplines

Crossing disciplines to play therapy and child psychotherapy provides further perspectives on managing this process when a child begins therapy (Bonner and Everett, 1986; Nevas and Farber, 2001; Nock et al, 2001; Cates et al, 2006). Attention to what Cates et al (p. 98) term the 'caregiver/therapist alignment' is seen as crucial. Preparing parents for their child's therapy can improve attendance (Cates et al, 2006), increase parental expectation of positive outcomes (Bonner and Everett, 1986), and enhance parental responsiveness to their child (Nevas and Farber, 2001). While the emphasis here lies less on establishing specific parental roles within sessions, the emphasis on preparation and clear communication between parent, therapist, and child within these disciplines may have much to offer music therapy.

2.7 Power and Perspectives within the Trio

Managing experiences of evolving roles and relationships within the trio can present particular challenges within music therapy practice (Woodward, 2004; Procter, 2005; Levinge, 2011). While parents might enjoy observing interactions between therapist and child, Woodward (p. 13) suggests that some 'may perceive this as undermining and threatening of their own parenting skills'. A new mother 'striving to establish her place' may, Levinge (p. 51) suggests feel her role further endangered by a therapist who appears to relate with ease to her infant. Musical play may also enable a 'change in power positions within the family' as roles and relationships are contested (Tuomi, 2017, p. 189). These texts allude to the issues of power that may be implicit within the trio. They also allude to power relationships which may be implicit in and around the trio, but questions of power arise more widely across music therapy. Rolvsjord (2004, 2010) deals with this issue explicitly through the framework of resource-oriented music therapy. Such an approach demands that:

> The therapeutic relationship should be a model of egalitarian relationships in general, and strive not to reproduce the power imbalances in society. (Rolvsjord, 2004, p. 105)

The institutional structures within which music therapy is offered, however, themselves manifest imbalances of power that threaten the therapeutic relationships with families. The hospital setting, for example, is described as a 'patriarchal system with many layers of power and hierarchy' by Baron (2017, p. 46), and as such it is perceived to have an impact on the music therapist's work with child and parent. Particular issues of power may also be resonant in practice with children and families at risk, where the role of the music therapist is specifically to 'observe, encounter, and assess the parent capacity and parent-child interaction' (Jacobsen, 2017, p. 200). The therapist can be seen as being part of a hierarchy of power, the role being complexified through the parallel intention to act as 'facilitator of the relation between parent and child' (p. 213).

Inequities of power may seep through institutional structures, but they can also be seen to reside in broader intersecting narratives of gender, sexuality, race, and ability. Recent years have seen an emerging body of music therapy literature examining the relations between questions of identity, power, and therapeutic process (Curtis, 2013; Hadley, 2013; Rolvsjord and Halstead, 2013; Halstead and Rolvsjord, 2015; Scrine, 2016). The extent to which such critical thinking is found in literature concerned with the clinical field of work with children, parents, and families is limited. Such literature

as there is addresses questions of gender and sexuality within the family in relation to music therapy practice (Pasiali, 2017; Teggelove, 2017). The changing nature of the conventional family unit is noted, together with a call for therapists to question assumptions and broaden perspectives accordingly (Pasiali, 2013). These suggestions are problematic in two particular ways. First, the implicit assumption appears to be that questions of identity, be they gender, sexuality, or other, belong solely with the family, rather than with the therapist, or in the dynamic between the two (Hadley, 2013). Second, in the therapist adopting a 'broad, inclusive perspective' (Pasiali, 2013, p. 223), issues of power might be assumed to be neutralised. Possibly the paucity of literature in this area signifies music therapy practice as rooted, particularly in terms of gender and in terms of 'deeply entrenched' institutional, cultural and societal structures (Scrine, 2016, no pagination), which remain largely unquestioned in everyday practice, or in its presentation.

The clinical area in which gender is addressed more specifically in the literature is that of practice within the NICU (Ettenberger, 2017a, 2017b; Mondanaro et al, 2016; Haslbeck, 2017). The NICU is noted, traditionally, as being 'matriarchal' in nature, (Mondanaro et al, 2016, p. 96), with attention focused on the health and wellbeing, as well as the relationship of the mother and baby. Fathers, in this context, are perceived to have been marginalised, in terms of both care-giving (Mondanaro et al, 2016) and receiving support (Ettenberger, 2017a; Haslbeck, 2017). The frequent need for fathers to return to work in order to support the family financially may preclude access to music therapy, often offered only within the working day (Haslbeck, 2017). This raises a question as to what the term 'family-centred care' means, whether within a NICU or, as in this study, within the CDS, and to what extent organisational structures, including those of music therapy, conspire to exclude or marginalise family members.

The author of an investigation of family-centred music therapy with parents and children with ASD acknowledges these issues, both in terms of practice and research (Thompson, 2012b, 2017b; Thompson and McFerran, 2013). Thompson, as therapist-researcher and first author, states her position thus:

> Musical interactions are intimate and personal, and so too are the relationships mothers have with their children. Throughout the study I reflected on questions and issues of power, control, and my role as a therapist. I continue to grapple with these questions, as they seem fundamental in a family-centred approach that respects the parent-child relationship.
> (Thompson and McFerran, 2013, p. 20)

Thompson comments on the intimate nature of the mother-child relationship. The majority of parents participating in the study were indeed mothers, but one father took part. What, then, of the father-child relationship? Is this to be understood as less intimate, or as being characterised by other qualities? While the author's consideration of roles and power inform the research approach and design, I would suggest that this example signals the extent to which assumptions of gender might inform thinking and discourse.

Within Thompson's study, sensitivities to power relationships directly inform practice decisions. By offering sessions within the family home, thereby 'casting the therapist in the role of the visitor, and the parent in the role of leader', Thompson (2012b, p. 84) suggests a means to mitigate, at least in part, imbalances in power. Rather than indicating fixed roles, Thompson appears to suggest a reflective therapeutic stance in which the therapist remains alert to issues of power within the trio. Gibbs (2005) proposes a similar stance in response to sensitivities of role in parent-infant psychotherapy. She describes 'putting the parents and their baby in the role of experts who are having to educate her into their ways of seeing and conceptualising their difficulties' (p. 74). The infant is ascribed an expert role within the trio, the therapist seeking to understand his or her particular 'way of seeing'.

Approaching practice with the intention to understand the 'ways of seeing' of another may present challenges in practice. Warren and Nugent (2010) note the following:

> Parents may be potentially biased in interpreting their child's developments, and have their own agendas and interpretations of their child's developments in sessions. Surveying parents' perceptions relies on the parents' understanding of what has happened in the music therapy sessions and of their child's developments. (Warren and Nugent, 2010, p. 27)

Examined in the context of understanding a parent's 'way of seeing', the stance here seems somewhat problematic. The authors appear to assume that the perspective held by the therapist holds greater validity than that of the parent, the 'agendas and interpretations' and bias of parents clouding perceptions. This is problematic inasmuch as it appears that the therapist is either free of bias, agenda, or interpretation, or, that these are to be privileged over those of the parent.

A subsequent question is raised by the authors concerning the use of language to describe events in music therapy. They comment:

> It was interesting to reflect on the words that parents used to describe what their child and they were doing in sessions, and how this may differ from how the authors would explain what was occurring. (Warren and Nugent, 2010, p. 28)

It is not, they suggest, the events themselves which differ, but rather the way in which those events are described. It raises a question of how events, and indeed experiences, within a music therapy trio of child, parent, and therapist might be described by those within it. This raises further questions about what parents and children might understand of music therapy: why they are attending, what participation might involve, and how it might evolve. As Jacobsen and Thompson (2017, p. 322) ask, 'does the family know what they are getting?'.

This question, to which I return later in the thesis, acts as the point at which I draw this part of the review to a close. I have, thus far, positioned the study within the historical and current bodies of music therapy practice and research literature, and that of related therapeutic fields. This has revealed the highly contextualised nature of music therapy practice and the relational work through which it appears. The review also suggests the ambiguous nature of the phenomenon of music therapy with a child and parent, as parental involvement, spoken or unspoken intentions of therapy, and the legitimising of voices are variously navigated. This study, concerned with the enactment of music therapy with child and parent, both emerges from, and is intended to contribute to, this body of literature.

The review turns now, though to a further literature set, relevant to the music-focused nature of this study. A guiding influence on my original conception of the music therapy trio was itself musical, in the form of a Mendelssohn piano trio (cf. Fig 1:1). Thinking musically gave me a way of considering practice. It also opened up a further body of cross-disciplinary literature as a further lens through which to investigate the enactment of the music therapy trio.

2.8 Exploring Musical-Social Processes

The practice-led nature of the study has a particular concern with the ways in which music therapy is done, in terms of the musical-social processes through which it

appears. In reviewing literature beyond music therapy, I use a further informing perspective from musicology and related music studies. Exploring literature particularly on performative processes within Western chamber music and jazz ensembles serves to illuminate further key issues in this study. The review considers material on ensembles ranging in size from duos upwards, and touching on literature concerning jazz groups. While the size of such jazz ensembles differs from that of the music therapy trio, a focus is not on the group size, but rather on the nature of the musical-social improvisatory processes at work. I begin, however, within music therapy literature, considering the conceptualisation of such processes. To do so, I focus on two particular areas, those of musicing and improvisation.

On Musicing and Improvisation in Music Therapy

I referred in the Introduction to Small's (1998) notion of musicking.[13] Key to Small's argument is the shift from noun to verb; music, he suggests, is 'not a thing at all, but an activity, something that people do' (p. 2). Its meaning is to be found in the ways it is enacted by and between people. As he comments:

> The act of musicking establishes in the place where it is
> happening a set of relationships, and it is in those relationships
> that the meaning of the act lies. (Small, 1998, p. 13)

It is in the turning outward of music, towards those who participate variously in it, that Small's ideas have found particular resonance in music therapy. Such resonance is most clearly found in literature concerned with music therapy as social action, and most notably within the discourse of community music therapy (Ansdell, 2002, 2014; Pavlicevic and Ansdell, 2009; Stige and Aarø, 2012; Wood, 2015, 2016; Ansdell and DeNora, 2016). In proposing a working definition of community music therapy in 2002, Ansdell explicitly aligns the two, noting:

> *Community Music Therapy* aims to develop theory consistent
> with its view of musicing as an engaged social and cultural
> practice, and as a natural agent of health promotion. (Ansdell,
> 2002, no pagination)

Given its egalitarian nature, the notion of musicing offered fitting support for the development of the broadened approaches to practice under the umbrella of

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[13] See page 16

Community Music Therapy. As such, the term has been variously appropriated and combined with other concepts, its uses denoting aspects of the musical-social work through which it is achieved.

The individual makes resourceful use of music in everyday life (Bonde, 2011; Batt-Rawden, 2013). Bonde (2011) draws on DeNora's (2007, p. 284) idea of the 'lay-therapeutic functions' of music, in proposing a 'lay-therapeutic musicking', while Batt-Rawden (2013, p. 53) coins the term 'self-musicking' to describe the individual engaging in musical activity with the intention to support their own wellbeing. Health musicking as a concept has found expression most fully in Nordic literature (Stige, 2002, 2012; Bonde, 2011; Trondalen and Bonde, 2012). Music therapy practice, Stige (2002, p. 200) suggests, is 'situated health musicking in a planned process of collaboration between client and therapist'. Beyond the therapy room, however, health musicking is understood as speaking broadly to the widest possible range of ways in which musical-social experiences promote health and wellbeing (Bonde, 2011).

Such health promotion may be at the level of the individual, but also across social groupings. 'Collaborative musicing' then becomes an 'outward and audible sign of musical community', of people doing music together (Pavlicevic and Ansdell, 2008, p. 364). Crucially, the essential characteristic of such musicing is its participatory nature. It is the quality and valuing of such participation that constitute what Ansdell and DeNora (2016, p. 171) term 'good musicking'. Musicing emerges from and also enacts an ethical attitude, summarised as 'collaborative respect in action' (Ansdell and DeNora, 2016, p. 172).

Within everyday music therapy practice, musicing frequently finds expression through improvisation (Pavlicevic, 1997, 1999, 2000; Aigen, 2001, 2009; Arnason, 2003; Wigram, 2004). Wigram (p. 33), in a comprehensive practical text on the subject, describes the practice of music therapy in Europe as being 'founded on a tradition of improvisation as a means to engage with people, and to build a musical relationship'. The musical and social appear to be separated here. Improvisation is understood as enabling two distinct intentions: the interpersonal, of engaging 'with people', and the building of a 'musical relationship'. Pavlicevic, drawing on an earlier paper on early parent-child interaction, resists the division between the two, suggesting that music therapy improvisation be understood:

> […] not as a "purely" musical event but as an interpersonal one
> (in the way that mothers and babies read one another's acts
> not as musical or temporal, but as emotionally expressive and
> communicative). (Pavlicevic, 2000, p. 275)

The intention of clinical improvisation, Pavlicevic suggests, is 'to create an intimate interpersonal relationships between therapist and client, through the musical event' (p. 272). The interweaving of musical and social within improvisation is further clarified by Arnason (2003, p. 134), who notes the 'co-created' nature of improvisations. Therapists, she argues, 'are not just producing music *for* their clients, they are *in* the music with their clients' (p. 134, italics author's own). The personal, social, and musical combine as people improvise together.

The 2014 paper by Macdonald and Wilson provides a useful overview of literature on improvisation within music therapy and its influence on health and wellbeing. The 'mechanisms' through which improvisation might bring about such benefits are, they note, not always specified in the literature reviewed (p. 6). They suggest two potential reasons for this: first, that authors often focus on 'demonstrating effectiveness of the intervention as a whole' (p. 7); and second, that difficulties arise in attempting to identify specific mechanisms, or processes.

Aigen (2005a, p. 51) refers to the 'mechanisms of music therapy process', which he suggests are to be found in the 'forces, experiences, processes, and structures of music'. He revisits these ideas in a subsequent paper (2009), in which he asserts the validity of rigorous analysis of musical material in music therapy, while firmly linking the musical with personal experience:

> […] it does not make sense to talk about music as an entity "in
> and of itself" distinct from the human experience of music.
> Aural phenomena of any type only become music in their
> interaction with the human mind. (Aigen, 2009, p. 264)

To talk about music is to talk about the person. The two, Aigen suggests, are inseparable. This line of inseparability is pursued further in community music therapy literature, specifically in terms of the indivisibility of the musical and social (Pavlicevic and Ansdell, 2004, 2008; Stige et al, 2010; Ansdell and DeNora, 2016). As Pavlicevic and Ansdell (2009, p. 366) succinctly put it, 'to separate the musical and the social does not make sense' when seeking to understand the complex interplay of processes through which group improvisation emerges.

Resisting the separation of musical and social underpins ways of looking at musical-social processes within this study. The intention is not to consider music within the music therapy sessions of child, parent, and therapist as separate from those who co-create it, either within or beyond the music therapy room. Given the improvisatory nature of music therapy in the practice investigated in this study, and the interweaving of personal, musical, and social, it is worthwhile to include here a brief survey on relevant jazz improvisation literature.

Considering the Jazz Ensemble

The intricate interpersonal and interactive processes within creative groups have been a particular research focus of the educationalist, R.K. Sawyer. Most notably, his focus has been on processes within highly creative groups, such as jazz ensembles or improvisational theatre (2003, 2006, 2012). It is the understanding of process in improvisational groups that makes Sawyer's writing of particular interest within the context of this study.

Sawyer's ideas on the complex interactive processes within groups have their roots in the concept of emergence. This term is used across a range of disciplines to refer to unexpected patterns and events that may arise out of multiple interactions within a system (1999, 2006). The emergent is seen to be highly contingent and unpredictable in nature, as described by the sociologist and philosopher G.H. Mead, cited by Sawyer (2006):

> The emergent when it appears is always found to follow from
> the past, but before it appears, it does not, by definition, follow
> from the past. (Mead, 1932, p. 2)

Sawyer (2006) proposes that emergence is evidenced in group performance in which it could be said that the whole is greater than the sum of its parts; that is, beyond the usual capabilities of any one individual, or collection of individuals, within the group. He adopts the term 'collaborative emergence' (p. 12) to describe emergence within creative groups. This, he suggests, is characterised by an inherent collective unpredictability, events arising through a constant evolving from what is past, met by an infinite array of creative possibilities which shape a present and, thence, future. Musicologist, Nicholas Cook (2014, p. 234), in a recent exploration of Sawyer's ideas, describes the notion of collaborative emergence as a model that is 'irreducibly social because jointly produced by the performers'. Sawyer (2000, p. 180) himself describes

the appearance of the emergent as 'a collective social process', developing in a later text his argument of how that social process might be enacted within a jazz ensemble (2006).

Jazz musicians, Sawyer (2006, p. 94) suggests, perform 'in the presence of an intersecting set of constraints'. These operate at various levels, including the social context of where, with, and for whom music is made; the overall genre of the music; the structure of the present musical work being played; and the influence of the "musical emergent" resulting from the performance up to the current moment' (p. 94). The finely tuned nature of this collective process is detailed thus:

> The ensemble is constantly suggesting and elaborating musical motifs, concepts, styles, and moods, and sometimes implicitly referencing other songs or other performances of the same song. To remain musical, the performer is required to perform something that retains musical coherence with the emergent. (Sawyer, 2006, p. 94)

In discussing the complex musical-social processes within the jazz ensemble, the work of ethnomusicologists Ingrid Monson (1996) and Paul Berliner (1994) predates and informs Sawyer's subsequent studies. Monson's study explores the function and practice of the rhythm section in particular, considering the ways in which interplay among members happens and is understood (1996). Berliner's exhaustive text draws on rich sources of material from interviews with jazz musicians to investigate the widest possible breadth of musical actions undertaken within improvisational groups (1994). Both authors describe specific terms associated with jazz, such as 'comping', described by Berliner (p. 315, italics author's own) as 'a term that carries the dual connotations of ac*com*panying and *comp*lementing' and 'striking a groove' (Berliner, 1994, p. 349; Monson, 1996, p. 26), through which the musical-social events within improvisation might be understood.

Crossing again to music therapy, Aigen (2013) examines such jazz concepts as comping and grooving and their potential relevance for music therapy practice and theory-building. His paper, building on previous writing by Pavlicevic (2000), argues the possibilities of bridging the domains of music therapy and jazz improvisation, suggesting that both include an:

> […] emphasis on process over product; the value placed on improvisation, spontaneity, creativity, intuition, and in-the-moment responsiveness; and, clearly differentiated and defined

> musical roles for participants that require a balance of freedom
> and structure. (Aigen, 2013, p. 1)

Aigen provides a template for considering jazz and music therapy improvisation in parallel that is valuable in the context of this study. Into this, I also add concepts from literature on musical-social processes within classical chamber ensembles.

Considering the Western Classical Musical Ensemble

The classical string quartet has long been the subject of investigation into musical-social processes from various academic quarters (Young and Coleman, 1979; Murnighan and Conlon, 1991; Davidson and Good, 2002). Psychologists Young and Coleman (1979, p. 12) presented the string quartet as being 'a particularly striking embodiment' of group processes. This they ascribe in part to the 'extraordinarily high level of co-ordination demanded from the group members' in order for the group to perform at an optimal level (p. 12). The collective nature of the ensemble's task of the ensemble is stressed further by Murnighan and Conlon, who say of the quartet:

> Their work is done only as a unit; they cannot perform a string
> quartet composition without all of the members working
> together simultaneously. (Murnighan and Conlon, 1991, p. 165)

The means by which such collective working is accomplished within the string quartet and other ensembles has been investigated in depth (Davidson and Good, 2002; Williamon and Davidson, 2002; Kokotsaki, 2007; McCaleb, 2011; Volpe et al, 2016). In an exploration of musical and social co-ordination within a student string quartet, Davidson and Good (p. 198) identify particular non-verbal gestures adopted by the group as a means to co-ordinate activity moment by moment. Music psychologist McCaleb (p. 4) also describes the non-verbal processes within a quartet through which players respond to what they see and hear, evaluating and adjusting their actions minutely in response. Almost instantaneous adjustments between performers occur as a result of both spoken and unspoken cues (Williamon and Davidson, 2002; Seddon, 2005). Williamon and Davidson (2002, p. 63), in a study of communication within piano duos, suggest that as familiarity with each other develops, players talk to each other less, their non-verbal cues, such as gesture and eye contact, becoming 'gradually more synchronous'.

The string quartet as an entity appears to pose particular issues in terms of power relations within the ensemble (Young and Coleman, 1979; Murnighan and Conlon,

1991; Davidson and Good, 2002). Each individual within the quartet can 'theoretically have one-fourth of the input' in terms of decisions relating to the musical or organisational running of the group (Young and Coleman, 1979, p. 169). Young and Coleman suggest, however, an underlying tension in this premise; the first violinist part might be conventionally perceived to be of greater musical interest, and might thereby allow for greater influence over the activity of the whole group. Murnighan and Conlon (1991) suggest another potential relational fault line within the quartet: that of its capacity to be divided into two numerically equal pairs. Within odd-numbered groups, such as the trio or quintet, 'intractable rifts are relatively unlikely to prevail' (p. 13), one or other pair holding a majority view when faced with performance decisions. Within the context of this study, this raised questions as to the ways in which the triadic nature of music therapy with a child and parent might be a stabilising or destabilising force, and how different pairings within it might exert influence.

Particular players may also assume, or be cast by the nature of the ensemble, into roles suggestive of certain responsibilities within the group (Young and Coleman, 1979; King, 2004; 2006; Kokotsaki, 2007). In an investigation of roles in three quartets while in rehearsal, King (2006, p. 262) suggests eight distinct roles which may be assumed by players: leader, deputy leader, contributor, inquirer, fidget, joker, distractor, and 'quiet one'. Players were perceived to change roles during rehearsal, to assume more than one role at a time, or to share a particular role with another player (King, 2004).

The instrument played may determine the performer's role within an ensemble, Kokotsaki (2007) suggests in a study examining perceptions of the ensemble pianist. The piano's harmonic, melodic, and rhythmic capacities suggest that the pianist often holds a 'regulatory function' (p. 657). This function, Kokotsaki suggests, is demonstrated by the pianist's rapid shifting of attention between his or her own playing, and that of others, in seeking to maintain the group's musical cohesion. Having sight of the full score may support the execution of this function, but it also differentiates the pianist from fellow players. This in itself raises questions of how such difference is experienced within the ensemble.

This study is concerned with the enactment of the music therapy trio of child, parent, and therapist. Literature addressing the musical-social processes within ensembles, and the means by which roles are negotiated and assumed within chamber ensembles provides a cross-disciplinary pool of theory and practice through which to understand

the music therapy ensemble. In doing this however, caution needs to be exercised, with terms or ideas not being transplanted without critical thought (Pavlicevic, 2000).

In referring to the full score Kokotsaki (2007) provides an example of difference that may need to be treated with caution in overlaying processes within the chamber ensemble on to the music therapy trio. Unlike the ensembles to which she refers, the music therapy trio does not use a printed score, nor is it concerned with the rehearsal and performance of pre-composed music. While the notion of the 'regulatory function' may be useful to consider in terms of how the trio comes into being, it is also essential to ask questions as to what, or who, might need to be regulated within the music therapy trio, and how, and through whom, that might be achieved.

Surveying the literature concerning processes within musical ensembles has offered a differently angled lens through which to consider the music therapy phenomenon of child, parent, and therapist. It has enabled ways of looking at musical-social elements beyond music therapy, adding, in turn, breadth and depth to the study. My intention, in making critical use of them, is not simply to appropriate concepts and ways of looking, but also to engage with them in such a way as to contribute further knowledge across disciplines (Pavlicevic, 1997).

2.9 Revisiting the Research Area

The range of literature considered in this review spans a broad spectrum. It has positioned the study in relation to current music therapy practice and research, highlighting aspects of thinking and practice that warrant investigation. Outlining literature from neighbouring therapeutic disciplines, as well as from the broader bodies of music and creativity studies, has provided further prisms through which to angle this enquiry.

The music therapy practice which is the focus of this study appears to occupy a middle ground among a range of overlapping discourses, disciplines, and practices. It takes place in the physical and cultural context of an acute hospital setting and balances, by its improvisatory, emergent nature, in a peculiar tension with the prevailing traditional biomedical model.

This service has involved parents in their child's music therapy in a range of ways for many years (Fearn and O'Connor, 2003; Flower, 2012; Wood et al, 2016). While at times driven by pragmatism, in terms of the necessity of a parent aiding their child's mobility or communication, other factors also shape parental involvement. These include the parental wish to see the child engaged in music therapy, the perceived benefit to the child of the parent's presence and participation in musicing, and the value of shared experiences in supporting the developing relationship between parent and child. The multi-faceted, dynamic nature of music therapy with a child and parent is evident within this particular music therapy service and reflected across the music therapy literature.

While the growing range of music therapy across a spectrum of practice is evident in the literature, some difficulties emerge. Often the detail of practice is unclear, leaving many questions unanswered: what do each of the participants 'do' in order to make the trio happen; how do the parent and therapist describe the experiences of the trio; and what specific techniques, if any, does the therapist find themselves drawing on? The suggestion by various authors that further exploration of the ways in which the relationship between therapist and the parent-child pair develops clearly signals the need for further research in this area (Edwards, 2011, 2014; Thompson, 2012b).

Inherent in a call for such research is a view of this area of clinical practice as essentially dyadic; that is, occurring between the therapist and child, or between therapist and parent-child pair. My contention is that music therapy with child and parent needs to be considered as other than dyadic; that is, it demands to be considered as a differently configured ensemble, co-created between those participating in it. This, I argue, is necessary for two key reasons. First, failing to question the dyadic model perpetuates a conventional therapeutic frame that does not appear to be reflected in everyday practice. Second, the continued assumption of a dyadic model constrains the potential for theoretical development in the field, which is problematic in terms of aligning theory with practice.

The intention in this phenomenologically-informed study is to step back from conventional understandings of practice and approach the phenomenon of the child, therapist, and parent in music therapy anew. The following chapter is an account of the Preliminary Study, methodology, methods, and data work, through which I pursued this aim stepping back from the familiar of everyday practice to explore the music therapy trio as it revealed itself. In it, I set out to understand how the experience of

music therapy was described by both therapist and parent, and how those descriptions might inform an understanding of the phenomenon. While the child's direct voice is absent in this process, for reasons that I address in Chapter 3, I sought to listen carefully for the child's experience and activity through the voices of parent and therapist. I also sought to investigate the musical-social processes within the trio, examining how an analysis of musical material might contribute to understanding the ways through which the trio comes into being.

Chapter 3 : Preliminary Study – The Music Therapy Trio

3.1 Introduction

This chapter details the activity and findings of the Preliminary Study. I outline the methodological grounding of the study, presenting the research stance and values. Following an account of the data work, I present and discuss the findings in relation to selected extant theory. Following the discussion I propose particular areas and questions considered to warrant further exploration, and the need to reconsider the research tools by which to do so. The chapter concludes with a brief consideration of the methodological strengths and challenges of this phase of the study, including discussion of the music therapy trio's ontological validity.

3.2 Methodological Perspectives

The Preliminary Study was an investigation of the phenomenon of what I notionally termed the 'music therapy trio'; that is, the trio created when a parent attends their child's music therapy. The intention was not to investigate developmental outcomes for the child or specific benefits for the child and parent attending therapy together. Rather, it was to explore the phenomenon of the trio as it showed itself in two particular ways: through descriptions of the experience of music therapy and an exploration of the musical-social processes through which the trio came into being.

The study was grounded in the following three research questions:

- How do a parent and therapist describe the experience of music therapy with a child in which a parent is also present?
- How might these descriptions inform an understanding of the phenomenon of the music therapy trio?
- How can an analysis of musical-social processes within the trio contribute to a greater understanding of the phenomenon?

The questions themselves signal the exploratory nature of this phase of the enquiry. I was concerned with stepping back from my familiarity with the phenomenon as a practitioner and cultivating a research stance that enabled me to approach the trio

afresh. This concern informed the methodological choices that were to underpin the whole enquiry.

Ansdell and Pavlicevic (2010) discuss Goethe's notion of 'gentle empiricism' as a research orientation particularly suited to explorations of practice. It is, they suggest, characterised by the paying of close and careful attention to the phenomenon itself in the setting in which it appears, and with as little interference as possible by the observer. This stance became a guiding principle for me in the study as a whole. My intention throughout was to seek to observe keenly and openly, attending to 'what is actually happening' as far as possible, while alert to my own preconceptions (Ansdell and Pavlicevic, 2010, p. 138).

I also intended to view the trio not as a fixed entity or finished product. Rather, my aim was to consider the trio as unfolding activity, with significant attention paid to the 'happening' of the activity. The physicist and philosopher Bortoft describes this perspective in terms of the natural world:

> A movement in thinking in which the position of attention is shifted from *what* occurs (downstream) into the *occurring* of what *occurs* (upstream). In particular, it is concerned with the happening of appearing.' (Bortoft, 2012, p. 95, italics author's own)

Within the preliminary study there were points at which my attention inevitably shifted downstream, with a necessary focus on 'what' happened. Orienting my attention to the 'upstream' as far as possible became a touchstone of my approach. This allowed the research focus to remain on the trio as an emergent, dynamic phenomenon.

To investigate the phenomenon of the trio in depth, I adopted a single case design. There is a strong tradition of case study research within psychology and the social sciences (Gomm et al, 2000; Smith, 2004; Smith et al, 2009; Yin, 2014). Smith et al (p. 30, italics authors' own) suggest that 'at one level, single case studies simply show us that (or how) something *is,* and can unfold this in an insightful manner'. Given the exploratory nature of this phase and the intention to observe the 'appearing' of the trio closely, this provided a suitable methodological fit.

Within music therapy research of practice with children and families, extensive use has been made of case study research. Cases may be either single or multiple and utilise a range of methods. These include the use of video analysis (Holck, 2004; Gilboa and

Roginsky, 2010), semi-structured interviews (Pasiali, 2012), and the use of parent journals and field notes (Sorel, 2004). The case study allows a flexible design frame, allowing methods to be shaped as appropriate to the area of interest.

Music therapists Smeijsters and Aasgaard define a case in the context of research as follows:

> […] a particular thing with functioning parts that is differentiated
> from its environment by boundaries and unfolds in the present.
> (Smeijsters and Aasgaard, 2005, p. 440)

While ascribing to the view of the trio as a 'particular thing', I did not intend to actively seek out the boundaries through which it might be differentiated, considering that such an approach might potentially close down emerging connections prematurely. Indeed, Yin (2014, p. 16) argues that case study research is particularly suitable when investigating a case 'in its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident'. My intention was not to separate the phenomenon artificially from the contextual realities of time, place, and person between and through which the case itself appears. I wished, rather, to understand the trio in the various contexts in which it showed itself.

My decision to adopt a single case design corresponded to the idiographic nature of the study (Smith et al, 2009). Understood as being 'concerned with the particular', the authors suggest that particularity lies not only in the detail of the specific case, but also in the surrounding contextual detail of people, time, and place (p. 29). By diving deeply into the particulars of a single trio, the objective at this point was depth of exploration, rather than a generalizable breadth, which is the hallmark of the nomothetic (Moses and Knutsen, 2012). As Ansdell et al note:

> The idiographic perspective serves not to guarantee
> generalizability, but to open up new areas of possible
> theoretical formulation, which can be subsequently worked
> through with other designs, perhaps with larger comparative
> samples. (Ansdell et al, 2010, p. 10)

My aim was not to suggest generalizability. Instead, I hoped to 'open up' to close empirical scrutiny the happenings of a single trio to enable new ways of looking at the familiar. In doing so, I planned to assume a 'dual focus method' (Ansdell et al, 2010). Ansdell et al argue for a parallel use of a detailed, 'bottom-up' inductive approach, taking empirical material as a starting point, and a 'top-down' abductive method,

exploring emerging material in the light of particular theoretical frameworks. In this study, the phenomenologically-informed 'upstream' orientation suggested an inductive stance, but I also intended to consider the emerging material in the light of extant theory, specifically that of collaborative emergence (Sawyer, 2003, 2006). I did not consider the two approaches to be mutually exclusive, but rather as allowing for a dynamic process between data and theory, in which both the fit, or lack of fit, would contribute to the research.

Considering Reflexivity and Epistemology

In making methodological choices, questions of reflexivity and positionality were brought to the fore, and require attention here. Reflexivity roots the researcher as not only inevitably linked to, but as an active catalyst in the area of research itself (Stige et al, 2009; Alvesson and Sköldberg, 2009; Edwards, 2012). This carries a responsibility for the researcher to actively consider their relationship both with what is being researched and also who it is being researched with. Stige et al (2009, p. 510) stress the need for the researcher to engage in a continuing process of self-critique, including inquiring into the 'assumptions guiding the research process'. This has meant recognising the ways in which my own personal and professional assumptions and values seeped into the assumptions and wishes I had for both this area of clinical work and for the study (Aigen, 1993; Edwards, 2012; Hadley, 2013). It has also meant acknowledging the multiple positions I have occupied within the workplace: researcher, practitioner, supervisor, and latterly manager, to name a few. More specifically, I have become aware of the privilege that those positions may confer in relation to research participants, colleagues, and families using the service (Muller and Gubrium, 2016). These issues have unfolded variously during the course of the research process, and my awareness of them has grown in response.

Questions of positionality do not only concern the researcher's relationship with the people, and place, of the study. They also necessarily extend to engagement with the research material itself, and the ensuing interpretative work. As Alvesson and Sköldberg note:

> There is no such thing as unmediated data or facts; these are always the results of interpretation. Yet the interpretation does not take place in a neutral, apolitical, ideology-free space. Nor is an autonomous, value-free researcher responsible for it.
> (Alvesson and Sköldberg, 2009, p. 12)

This view challenges a notion that the proposed inductive approach might offer an uncluttered access to data. It firmly contextualises the research process in either an institutional or ideological space. Moreover, the authors plant the researcher as an active and implicated partner in processes of making meaning.

Nor is the researcher the only party concerned with either generating, or making meaning of experiences. Smith (2011) outlines the active work of both research participants and researcher in his clear directive:

> Experience cannot be plucked straightforwardly from the heads of participants, it requires a process of engagement and interpretation on the part of the researcher. (Smith, 2011, p. 10)

Engagement can be understood as the researcher's continuing relationship with the area of interest or phenomenon (Stige et al, 2009). Here, I take engagement to refer more specifically to the quality of the encounter between researcher and research participant. In parallel with encounters in music therapy practice, there is a commitment to listening closely, attending to the detail of what is being said (or, in music therapy, played or sung), and how, and finding responses that enable a developing dialogue. The process of interpretation begins with such engagement and thus involves a double hermeneutic (Smith, 2004, 2011); that is, an intertwined interpretative process by which the researcher seeks to 'make sense of the participants trying to make sense of what is happening to them' (Smith, 2011, p. 10). It is through attending with care to the dual processes of engagement and interpretation that I understand it as being possible to work towards generating knowledge.

Considerations of interpretation, methodology, and reflexivity are all tightly connected with epistemological reflections (Carter and Little, 2007; Edwards, 2012). I favour the working definition of epistemology offered by Alvesson and Sköldberg (2009, p. 40), who describe it as 'questions concerning what and how we are able to know'. As Carter and Little suggest, engaging with epistemology is an inescapable part of research and inextricably linked with reflexivity:

> A reflexive researcher adopts a theory of knowledge. A less reflexive researcher implicitly adopts a theory of knowledge, as it is impossible to engage in knowledge creation without at least tacit assumptions about what knowledge is and how it is constructed. (Carter and Little, 2007, p. 1319)

In reflecting on this, I adopt a position from which I understand knowledge as being created within and between people, and being context-dependent, generated differently dependent on time, place, and circumstance. While different knowledge may be held by different people, my understanding in this study was that any new knowledge generated would emerge through the engagement of all those involved.

This is not to deny the value-laden nature of knowledge or the privileging of one kind of knowledge over another. In recent years, the notion of 'epistemic injustice' has gained traction within healthcare discourse (Fricker, 2007; Carel and Kidd, 2014). This can be understood as the lack of credibility perceived to be afforded to the experience and knowledge of patients by healthcare professionals. Conversely, professionals may be considered 'epistemically privileged' by patients and colleagues through the fact of training and perceptions of expertise (Carel and Kidd, 2014, p. 530). While relating specifically to healthcare provision, I would suggest it would be naïve to assume that similar injustices and privileges might not be present in the research arena. I was concerned to be alert to this possibility, given the potential power imbalances present in the healthcare context (Muller and Gubrium, 2016).

The epistemological and methodological approaches discussed to this point underpinned the study. Having grounded it in these terms, I move now to outline the data work itself, beginning with the activity of recruitment.

3.3 Research Ethics and Recruitment

All necessary approvals for the study were granted by the academic institution (Nordoff-Robbins Research Ethics Committee) and national and local (Chelsea and Westminster Hospital NHS Foundation Trust) NHS committees. I chose not to research my own practice directly, considering that a fuller investigation would be possible by exploring the trio from 'without' rather than 'within'.

For the purposes of ethical approval, the parent and therapist to be recruited were deemed participants, and a comprehensive assessment of potential risks, burdens, and benefits was completed. As researcher, I was also considered a participant and so included within the ethics approval process. The child, not being directly involved in the research activity, was not deemed (in the terms understood within the ethics

application process) a participant, but all due attention was given to issues of confidentiality and safeguarding.

The four music therapists employed within the service at the time were invited to participate by letter. Two indicated their wish to be involved, one of whom met the inclusion criteria and was recruited.[14] The parent whose child was having music therapy with the recruited therapist was then invited and recruited to the study. While it proved unnecessary, provision of interpreting services was made should the recruited parent wish to make use of them.   Participants were informed about the procedures for secure storage of data related to the study.[15] Ongoing governance of the research process was monitored by the institutions that held an interest in the study.

Recruitment to the study placed each participant, including myself, in new and potentially more complex roles in relation to each other and the service. Therapist and parent were no longer identified solely as provider and recipient of music therapy; they now shared roles as participants. This involved them in either altered or new relationships with myself and each other. The therapist, for example, voiced concern to me at recruitment that, as researcher, I might be privy to opinions expressed by the parent on a child's music therapy which she, as therapist, might not hear. This was a reminder of the potential power imbalances present both in therapy and in the researching of therapy, and of the need to 'take care that the interviews are beneficial' (Dreier, 2008, p. 50). It was important to acknowledge these concerns both at the time of recruitment and as the study progressed.

People and Place of the Study

In chapter 1 I introduced the institutional context in which the study is situated (cf. p. 17). I now zoom in further, both to describe the immediate physical surroundings, and to provide relevant background to the recruited trio.

Music therapy takes place in a large, well-equipped room within the CDS. It is next to clinic rooms used by other disciplines, which enables informal cross-disciplinary

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[14] The differentiated inclusion and exclusion criteria, information sheets, and consent forms are included as Appendix 3.

[15] Data in the form of audio recordings, written transcripts, and video material were stored securely in line with the guidelines of the host NHS Trust. These guidelines also governed the time frame within which research data was to be destroyed at the end of the study.

contact between practitioners, and occasional encounters between families and familiar staff.

Figure 3:1 Music Therapy Room within the Child Development Service

The music therapy room in the CDS (Fig. 3:1 above) contains two upright pianos and an extensive selection of other musical instruments. There are a number of chairs in the room and two large mats for sitting on the floor. On one wall is a one-way mirror, used occasionally by trainees, parents, and other professionals to observe sessions. On another, a wall-mounted bracket allows for the fixing of a video camera. It is in this room that the everyday business of music therapy practice takes place.

Barney,[16] the child in the recruited trio, was three years old at the time of the study. He has a diagnosis of global developmental delay, affecting all areas of his development, and has been known to the CDS since an early age. Barney was referred to music therapy when he was two and, following assessment, attended a ten-week course of individual sessions at the CDS. He subsequently attended a music therapy group in a local Children's Centre[17] before returning to the CDS for a further block of music

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[16] All names have been changed throughout the thesis to protect confidentiality.

[17] Children's Centres offer families with pre-school children a range of early years services. Funded by government and run by local authorities, their services are designed to improve health and education outcomes for children, provide support for parents, and be responsive to the needs of families in their locality. (https://www.westminster.gov.uk/childrens-centres)

therapy sessions. His mother attended every session with him, and the same therapist worked with them throughout.   Having the same therapist throughout was an unusual occurrence, as not all therapists in the service work both on the CDS site and in community settings. At the time of the preliminary study, therapist, child, and parent had known each other for approximately one year. The trio were recruited to the study towards the end of the last block of sessions.

In the following section I outline the methods used in addressing each research question. Although addressed separately here, there was in fact significant crossover between questions and methods, which became apparent in the analysis phase, and which I address later.

3.4 Data Collection

Investigating Experiences

The semi-structured research interview has long been the method of choice within qualitative research for investigating human experience (Smith and Osborn, 2003; Larkin and Griffith, 2004; Smith et al, 2009). Smith and Osborn's description of it as a 'co-determined interaction' alludes to its inherent flexibility; new areas of interest can be explored as they arise from dialogue between researcher and participant (p. 57). Music therapy researchers have made substantial use of the format (Arnason, 2003; Elefant, 2010; Lindenfelser et al, 2008; Thompson and McFerran, 2013). Lindenfelser et al recount the interview process through which the researcher sensitively follows the parent's lead as they describe experiences of music therapy with their child as the child nears the end of life. The flexibility of the method described confirmed it as a model suitable for this study's exploratory nature.

To this point in this thesis, the trio has been described as child, parent, and therapist. The child, however, has not been deemed a participant in the study, and the first research question does not suggest an intention to explore the ways in which the child describes the experience of music therapy. Some clarification is helpful here. The majority of children attending music therapy within the CDS have significant difficulties with verbal communication and cognitive functioning. It was extremely unlikely that the child recruited for the study would be able to describe verbally his experiences of music therapy, as was indeed the case. Had the child been able to participate, any ethical and therapeutic implications would have been considered through dialogue with child,

parent, and therapist. Given the child could not be directly involved in the research process, I was, however, concerned that his voice be included as fully as possible in the study. I imagined that this may happen in part through both parent and therapist describing their perceptions of the child's experiences at interview.

Video in Research: The Video Elicitation Interview

As part of everyday practice within the service, therapists make regular video recordings of sessions, the frequency of recording agreed in discussion with parents. Video material may be reviewed by therapists in supervision, and watched with parents at the end of a child's course of therapy. Given the uses made of video in practice, and the intention to keep practice focal in the study, I decided to use video as a specific research tool. The semi-structured interviews were intended to generate opportunities for participants to discuss and describe their experiences as freely and in as much detail as possible. I wondered how watching video of the trio in music therapy might add further substance to the interviews. Could the viewing of video guide the direction of the interview to some extent, the visual material offering a springboard for discussion?

There is a growing use of video technology within qualitative research (Heath et al, 2007; Heath et al, 2010; Henry and Fetters, 2012; Jewitt, 2012; Knoblauch, 2012; Luff and Heath, 2012). The use of video often serves as an adjunct to other qualitative methods in studies which investigate how events or interactions occur. For example, Heath et al combined video and conversation analysis in an innovative study of interactions within healthcare settings. The resulting method, they suggest, allows for:

> […] the detailed scrutiny of activities and events as they arise within actual, practical situations and provides the opportunity to explore the ways in which health care is accomplished within everyday organisational environments.' (Heath et al, 2007, p.114)

Within music therapy research concerned with children, there is also reference to the use of video material as research method (Holck, 2004, 2007; Holck et al, 2005; Haslbeck, 2013b, Vlachova and Collavoli, 2014). Video is primarily analysed by the researcher as a means of investigating participants' activity. Holck's 2007 paper, for instance, illustrates the effective use of video analysis within an ethnographically informed study of interaction within music therapy. A number of studies use video as a means to generate further data (Sorel, 2004; Strange, 2014). Sorel, in a comparable study of music therapy with a mother-son pair, selected and incorporated video

extracts into interviews. As she notes, 'the excerpts helped to provide a structure for the interviews and our discussions and seemed to enable the participants to remember particular events more clearly' (p. 35).

Sorel's research foreshadows later developments in the use of video in qualitative research, notably in the concept known as VEI, the Video Elicitation Interview (Henry et al, 2011; Henry and Fetters, 2012). Defined as 'a method in which participants are interviewed about an event while watching and reflecting on a video-recording of that event' (p. 934), VEI has been developed largely as a tool for studying interactions between medical practitioner and patient. Henry and Fetters (2012, p. 119) document three main areas of participant experience that emerge through video elicitation interviews: recalling, reliving, and reflection. Participants, they suggest, might recall thoughts and feelings experienced during the recorded event; they may relive it, even displaying bodily or emotional responses to events shown; and they may also reflect on the actions and thoughts of themselves, or others, at the time of the event.

In this study, the VEI offered an apposite framework through which to uncover the participants' experiences in depth. It expanded the conventional semi-structured interview model, allowing everyday music therapy practice to remain in the foreground. Viewing a session in which both parent and therapist also participated focused each interview on a single shared event, linking the differing perspectives of participants. In selecting the particular video recording to use at interview, my intention was to select the recording of the most recent session (Henry and Fetters, 2012). Owing to technical difficulties with recording equipment during the course of therapy, only one complete session had been recorded with this particular trio. The available video then became the basis both of the video elicitation interviews and the study's later phases.

Neither myself nor the therapist, nor the parent viewed the video prior to interview. Rather than purposively selecting extracts, my intention at this stage was to remain as open as possible to emergent material. Using a complete session without prior viewing offered the most helpful way of achieving this, ensuring the focus remained 'upstream' without prematurely closing down potential areas of interest (Bortoft, 2012).

Following recruitment, therapist and parent were invited to meet me for separate research interviews. I had chosen not to meet with them jointly, with the thought that the presence of the other might inhibit, rather than encourage, conversation. Interviews took place three and seven weeks, respectively, after the recorded session,

which was itself the final session in a scheduled block of sessions. Figure 3:2 provides the timeline of this process. The timeframe was determined due to planned holidays.

Figure 3:2 Timeline of Data Collection

The interviews took place in the familiar music therapy room, the furniture arranged in such a way as to enable discussion, while also ensuring that the laptop screen on which the video played could be seen easily. The use of the laptop routinely used by the music therapy service was deliberate; all parties had previously viewed video material on this screen, which was adequate in size and sound quality. While working to ensure both research participants felt as at ease as possible, there were unavoidable factors which contributed to inevitable differences in their experience. Both participants, for instance, had different relationships to the setting of the music therapy room in which the interviews took place. The familiarity of watching themselves and discussing music therapy video material also differed between them. These differences were acknowledged in discussion with both participants.

Each interview was planned to last for no more than one hour and was audio recorded. Participants were reminded of the intention of the interview, which was to find out about their experiences of music therapy. The participant was invited to watch the session video recording with me, and was asked to pause the video at any point in order to make any comments that they wished. The timing of each pause point was noted in order to generate a further data set, to which I return shortly.

Given the exploratory nature of this study, the invitation to participants to comment on any aspect of the video was deliberately broad. A sample transcript of the start of the

interview with the therapist is included in Table 3:1.[18] This demonstrates the way in which the researcher, identified as CF, introduces the scope and format of the interview to the therapist, and the means through which the therapist seeks clarification. All participants' names have been changed throughout. The therapist is referred to as Laura and the child as Barney. The parent remains anonymous, although she is often referred to as Mum.

CF – What we're going to do today is just to find out a little bit about your experiences.

Therapist – Mmm

CF – Really, it's about what it's like for you being in music therapy with Barney and his Mum. And what we're going to do is just watch some of the video and I'm just going to ask you to pause it, stop it, and whatever the easiest thing to do is, it's probably just to hit the pause…

Therapist – Yeah

CF – At any point that you want so just to say anything that comes to your mind.

Therapist – OK

CF – About what you're seeing right now, or what it reminds you of, or, or anything at all.

Therapist – Mmm. OK. I don't know, do I need to give you any kind of details about, kind of background or anything, or is that just if it comes up?

CF - Well I was just going to ask you, perhaps as a way of starting, whether you can just say a bit about how you came to, to be in this session I suppose, how you came to be in music therapy with Barney and his Mum anyway? And you can give me as much or as little detail on that as possible, but maybe that's a good place to start?

Therapist – Mmm yeah, yeah, just to give some background. So Barney's a little boy who I've seen quite a lot of over the past year or so. So I was involved in his initial assessment when he was referred here to the core service, and then picked him up off the waiting list for a block of individual sessions.

Table 3:1 Sample of Therapist Interview Transcript

The course of discussion was subsequently guided by the participant's responses to the viewing of the video recording. Clarification of comments was requested at times, or supplementary questions were asked to elicit fuller responses from participants.

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[18] In this and subsequent uses of quotations from interview transcripts, the text is generally presented without the inclusion of conversational idiosyncrasies such as hesitation or repetition which are present in the original audio recording. These are included where deemed necessary to convey particular meaning, but otherwise removed for ease of reading.

Reflections on the Interview Process

The video elicitation interviews evoked a wide array of responses in me. In part, these were triggered by my familiarity with viewing and talking about music therapy video as a practitioner, colleague, and supervisor. My 'looking' as researcher was intimately bound up with these roles and relationships.

For example, as a practitioner and supervisor, I was immediately engaged by the music therapy work in the video. My attention was partly focused on the child, whom I had not previously met: his physical appearance, his smile, his level of disability, and his musical presence. I was also aware of my immediate responses to the activity of the practitioner, evaluating these in the light of my reading of the child. As the colleague of a therapist for whom at the time I had no managerial responsibility, the interview offered a rare opportunity to sit, undisturbed, to look at music therapy practice in depth together. Given the network of roles within the music therapy team, I was aware that, at another point in time, we might have viewed the video together within the context of a supervisory relationship.

From the perspective of researcher, I had further responses. These included an immediate one of disappointment in the quality and framing of the recording itself, in which faces were not always fully in view. This was an unforeseen consequence of using video material recorded as part of everyday practice within the service, rather than being specifically positioned for the purposes of the study. I return to this issue later, noting it here as a significant part of the jumble of responses within the research interview.

The video elicitation interviews triggered a growing awareness in me of the complex ways of looking which the interview method engendered: multiple layers of activity and interactivity appeared, both within the video of the event, in the interview itself, and in the dynamic relationship between the two. I noted my experiences of this multiplicity following my interview with the parent in the reflective journal I kept (Table 3:2).

I am aware of the various levels of observation going on here.
I notice myself observing….

- In (music therapy) session – parent watching child.
- In interview – parent on herself watching child in session.
- In interview – parent comments on child in session watching therapist.
- In interview – researcher watches parent in session.

In interview – researcher also notices parent noticing things.

Table 3:2 Sample of Journal Notes Following Interview with Parent

My reflections at the time hint at the complexity, not only of the interview method but of the trio itself. Indeed, through the interviews the trio began to reveal itself as a multi-layered, intricate phenomenon, warranting research attention.

Considering Microanalysis of Video Material

In addition to the interview process, and in response to the second research question, I planned to explore how an analysis of musical-social processes might further an understanding of the trio. To do this, the primary data of the session video, viewed in interviews, was used. A series of analytic steps, described in detail later in this chapter, precedes microanalysis of a short extract of video.

Microanalysis is defined by music therapists Wosch and Wigram (2007) as:

> […]a detailed method investigating microprocesses.
> Microprocesses are processes and changes/progressions
> within one session of music therapy. (Wosch and Wigram,
> 2007, p. 22)

Utilised particularly in exploratory studies in music therapy research, Trondalen and Wosch (2016) note three distinct forms of interpretivist microanalysis. They suggest video microanalysis, in which the video material is of primary interest; music microanalysis, where music is the main focus; and text microanalysis, using spoken or written words as the subject.

The intention in selecting and subjecting an extract of video to microanalysis was twofold: it offered both a means by which the child's activity in the trio could be directly investigated, while investigating how this method might amplify an understanding of the trio, specifically when combined with the IPA-led analysis of interview material. The governing factors in selecting an extract and determining the 'right level' of analysis

were not fixed at this stage (Pavlicevic, 2010). Rather, they were understood as emergent design processes, developed in response to the data gathered (Aigen, 2005b).

While decisions of levels of analysis were pending, the underlying objective for employing microanalysis could be clearly articulated. Lee (1992, 2000) argues forcefully for the imperative in music therapy research of rigorous analytic processes, stating that:

> The investigation of musical components within therapeutic improvisation holds the essential key for fully understanding the music therapy process itself. (Lee, 1992, p. 79)

Some years later, Pavlicevic (1999, p. 48) critiqued Lee's position, providing a frame through which to close what she terms the 'unsatisfactory gap between the musical event and its personal/therapeutic meaning'. She suggests that if improvisation in music therapy is considered as '"more than" a musical event' then:

> […] an analysis needs to be generated that (i) acknowledges and attempts to represent the interface between the musical and personal by drawing from both musical and inter-personal /psychological contexts and (ii) presents the musical and the psychological as compatible, rather than competitive, mutually exclusive discourses. (Pavlicevic, 1999, p. 48)

A contemporary perspective on the question of analysis is offered by the musicologist, Cook (2014). He argues for a shift in analytic approach from one that studies 'music *and* performance' to one that considers 'music *as* performance' (p. 4, author's own italics). The more traditional musicology approach to analysis of 'page to stage' could, or even should, he argues, be reversed, using performance as a lens through which to understand the written score.   As John Eliot Gardiner, choral conductor writes:

> The analysis of musical structure has its uses, but it gets you only part of the way: it identifies the mechanical bits, and describes the component engineering, but it doesn't tell you what it is that makes the motor purr and hum.' (Gardiner, 2013, p. xxxiii)

These authors, from different disciplines, appear closely linked in their concern for what I consider a music-in-action approach to an analysis of the musical score. The wish to view the trio as a dynamic interplay of musical-social processes, to find the 'purr and hum' itself, informed my approach to the microanalysis. I was aware that, in the

process, I hoped to notate the activity of a session section, as recorded on video. While making every effort to notate elements as faithfully as possible, a written score would inevitably emerge as my own interpretation of the events I saw and heard. I hoped to ensure that the analysis might interact with the perspectives of those within the trio, as expressed at interview, in a fluid exchange between page and stage. The hope was that, in so doing, the study's scope could be expanded, enabling the two research questions, and various methods, to speak to each other and offer a rich account of experiences and processes within the music therapy trio.

3.5 Data Analysis

The Preliminary Study's design and research activity were anchored in the primary research questions:

- How do a parent and therapist describe the experience of music therapy with a child in which a parent is also present?
- How might these descriptions inform an understanding of the phenomenon of the music therapy trio?
- How can an analysis of musical-social processes within the trio contribute to a greater understanding of the phenomenon?

The questions were addressed through two parallel streams of analytic activity: thematic analysis, informed by IPA, of the data gathered at interview, and microanalysis of existing clinical video material. Figure 3:3 provides a guiding diagram of the data work activity. It indicates the activity's sequential steps, illustrated with brief descriptors. I refer to the various steps in order to guide the reader through the following account.
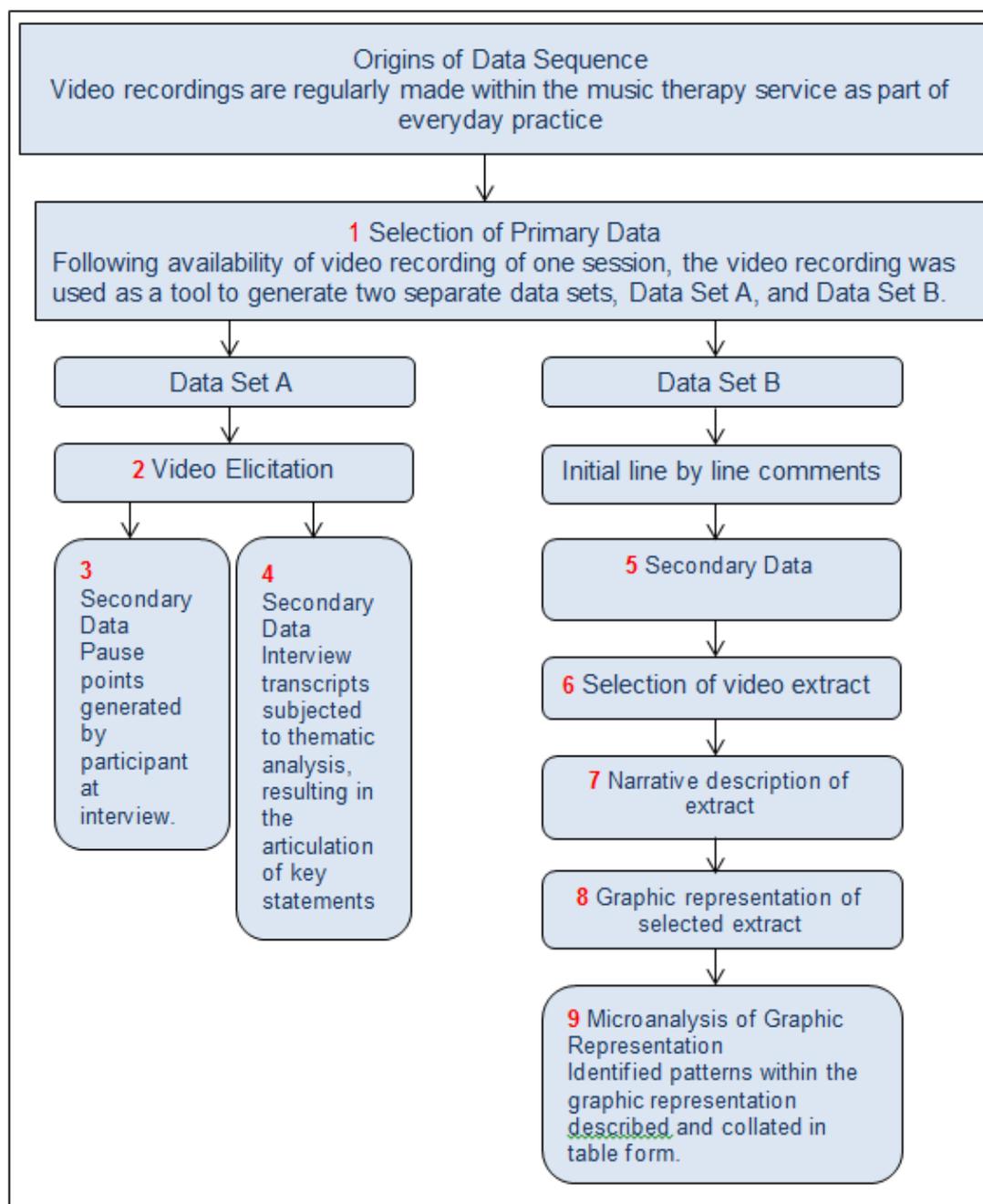
Figure 3:3 Origins and Sequence of Data Activity

Origins of the Data Sequence – Video Material

As noted above (Fig 3:3), the everyday recording of music therapy in the service provided the originating video material from which the ensuing data work followed. A full descriptive account of the video of the available session was completed at step 7 (marked in red), and is included as Appendix 4. I include here a brief descriptive overview of the material, as a means of further contextualising the trio and the subsequent account of the data work (Table 3:3).

On arrival, the mother places the child in a sitting position on the floor mat, putting his glasses on and talking with the therapist about the child, as she and the therapist also sit down on the mat. The therapist sits in front of the child, the mother just behind and to his left.

The therapist begins to strum one guitar, and sings a hello song, while the child plays with a second guitar which lies on the floor. She adapts her singing in response to the child's vocalisations, and his guitar playing. Together they engage in an extended period of vocal and guitar play, which the therapist draws to a close, moving the guitars away.

The therapist initiates a period of play with the tambourine, moving the instrument between the three of them, singing as she does so.

Drawing the tambourine play to a close, the therapist brings a large floor drum towards the child, and stands up to take beaters from a box. An extended period of improvised play follows, in which, at different times, each of the three players use hands as beaters to play the drum, the therapist and mother also singing or speaking at various points. The therapist picks the guitar up at one point, which appears to draw the child's attention away from the drum. He continues to play with both instruments, shifting his gaze between them.

The therapist introduces a box of smaller instruments, moving the large floor drum away as she does so. As the child plays predominantly with a hand bell from the box, the therapist uses her flute to accompany his play. At one point, the child, parent, and therapist all play with bells before the therapist initiates tidying up. This activity takes some time; both the therapist and mother spend time encouraging the child to place instruments in the box independently.

A period of play with the large ocean drum follows. The mother appears to observe rather than participate, and the activity takes place between the therapist and child. Both parent and therapist notice that it is nearly time to finish the session and negotiate a move to the piano, the parent lifting the child while the therapist organises chairs. The mother sits at the treble end of the piano with the child on her lap, the child immediately beginning to play clusters with both hands on the keyboard. The therapist sits towards the bass, and begins to improvise with the child's playing, before shifting the music in to the familiar goodbye song. As the song ends, therapist and mother talk briefly while the child continues to play.

Table 3:3 Descriptive Overview of Session Activity

The session recorded on this video acted as the basis for the Video Elicitation interviews (VEI) and the microanalysis process. Two data sets, A and B, emerged from these processes, the analysis of which is now reported in detail.

3.6 Data Set A
Adapting IPA Analytic Methods

The preliminary study focused on gaining an in-depth understanding of the participants' experiences and the particularity of the single case. Given this focus, Interpretative Phenomenological Analysis (IPA) was used as a congruent theoretical frame for data analysis (Smith, 2004; Smith et al, 2009; Smith, 2011). IPA's focus on the lived experience and the meanings of experiences for individuals, together with its

idiographic nature and flexibility of method, suggested it as an appropriate method, well aligned with the purpose of the study (Smith, 2011).

The analytic process did, however, differ in a number of ways from conventional IPA methods. The use of video differentiated the interviews from the semi-structured model suggested by Smith and Osborn (2003, p. 55). Smith et al (2009) also suggest IPA is best suited to investigating experiences across a homogenous sample of participants, enabling clear identification of areas of consonance or dissonance. Exploring the experiences of a parent and therapist inevitably made differing perspectives a central feature of the study. The sample's homogeneity could be considered to lie, if anywhere, in a shared involvement in the event of the music therapy trio (Smith et al, 2009, p. 49). These incongruities were acknowledged as part of this study's particularity, and were not considered as an obstacle to the use of IPA.

Video Elicitation Interview: data collection and analysis

The available video formed the basis for the VEIs (Fig 3:2, step 2) described previously (Henry and Fetters, 2012). At separate interviews, each participant watched the video in full, being invited to pause the recording at any point to comment on any aspect of it.

At interview, timings of pause points were noted to the nearest second, creating a secondary layer of data (Fig. 3:2, step 3). These timings were gathered with a view to their potential value in the subsequent selection of one or more extracts of video for microanalysis. My own reflective notes also offered a means of catching my own immediate responses after interviews.

Following each interview, I transcribed the audio recordings using Transcribe® software, which allows audio material to be significantly slowed without dropping in pitch. The process of transcription itself is described by Smith et al (2009, p. 74) as 'a form of interpretative activity'. Details such as repetitions, incomplete words, pauses or laughter all carry potential significance in the grasping and conveying of meaning. While alert to this, Smith et al recommend that a clear, written representation of verbal material provides an adequate level of detail for IPA (p. 74). I took this as a guiding principle in the transcription process. Examples of both transcripts are included as Appendix 5.

Drawing on IPA guidance, I read the material repeatedly, familiarising myself with content and language styles. My intention was to approach the material in as open a manner as possible, allowing initial impressions both on what was expressed, and the ways in which it was expressed, to arise. I made free, initial comments on the text, working line by line, and aiming to 'produce a comprehensive and detailed set of notes and comments on the data' (Smith et al, 2009, p. 83).

Throughout the analysis I moved between the two transcripts. In this too, my method diverged from a conventional IPA approach, in which each case is analysed in depth before the next is begun (Smith et al, 2009, p. 100). I had chosen to view the music therapy trio of child, parent, and therapist, considering each individual as part of the larger, overall unit (Aigen, 1997; Sorel, 2004). Moving between transcripts allowed the differing, yet interconnected, perspectives of parent and therapist to emerge, enabling a sense of the trio as a whole to appear.

I include below samples of the initial, freely written comments written by myself against the respective lines of the interview transcripts firstly from the therapist (Table 3:4), and then the parent interview (Table 3:5). In each example, line numbers match the line numbering system in the transcripts. The abbreviation Th. in Table 3:4 refers to the therapist.

212 Barney might find structured play too much. Question of waiting for turn?
213 Or having found something you really like
214 Suggests Barney might withdraw focus
215 suggests reason for withdrawal of focus – too difficult for Barney
216 Easier for Barney to take turns, share with 'familiar' mum or Th. Will come back
217 Feeling of a tightrope with him
218 When will it be too much for him or frustration too great
219 Wonders whether ok for Barney if Mum and Th can play. Not being sure in first
220 sessions if that would feel ok for Barney.

Table 3:4 Sample of Line-by-Line Comments from Therapist Interview Transcript

50 Recalls remembering in session noticing this change
51 Also comments on the detail of the way he is playing the guitar
52 Observes that this has developed in MT
53 Links it 'we' trying to work on his fine motor skills – who is we?
54 Describes in detail changes in his play, towards more intentional play
55 Comments on his thinking process 'he's worked out'…
56 Links Mt play with home, doing it at piano at home
57 And playing ukulele at home
58 Her feeling of it is 'it's really lovely'.

Table 3:5 Sample of Line-by-Line Comments from Parent Interview Transcript

Initial Groupings

Working across the two sets of initial comments (Fig.3:3, step 4), I drew each set into broad, and extremely loose groupings. This enabled me to begin an exploratory, broad-brush sweep across the material, which at this point was largely content-driven. The groupings are indeed reflective both of my understanding of the content being expressed in any one line and the ways in which that content was expressed.

'Reflecting' and 'recalling' are two of three distinguishable types of responses commonly noted in analysis of VEI material (Henry and Fetters, 2012). I have used these as two of the headings while also adding a further grouping which I term 'describing'. This includes providing background information which supplements and contextualises the video material. The third response noted by Henry and Fetters (2012, p. 119), 'reliving', is described by the authors as someone showing 'physiologic or emotional changes in response to the events in the video recording'. While watching the video, the parent tapped her foot in time to the music, smiling as she watched herself and the therapist laughing together on the recording. An equivalent demonstration of reliving the experience was less evident in the therapist interview. I have chosen not to include this as a specific grouping in the Table below (Table 3:6).

Interview – Therapist	Interview – Parent
Describing: Background information Activity and content of sessions Relational work with parent Liaison with other CDS professionals Physicality and positioning of mother and child in the session	Describing: Background information Activity and content of sessions Child's development Activity of the therapist Home and family life Links between music therapy activity and everyday musical activities Links with other CDS professionals Physicality and positioning of the child in the session
Reflecting: On the parent's experience of music therapy On the child's experience of music therapy On activity of sessions, and her own decisions	Reflecting: On the child's experience of music therapy
Recalling: Reflections from within the session itself, prompted by video watching Relating previous events to the present	Recalling: Reflections from within the session itself, prompted by video watching

Table 3:6 Initial Groupings from Interview

While the process of grouping the initial line comments in this way was not, in itself, to be of any great analytic significance, it did bring to light two previous aspects of interest. First, it revealed a particular linguistic ambiguity in the use of personal pronouns in the transcripts.   For example, the therapist comments that 'things have opened up a bit in terms of the way that we can play together' (Th, 175), or the parent notes 'at home we've been practising this' (P, 201).[19] Phrases such as these contain an inherent ambiguity. To whom, exactly, is the pronoun taken to refer? For instance, does the 'we' of which the therapist speaks, include only herself and the child, or is it taken to mean the parent as well? Equally, who is the 'we' at home who has been practising? It was unclear to me whether this included the father or only mother and child. In these instances, and others like them, I found that further contextual detail was needed in order to make the meaning explicit (Sawyer, 2006). While uncertain of its significance at this point, the ambiguous nature of such language suggested to me that the trio may be characterised as shifting and fluid in nature.

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[19] In this chapter, and throughout the thesis, quotations from the therapist or parent interview are referenced by either Th or P, followed by the line number in the transcript.

This was emphasised by a second feature of interest. The material in both transcripts circled between discussion of individuals, pairs, and the three as a whole. While both therapist and parent spoke of their own experiences, they discussed not only the other individuals but also the three possible pairings within the room; that is, the pairs of child/parent, child/therapist, and parent/therapist. A further layer was added in material addressing the trio as a whole unit. The varying perspectives of parent and therapist began to become apparent, suggesting the trio to be a multi-faceted phenomenon.

The ambiguity of language, together with the complexity of the emerging narrative, began to suggest the web of relationships, roles, and activity within the trio. This raised, for me, a question as to the extent to which complexity might be revealed to a greater degree through the use of video at interview, as opposed to a more conventional interview format. The VEI may allow opportunities for participants to register occurrences, interactions, and thoughts which may not have been noticed at the time of the event itself (Henry and Fetters, 2012, p119). This enabled the interviews to remain 'upstream' in their perspectives, the use of video offering a focus on the new or renewed appearing of the trio (Bortoft, 2012). Richness was evident in the transcripts, which emerged as a composite of experiences and activity from both within the session and the subsequent reviewing at interviewing of video material at interview.

An Emerging Umbrella Focus

From my evolving understanding of the ways in which both therapist and parent circled between discussing individuals, pairs, and the whole trio, I became interested in using the ideas of the individual, pair, and trio as an umbrella under which to categorise material drawn into these configurations. While ultimately I did not pursue this line of enquiry further, for reasons which I explain shortly, I include here a brief summary of this activity as part of the analytic process.

Close reading of the data suggested that both research participants described and discussed individuals (including themselves), each possible pair, and the trio itself. As an analytic exercise I therefore grouped the material and articulated statements in each area (Table 3:7).

The table's left-hand column lists what I have termed the Umbrella Focus, by which I mean the attention being paid by participants to the individual, pair, or trio. The second column indicates towards whom attention is directed. The two right-hand columns

present the resulting statements, first for the parent and, on the far right, for the therapist.

Umbrella Focus	Attention Directed Towards…	Statements – Parent Material	Statements – Therapist Material
The Individual within the Trio	The Child	Identifies the developing skills of the child in a range of areas	Identifies the developing skills of the child in a range of areas
		Reflects on the emotional experiences of the child	Reflects on the emotional experiences of the child
		Identifies areas of difficulty for the child	Identifies areas of difficulty for the child
	The Parent	Describes the emotional impact of her experiences	Reflects on the experiences of the parent
		Reflects on the parental role within sessions	
	The Therapist	Reflects on the role of the therapist	Reflects on the musical actions and impulses of her role as therapist
			Questions and reflects on her practice as therapist
Pairs within the Trio	Parent and Child	Reflects on the parent / child relationship within the session	Reflections on her observations of the parent / child pair
	Therapist and Child	Observes and comments on interactions between therapist and child	Identifies her emotional responses to the child in her role as therapist
	Therapist and Parent	Reflects on the therapist's involvement of herself as parent	Reflects on aspects of the relationship between therapist and parent
The Trio	Child, Parent and Therapist	Reflects on the functioning of the three together	Reflects on the functioning of the three together

Table 3:7 Statements under an Umbrella Focus

The statements, as articulated in Table 3:7, presented some difficulties in terms of analytic level. They appeared largely descriptive in style, lacking at this point a level of questioning taking them beyond the 'superficial' (Smith et al, 2009, p. 90). While they serviced to identify and group together the content discussed by both parent and therapist, they did not contribute an in-depth understanding of the ways in which the individuals described their experiences in music therapy. Nor did they serve to keep an 'upstream' focus on the appearing of the trio, focusing attention more firmly on *what* occurred, than, as Bortoft (2012, p. 95) suggests, 'the *occurring* of what occurred.

Clearly separating the individual, pair, and trio seemed to compound this difficulty, threatening to reduce the richness of the transcripts into over-simplified and concretized statements. These, then, did not faithfully reflect the complexity of the experiences being described. Moreover, in casting material into its component parts, my wish to keep a sense of dynamic connections between those parts and the phenomenon as a whole became endangered, Revisiting the data a further time as part of the iterative process was necessary, then, in order to deepen the level of analysis (Smith and Osborn, 2003, p72).

Reorientating the Analytic Process:

This analytic decision marked a reorientation point in the analytic process. Having been alerted to the trio being described in terms of individuals, pairs, and a whole, I stepped aside from using these terms as organising structures, revisiting again the original material. For clarity, I include a diagram outlining the detail and sequence of analytic activity both to this point and subsequently (Fig. 3:4).[20]

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[20] Figure 3:4 can be viewed as an expanded description of the activity of Data Step 4 in Fig. 3:2

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┌─────────────────────────────────────────────────────────────┐
│   ┌──────────────────┐              ┌──────────────────┐      │
│   │    Therapist     │              │      Parent      │      │
│   └──────────────────┘              └──────────────────┘      │
│            │                                 │                │
│            ▼                                 ▼                │
│   ┌──────────────────┐              ┌──────────────────┐      │
│   │   Transcription  │              │   Transcription  │      │
│   └──────────────────┘              └──────────────────┘      │
│            │                                 │                │
│            ▼                                 ▼                │
│   ┌──────────────────┐              ┌──────────────────┐      │
│   │ Working vertically│              │ Working vertically│     │
│   │ – line by line    │              │ – line by line    │     │
│   │ labelling         │              │ labelling         │     │
│   └──────────────────┘              └──────────────────┘      │
│            │                                 │                │
│            ▼                                 ▼                │
│   ┌──────────────────┐              ┌──────────────────┐      │
│   │ Cluster headings │              │ Cluster headings │      │
│   └──────────────────┘              └──────────────────┘      │
│            │                                 │                │
│            ▼                                 ▼                │
│   ┌──────────────────┐              ┌──────────────────┐      │
│   │ Working          │              │ Working          │      │
│   │ horizontally –   │              │ horizontally –   │      │
│   │ comparing cluster│              │ comparing cluster│      │
│   │ headings         │              │ headings         │      │
│   └──────────────────┘              └──────────────────┘      │
│            │                                 │                │
│            └──────────┐          ┌───────────┘                │
│                       ▼          ▼                            │
│           ┌───────────────────────────────┐                  │
│           │  Towards emerging statements  │                  │
│           └───────────────────────────────┘                  │
│                          │                                    │
│                          ▼                                    │
│               ┌──────────────────┐                            │
│               │  Key statements  │                            │
│               └──────────────────┘                            │
│                          │                                    │
│                          ▼                                    │
│               ┌──────────────────┐                            │
│               │      Themes      │                            │
│               └──────────────────┘                            │
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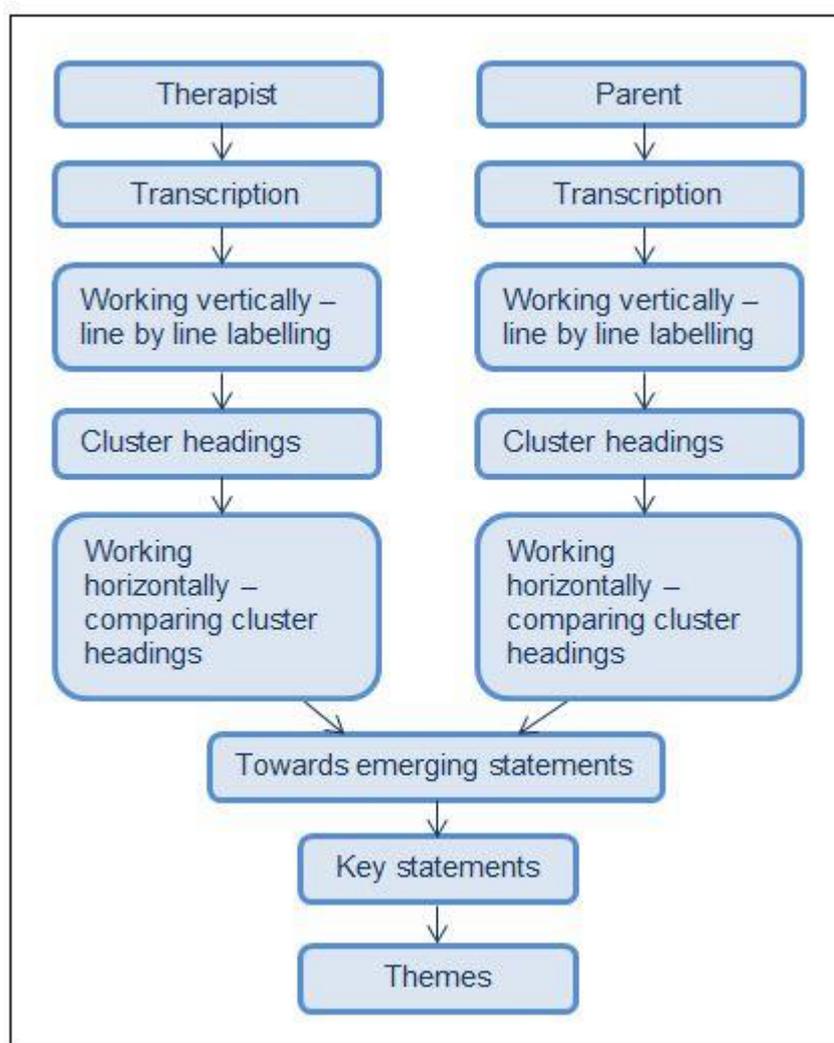
Figure 3:4 Overview of Analytic Activity

Towards Emerging Statements

At this stage in the process I returned to the original transcripts, re-reading and noting words, phrases or sections that seemed particularly resonant. I brought these notes together with the existing initial comments, broad groupings, and statements to create a set of emerging statements for each participant. These emerging statements were rigorously examined in the light both of the research questions and the text itself (Smith, 2011).

Eleven emerging statements were created from the therapist material, and nine from the parent. I include the emerging statements in the tables below (Tables 3:8 and 3:9), together with a brief explication, and single supporting quotation. Given their size, the full tables are included as Appendix 6.

Therapist Transcript – Emerging Statements with Brief Summary	Supporting Quotation
Making sense of the child in music therapy in the present in relation to the past. Music therapy as a process, enabling a developing sense of the child over time. The past is used as a touchstone by which change is considered, and the feeling of being with him understood.	Line 58-60 'So there's been quite a positive feel I think to this block…and being able to focus on him, being able to see what he's doing that he wasn't doing.'
The child emerging as a relating individual A growing sense of the child in relation to others. The capacity to relate finds expression through gaze and sound. Those expressions are imbued with meaning by those around him.	Line 102-104 '(Previously) there's been very little kind of eye contact at all or acknowledgement really of, but over this block, especially at the start you get this real sense of (*audible outbreath, as though imitating child*) 'Ahh, you're here too'.'
The emerging possibility of a trio Physical developments in the child create different musical-relational possibilities. Roles can change in the light of growing capacities. Different configurations and events then become possible.	Line 107-110 'Previously he's not been as physically strong, so it was a lot of me and him playing and her kind of being physically supportive rather than being involved….literally holding him up at the drum. There's been a bit of a sense of opening out a bit I think so it's a bit more of a trio at times rather than a kind of straight line or something.'
Making sense of the child's sensory activity Entering the world of the child in making meaning of his activity, considering his need for sensory input. Attention to child's experience offers ways of understanding qualitative changes in interactivity.	Line 353-357 Commenting on the child's use of a hand held bell, 'He becomes quite fascinated with things that are near his face and his mouth and especially that I think he has the bell on his mouth and he flicks it along, feeling the sense of it and the feel of it as well as hearing the sound.'
Making sense of the child's experiences of transitions and endings Closely attending to the child's experience of changes. A sense of fragility, of needing to step carefully in response to his difficulties. This shapes therapist's approach.	Line 208-210 'There was a moment there (*on video*) of him wavering a bit I think, or just showing a tiny bit of the distress that I've seen before when something's gone, or finished or, in the group if it got too loud…it just always feels a bit of a tightrope with him as well about when is it going to be too much.
Attuning to the close attunement of parent to child	Line 97-100

Closely attending to the active relating of parent and child. Making meaning of parental experience through the lens of child's relational activity, and drawing on previous knowledge together with present observations.	'That moment there when he when he looked up has been one of the key differences I think in this block. There's a kind of smile on Mum's face when he does that because previously it's been very hard to tell what his awareness is of other people playing with him.'
Speculating on the parent finding a role Making meaning of the parent's experience. How does it feel to be a parent in music therapy? The parental role is not fixed, but continually being found.	Line 320-326 'I think I noticed there that Mum stopped playing a lot or she started a bit and then paused again and I think at the time I was thinking 'oh', 'cos she's always very attentive to kind of what his expression is or how he's playing but watching it I was wondering if she was wondering how to play or how to be part of it a bit.'
Following the parent's initiatives Sensitivity to the parent as active and initiating. Adapts to fit around parent activity, valuing and privileging what parent brings to music therapy. Linking therapy and home worlds.	Line 154 - 159 'I think Mum's working on that at home as being a strategy for helping him to manage a transition….'Cos she'd brought it up a few times it felt quite important to try and bring it in to what we were doing here.'
Accompanying parent and child Actively responding to potential moments of parent/child connection by offering musical support. Giving them 'something to play within'. Privileges parent/child relationship.	Line 302-306 'Giving them a bit of a framework to play as part of. Maybe because I imagine that Mum playing with Barney in that way might be quite difficult for her to know how to keep it going or how to sustain it. And so that my role might then be to give them something to play within.'
Balancing relationships within the trio A fragile balancing, responding to the child, while drawing parent in. Privileging the trio. Continually making sense of the parent's experience.	Line 452-458 Commenting on playing at the piano, 'It feels a bit more companionable at the piano, we can be side by side and maybe that's just easier for him and he can see my hands rather than all of me. But I think the effect is or how it ends up, is that it's me, very definitely me and him. And Mum's physically holding him, and not playing, so it feels like just the two of us rather than the three of us.'
Contextualising the trio in terms of other people and places Holding in mind connections with other people and places, and how they relate to the detail of music therapy activity. A flow in and out of the therapy room, permeability.	Line 85-92 On the decision to start each session with the guitar, 'Mum has talked quite a lot about how they have one at home and I think Dad plays the guitar…

Table 3:8 Emerging Statements – Therapist

Parent Transcript – Emerging Statements with Brief Summary	Supporting Quotation
Making sense of the child in music therapy in the present in relation to the past. Intimate knowledge of the child brings perspective on developments over time. Music therapy as a focal point for observing and noting change.	Line 50-54 'The only other thing I was going to say as well is the way he's playing the guitar. That again he's learned from music therapy, which, because we're trying to encourage his fine motor skills, it's brilliant. He used to just flick stuff, he'll actually single them (the strings) out.'
The child emerging as a relating individual Witnessing the emergence of the child actively relating to others. Valuing the child's growing capacity to connect through voice and gaze. Keenly observing details of interactivity.	Line 82-89 'I can see that he actually looked at Laura and was engaging with her, which is really lovely, and he is vocalising to her. I keep talking about vocalising but it is such a big thing. He's actually having almost a conversation with her there.'
Experiencing music therapy as a positive event Parent's experience is mediated through the child's experience. Music therapy is seen through his eyes. Relief for parent of attending music therapy in comparison to other therapies.	Line 121-124 'Generally just coming to this has always been really positive, and he just loves it, he never wants it to finish, so from my point of view that's great, 'cos I can see he's happy, he's not crying. He's enjoying himself. It's really nice.'
Making sense of the child's sensory activity Finely aware of child's particular sensory needs. Child's shifting capacity to interact at any one time measured through parent's understanding of wider issues.	Line 289-295 'Sometimes Barney will get very drawn in by particular things, like toys and instruments. So here I was thinking he's not engaging so much in what's around him because he's worked out that there's a vibration coming off the bell which he can put to his mouth.'
Making sense of the child's experiences of transitions and endings Witnessing the child making meaning of changes and transitions. Actively working to help child manage.	Line 348-363 'From the beginning (of music therapy) he just loved the piano. And we always try and make sure at the end of each session that's what we finish on as well. And so it's like the real treat at the end to get the piano time. He wouldn't ever finish if he had the choice with the piano I'm afraid!'
Finding a role Assumptions about parent role in therapy, privileging the child as leader, and the child/therapist relationship. Reflecting on changing involvement and role over time.	Line 140-147 'I know that when I, when I first started music therapy I was really conscious, I don't know why, not to get involved and to let Barney be the one to initiate. I was quite nervous about that at the beginning, so I wasn't sure what I was supposed to do.' I guess it must just depend on the parent and the situation.'

Valuing the witnessing of the child as an interactive individual Valuing being the 'third party', not being directly involved. Music therapy offers opportunities to witness child responding and relating, independent of parent.	Line 269-276 'It's just nice to watch how he responds, and see what he's doing, 'cos, you know, then I'm the third party, I'm not the one doing the therapy. You know often a lot of the things that we're doing we're being taught so we can do it at home. But it's nice sitting there and watching, seeing how he responds, 'cos you can really see that in here which is nice.'
Linking music therapy activity fluidly with other people and places Appropriating and transforming activities from therapy to home. Therapy as fluid, reshaped in the context of home and family.	Line 325-329 'At home now we play a game with up and down with a cloth, and we do a similar song to the one Laura made up. But I got the idea from Laura..'
Observing the child is contingent on pragmatics Experience is shaped by practicalities. What you see is dependent on where you look from. Differing perspectives on events in therapy.	Line 76-84 'You can't always see, like where I'm sitting there you can't see the eye contact side of things so that's interesting, because I can see he's looking right at the guitar. (It) is obviously where I'd chosen to sit. Barney will often look around, and he'll look out a window, you can't always tell where he's looking if you're sitting behind him.'

Table 3:9 Emerging Statements – Parent

A number of the emerging statements mirror each other; for example, 'making sense of the child in music therapy in the present in relation to the past', or 'the child emerging as a relating individual'. The decision to use the same wording was intentional, but only if it was deemed to give an accurate articulation of emerging meaning. I considered this to be appropriate given the ultimate analytic objective of bringing both together.

Towards Key Statements

As a further phase (Fig. 3:4), I considered, in turn, both sets of emerging statements; that is, the eleven of the therapist, and the nine from the parent interview. In this process of distillation, I identified areas of overlap, drawing some emerging statements together. From this I articulated five key statements in both sets (Tables 3:10 and 3:11). The emerging statements are in the left-hand columns, and the refined key statements in the right.

Emerging Statements – Therapist	Key Statements
Making sense of the child in music therapy in the present in relation to the past	The child in time emerging as a relating individual, with complex needs.
The child emerging as a relating individual	
Making sense of the child's sensory activity	Understanding the ongoing developmental needs of the child through the lens of music therapy activity.
Making sense of the child's experiences of transitions and endings	
Speculating on the mother finding a role	Speculating on and responding to the mother's finding of a role.
Following the mother's initiatives	
Attuning to the close attunement of mother to child	Attuning to, and accompanying the mother and child as a pair.
Accompanying mother and child	
Balancing relationships within the trio	The trio appears as a set of dynamic relationships, manifested in relation to people and places.
Contextualising the trio in terms of people and places	

Table 3:10 From Emerging Statements to Key Statements – Therapist

Emerging Statements – Parent	Key Statements
Making sense of the child in music therapy in the present in relation to the past	The child in time emerging as a relating individual
The child emerging as a relating individual	
Making sense of the child's sensory activity	Understanding the child's ongoing developmental needs through the lens of music therapy activity
Making sense of the child's experiences of transitions and endings	
Experiencing music therapy as a positive event	Experiencing as positive the witnessing of the child as an engaged, interactive partner
Valuing the witnessing of the child as an interacting individual	
Finding a role	Finding a role as parent happens within evolving relationships and pragmatic factors
Observing the child is contingent on pragmatics	
Linking music therapy activity fluidly with other people and places	Music therapy as part of everyday life

Table 3:11 From Emerging Statements to Key Statements – Parent

In articulating five key statements I considered this as the point to bring the two sets of statements together. I include them in Table 3:12, below, presented alongside each other. Presenting them in this way is not only a pragmatic step for ease of reading. It also signals the point in the analysis at which the two distinct analytic units combine to then be considered as integral parts of a larger whole.

Therapist – Key Statements	Parent – Key Statements
The child in time emerging as a relating individual	The child in time emerging as a relating individual
Understanding the child's ongoing developmental needs through the lens of music therapy activity	Understanding the child's ongoing developmental needs through the lens of music therapy activity
Speculating on and responding to the mother's finding of a role	Finding a role as parent happens within evolving relationships and pragmatic factors
Attuning to, and accompanying the mother and child as a pair	Experiencing as positive the witnessing of the child as an engaged, interactive partner
The trio appears as a set of dynamic relationships, manifested in relation to people and places	Music therapy as part of everyday life

Table 3:12 Drawing Together Key Statements

Of the five key statements from each transcript, the first two are consonant with both participants; these relate particularly to the child as experiences in music therapy. While the following statements differ in detail, they arise from similar areas of experience: the finding of a parental role, a focus on the relationship between a pair and individual in the trio, and the linking of music therapy with person and place.

I sought to articulate the statements in dynamic language, suggestive of an active process of experiencing. For example, the therapist is 'speculating on and responding to the mother's finding of a role', in which both therapist and parent are felt to be active. Expressing statements in these terms has retained a phenomenological focus on the

trio appearing dynamically through the lived experiences of those within it (Bortoft, 2012). I develop these ideas further in discussion later in this chapter.

Towards Integrated Themes

In the final analytic step (Fig. 3:4), I worked horizontally across both sets of key statements, drawing them into a set of integrated themes through which the trio's appearing could be understood (Table 3:13).

- The trio appears through the parent and therapist sharing a focus on the child
- The trio appears through the differing perspectives of parent and therapist
- The trio appears through collaborative processes
- The trio appears through parent and therapist sharing a focus on the finding of a parental role
- The trio appears through changing forms, person, and place

Table 3:13 Integrated Themes

I return to a discussion of these themes later in this chapter, at which point I develop them in conjunction with findings from the microanalysis of video material (Fig. 3:3, data step 9). Before describing the activity of the microanalysis phase, however, I want to comment briefly on the analytic process to this point.

Concluding the Analysis of Interview Material

In articulating the integrated themes, I was satisfied that the material had been explored as thoroughly as possible at this point. The early analytic steps, including the umbrella focus, in which I explored the rather concrete configurations of individuals, pairs, and three, could now be seen as a necessary and indeed useful part of the process. These steps informed my decision to revisit the material, ultimately adding strength and depth to the analysis.

Having presented the integrated themes in written language, I also, in concluding this phase, explored ways of presenting the thematic material more creatively (Appendix 7). Returning to the key statements, I created a diagram to present them in graphic form. This allowed me to consider further the distinctive perspectives of parent and therapist, playing, through the positioning of key statements, with a spatial representation of overlap or distance. The key statements are placed in the diagram in such a way as to represent either the person or persons to which the statement relates, and are not to

be considered fixed in any objective sense. My intention was to represent the statements within the notional frame of the trio as a means of keeping the phenomenon as a whole in mind. Its primary purpose was as a creative 'thinking' tool, through which I might play with the findings.

The graphic representation marks the culmination of research activity on Data Set A, gathered through VEI. The focus now turns back to the primary data of the video recording and the process of microanalysis (Fig. 3:3, data step 5).

3.7 Data Set B
Microanalysis of Video Material

The third research question in the Preliminary Study asked the following:

- How can an analysis of musical-social processes within the trio contribute to a greater understanding of the phenomenon?

I was curious to know the extent to which an investigation of musical-social events within the session could enlarge my understanding of how the music therapy trio 'worked', and how it might be seen to come into being (Ansdell and DeNora, 2016). Microanalysis of a section of video offered an appropriate analytic method for achieving this, allowing a means through which 'the ways in which people do things together' might be elucidated (Holck, 2007, p. 30). In terms of the three types of microanalysis proposed by Trondalen and Wosch (2016), the method used here combined approaches, attending to the musical-social activities of the trio as viewed on the video, and integrating a textual layer into the emerging whole. I anticipated that the child's activity, having been spoken of at length at interview, might now be revealed more directly in this process.

Holck (2007) outlines a four-stage microanalysis framework: data selection, transcription, pattern generalisation, and interpretation. I have drawn loosely on this model with a number of particular caveats. First, data selection was informed by a number of analytic steps, outlined in the following section (Establishing an Overview), and including writing narrative accounts and segmenting video on a temporal basis. Second, I have focused on pattern identification which I have taken to mean classifying discrete musical events that are repeated at least once. My concern has been identification, rather than generalisation, given that the intention was not to track

recurring patterns across a number of samples. Finally, I have not considered interpretation as only contained within a discrete stage of the microanalysis process, but rather as a constant, underlying activity through which the form of the microanalysis is shaped. In keeping with understanding the interpretative nature of interview transcription within the phenomenological tradition, I suggest that decisions made during the microanalysis process about, for instance, the level of detail to include or omit, are also interpretative decisions (Smith et al, 2009). They arise from what the researcher might deem to be important or worthy of pursuit at any one time, and therefore influence the course of the process. I was mindful of this in the process of selecting one or more extracts of video for microanalysis.

Establishing an Overview

The first analytic task (Fig 3:3, data step 5) comprised viewing the video of the complete music therapy session a number of times in its entirety, without making notes. Only then did I write a full account of the whole session, viewing and pausing the video as I did so. This account, included as Appendix 4, detailed the observable activity of each person as fully as possible, including timings of events or transitions between events. I then partitioned the account into timed segments, taken to mean distinct periods of activity marked by moments of change (Abrams, 2007, p. 96). Presented below (Table 3:14) are the segmented timings, together with the length of each segment, and brief, functional descriptors of the content of the segment.

Number of Segment	Start Time of Segment on Video	Duration of Segment (mm.ss)	Brief Descriptor of Main Activity in Segment
1	2.14	00.51	**Arrival.** Parent and therapist talk. Child strums guitar.
2	3.05	02.25	**Hello song**. Therapist and child use guitar and voice. Song extends to include further vocal and guitar play.
3	5.30	00.50	**Transition.** From guitar to tambourine.
4	6.20	02.57	T**ambourine play**. Therapist, child, and parent use tambourine.
5	9.17	00.27	**Transition.** Therapist Introduces floor drum, fetching beaters
6	9.45	04.22	**Floor drum play 1.** Therapist, child, and parent use floor drum with beaters and hands. Therapist also uses guitar.
7	14.07	01.49	**Floor drum play 2.** Therapist has moved guitar

			away. Therapist, child, and parent use floor drum.
8	15.56	00.44	**Transition.** Therapist introduces box of small instruments. Therapist and parent talk. Remnants of therapist and child drumming.
9	16.40	06.38	**Small instrument play.** Therapist, child, and parent use small instruments from box. Therapist uses flute.
10	23.18	01.44	**Tidy up time.** Therapist, child, and parent put instruments in box.
11	25.06	03.59	**Ocean drum play.** Therapist and child play, parent watches.
12	29.05	00.55	**Transition.** Therapist, child, and parent move to piano.
13	30.00	05.19	**Piano play.** Therapist and child play piano, parent holds child on her lap and watches. Therapist sings and signs goodbye to child.
14	35.19	00.39	**Leaving.** Therapist and parent talk. Child continues to play.
15	35.58	-	Video stops.

Table 3:14 Segmented Timings and Descriptor

Selecting a Video Extract

The three interlinked processes of repeated viewings, creating a narrative account, and segmenting the video served to familiarise me with the video material as a whole. Each step contributed to the selection of a specific extract (Fig. 3:3, data step 6) which was also guided by the pause points generated at interview (Fig. 3:3, data step 3).

As an overarching principle in the selection of one or more extracts, I continued to seek to foreground the phenomenon of the trio. This guided the selection towards an 'open' rather than 'problem-based analysis approach' (Holck, 2007, p. 31). Consequently, the timings from the table above guided my selection towards segments of video in which all three individuals were overtly active. I then revisited the pause points generated by parent and therapist at interview. I was interested, if possible, to choose a section on which both participants had commented, considering that any such sections might offer a rich source of material for microanalysis.

Ultimately, I selected one ninety-second section, in which both therapist and parent had paused the video twice, using this as a frame within which to analyse fifty seconds of material (9:57–10:47). This extract can be found in Segment 6 of Table 3.14. A review of the interview transcripts highlighted the strength of the participants' responses to

events in this section. These responses had been of particular interest during the thematic analysis: as both had paused the video twice in this section, it brought the differing perspectives of parent and therapist sharply into view. I had also become interested in this section when writing the narrative account of the session; the complex, multi-voiced interplay within the trio at this point had necessitated repeated, slowed viewings in order to describe clearly. These factors all pointed towards this extract warranting a detailed examination.

Having selected the extract, I completed a narrative account of the section (Table 3:15).   While already recounted in broader strokes in the complete narrative (Appendix 4), in this account the analytic task demanded I zoom in to describe events in greater detail (Pavlicevic, 2010). To do this, I viewed the video using Elan video software; the variable playback speed allowed me to tease out fine details, which was necessary in tracing rapidly unfolding events. The narrative account includes timings, to the nearest second of activity.

The selected extract (9:57–10:47) is part of a longer passage of play (Table 3.14, segment 6), which begins at 9:45 and ends at 14:07. The timed pause points at interview were 9:48 and 11:25 for the parent and 9:57 and 10:37 for the therapist.

Throughout this passage, the therapist, child, and parent, sit on the mat, gathered around a large, low, floor drum. The therapist, Laura, has just taken beaters from a box to give to the child and mother. The child, Barney, beats the drum with his beater, before dropping it. At this point, his mother helps him to grasp it again, asking the therapist as she does so, 'You don't mind if I help him, do you?'. The therapist responds quickly, saying 'No, not at all', the extract beginning shortly after this comment.

9:57 Barney plays with uneven two handed flat hand beating on floor drum, looking at the drum. After two sounds, Laura joins him on floor drum, using beater in right hand (rhythm - quaver, quaver, rest, quaver – repeated once).

9:58 Parent plays first of five regular beats on floor drum. Laura and Barney sound drum simultaneously, Laura then stopping while parent plays. Barney continues beating with irregularity. Final beat of parent coincides with a quaver rest from Barney who then sounds quaver, quaver on his own.

10:01 Laura using beater in left hand on tambourine beats simultaneously with Barney (quaver, quaver rest, quaver) repeated 2 and half times. Repetition of the rhythmic unit suggests regular pulse and possible 6/8 time signature. While Laura and Barney play, parent has turned beater round in her own hand and offers it to Barney.

10:03 Barney takes proffered beater in right hand. Laura puts down left hand beater. Parent sings/speaks pitched phrase 'Barney do it' (in 6/8 time signature, of crotchet, quaver, quaver, crotchet) , repeated as Barney makes beating motion with beater in direction of drum, creating air beats (rhythm of repeated dotted crotchet pulse).

10:05 Following his first sounded beat, and simultaneously with his second, parent sings/speaks upward duplet 'That's it', then on the 4th of his sounded beats, beginning expansive phrase saying 'good boy!', with upward sweep of pitch on 'good' and extended downward sweep on 'boy'.
Laura using beater in right hand begins to play dotted crotchet pulse on floor drum, matching Barney.
Barney also uses LH on floor drum, creating uneven additional beats.
Laura also picks up and matches parent's vocal swoop on 'good boy', also descending in pitch. Barney and parent are now silent, and Laura finishes phrase with three final dotted crotchet beats on floor drum, emphasising the pulse with her voice, singing 'Boom, boom, boom', before pausing.

10:10 All three players silent.

10:11 Barney resumes dotted crotchet pulse with one sounded beat followed by air beats. At first beat Laura hands her beater to parent, with unclear comment. Parent takes beater in her left hand and joins Barney's play with same pulse at the point of his 5th air beat. She sounds four beats.

10:16 Barney sounds next beat, parent has now paused. Laura sings/speaks 'play together' (crotchet, quaver, quaver, crotchet), picking up the guitar as she does so. Barney continues to beat, looking towards the guitar. Parent begins to beat again in pulse, as Barney's beats become air beats, and Laura sings/speaks 'Yeah' over one dotted crotchet beat.

10:18 Barney and parent continue for three further matched beats (Barney in air, looking at guitar). One beat rest for both, Barney holding beater raised in right hand. Laura is looking towards child. Parent says to child in duplet rhythm, 'look that way' (slightly unclear). Unidentified external sound made on next beat, then one further paused beat from all players.

10:21 Parent sings/speaks 'Barney do it (crotchet, quaver, quaver, crotchet)', pitched E above middle C to B below. Followed by Laura in low pitched sing/speak, drawn out phrase 'Co-py yo-u' at point where Barney begins regular pulse in air beats. Four air beats, and then begins sounded beats, also in pulse.

10:25 On third of Barney's sounded beats, Laura begins to strum guitar, on chord of E major, using dotted crotchet, crotchet, quaver pattern. Barney continues to drum, parent moves drum closer to Barney. Following repetition of guitar pattern on E, changes to chord of A major, and slightly quicker pattern of crotchet, quaver, crotchet, quaver leaving the final quaver chord sounding.

10:28 Barney pauses drumming at final guitar chord. Guitar sounds but all players silent.

10:30 Barney drops his beater, reaching towards the guitar. Both Laura and parent laugh, Laura singing 'oh dear, have I distracted you', accompanying with less regularly pulsed guitar chords on E major. Parent plays single drum beat before Laura plays guitar chord of A major.

10:35 Laura leans towards Barney with guitar, Barney reaches left hand to guitar, playing two downward strumming actions while Laura fingers chord of A major.

10:36 Laura plays with right hand on drum (quaver, quaver rest, quaver), repeating it two and a half times before pausing, in which all players are silent for one dotted crotchet beat. Barney has looked down towards a beater on the floor.

10:38 Laura strums three further downward chords of A major on guitar, as Barney picks up beater in his right hand. Barney plays two beats on drum, before dropping beater and reaching again towards guitar with his left hand. Laura sings, 'Ah-ahh', and parent begins a series of three beats on floor drum using beater in her left hand.

10:42 Laura strums guitar, continues sung phrase in time with parent's second beat. Laura delays the placing of the next beat, and parent places it in time, following which she stops

playing, lifting her left hand with the beater up towards her face.   As this is happening, Barney reaches towards the guitar with his left hand, Laura continuing her sung phrase (which appears to be a melodic phrase taken from the Hello song at 3:29) as he strums three downward movements which Laura fingers as A major then E major.   Laura slows melody to follow his strumming movement.

10:47 End of extract.

Following the end of the extract, the musical activity continues to focus around the guitar and floor drum. The child alternates between using his hand and a beater on the drum, looking between the drum and the guitar throughout this passage. The therapist signals the end of this episode of play by placing the guitar on the floor.

Table 3:15 Detailed Narrative Account of Selected Extract

This detailed narrative provided an orienting basis from which to understand events within and between child, parent, and therapist. Completing the narrative also prompted a further consideration of method. The activity of writing highlighted the inherent limitations of written language as an adequate tool for the stated purpose; it was simply not possible, through words, to describe the simultaneity of emerging events within the trio. Nor was it possible to convey effectively the intricate interplay of sound, gesture, and movement between each individual and pair. In order to better capture and represent the multiple layers of concurrent and interlinked activities, it became necessary to explore graphic means of representation.

Developing the Graphic Score

As a starting point in creating a graphic score, I used a conventional Western classical music notation system. Notation allowed the representation of simultaneous activity, thereby enabling a level of detail through which musical processes and structures could be investigated (De Backer and Wigram, 2007; Haslbeck, 2013b; Suvini et al, 2017). The preliminary notation, completed manually, had the appearance of a conventional score, albeit with certain adaptations. I chose, for example, not to specify a time signature, nor to add bar lines, judging that their inclusion constrained, rather than contributed to, an understanding of the improvisation (Wosch, 2007). In contrast, I included a key signature at an appropriate point both to avoid the unnecessary use of accidentals and to reflect an emerging tonality.

Additional written text was subsequently added to the evolving score, recording a range of musical or extra-musical details (Table 3:16). These animated the original notation, emphasising the emergent nature of the improvisation through the detail of who did what, with whom, and how.

- Noting instruments played, and with what (for example, beater or hand on the floor drum)
- Noting the passing or moving of instruments and beaters between the triad, using text and dotted lines to indicate direction of movement
- Marking timings (in line with the narrative account)
- Transcribing spoken or sung words or sounds below the appropriate musical stave
- Including approximate metronome markings
- Marking non-traditional musical symbols, indicating for instance drum beats which did not sound, or to note two individuals beating at the same time during a period of less organised pulse
- Noting extraneous environmental sounds

Table 3:16 Additional Notes Added to Graphic Score

A further layer was added to the score through the insertion of words spoken by participants at relevant pause points. As the parent pause points occurred immediately prior to and after the music score began and ended, I also added text from the session's narrative account, linking the parent's text with the notation. While I had originally planned to work on a rough, hand-written version, later transferring it into a software programme such as Sibelius, the increasing layers of material prohibited such a transfer. Ultimately I decided to allow the working document to stand as the final representation, including it as Appendix 8.[21]

Music therapy literature details a spectrum of approaches to describe, represent, and analyse the activity and interactivity of sessions, either for clinical or research reasons (Cohen et al, 2012). This includes detailed verbal descriptions and analysis (Forinash, 1990; Trondalen, 2007), conventional musical notation (Lee, 1992, 2000), and graphic notation (Bergstrom-Neilsen, 2009; Gilboa, 2012; Cohen et al, 2012). Key to the choice of method is the imperative for a good 'fit' for the needs of any particular purpose (Lee, 2000; Haslbeck, 2013b).

The graphic score in this study (Appendix 8) is a composite document; it comprises notation of musical activity as observed on video, explanatory notes, participants' words, and bridging passages of narrative description. Its composite nature is vital in connecting the two aspects of data work, and in keeping the trio's appearing, as expressed through the words of those within it, sharply in focus. The graphic score reflects the study's emergent nature in which single steps have influenced successive

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[21] Appendix 8 includes the handwritten working document and also a version written on Sibelius software. This is intended for ease of reading if watching with the video extract.

decisions, and in which the detail of the eventual design has, to some extent, followed the flow of the unfolding research material.

Identifying Patterns

Once complete, I was able to examine the score for discrete events that could be seen to be repeated at least once within the extract (Fig. 3:3, data step 9). By discrete events, I include not only specifically musical patterns, but also what I term relational events: that is, patterns of activity between one or more individuals. Adopting a broad perspective at this point remained in keeping with the study's exploratory nature (Holck, 2007).

I identified fourteen discrete patterns; the complete table is included as Appendix 9, and a summary list appears below (Table 3:17). Within the full table, each pattern is identified with a letter, between A to N, described briefly, and the timings of each pattern noted. A single example of each pattern is also marked below the relevant stave in the graphic score.

The summary of patterns demonstrates those described using conventional musical terms, such as rhythm or melody (J-N), as well as repeated patterns of what could be termed para-musical activity between individuals (A-I). For instance, pattern B refers to the specific activity of the therapist and child pair in which the child could be identified as playing two drum beats, or guitar strums, before the therapist joined him.

Identifier in score	Summary Description of Patterns
A-E	Repeated episodes of differentiated activity within pairs; that is, within therapist and child pair, parent and child pair, or between both pairs.
F-H	Episodes of activity within the trio.
I	Handovers of activity between therapist/child and parent/child pairs.
J-L	Rhythmic patterns
M	Melodic patterns
N	Emergence of tonal centre

Table 3:17 Summary of Patterns

The process of identifying and describing patterns in this way was largely useful as a heuristic rather than a precise tool, offering an adequate means to uncover repeating events. Thus, patterns frequently overlap or occur concurrently. For example, patterns A, B, C, I, and J can all be seen on the graphic score to occur between 9:57 and 10:01. There may also appear to be fewer clearly musical patterns than para-musical. This is a result of the descriptors used giving weight to the relational, rather than purely musical. Pattern A, therefore, is labelled as 'episodes of playing concurrently' between the therapist and child, rather than designated by specific musical content.

Patterns were identifiable from the activity of either individuals, pairs, or the trio as a whole. This created a link between this phase of the data work (Fig 3:3, data step 9), and the findings grouped under the umbrella focus (Table 3:7), in which I noted that 'both participants described and discussed individuals (including themselves), each possible pair, and the trio itself.' (cf. p. 86). The two sets of findings converge to some extent to indicate not only that the trio might be experienced as a fluid, shifting phenomenon, but that the trio can be seen to appear through events between people which are constantly reconfigured in an intricate and dynamic process.

Returning to the patterns, two idiosyncratic patterns emerged which benefit from further explanation at this point. The first of these, pattern N, is described as the emergence of a tonal centre. This refers not to a repeated pattern of tonality but rather to an emergent tonality, repeatedly suggested in fragments from 10:03 but only fully finding form at 10:25, as the therapist sounds a chord of E Major on the guitar. As an extended event, underpinning the ongoing musical-social activity, it highlights the moment-by-moment layering accomplished between parent, child, and therapist together. While the therapist may bring tonal stability through a guitar chord, the seeds of that tonality have effectively been collaboratively sown previously.

A further anomaly is seen in pattern F, in which the trio sounds as a whole, either singing or playing, for a period of three seconds. This is a singular rather than recurring event included here precisely because of its singularity; this is a unique event within the extract and within the session as a whole. I discuss both of these anomalies in the discussion section that follows.

Concluding the Microanalysis of Video Material

Taken as a whole, the analytic processes of the microanalysis consisted of a number of consecutive steps: writing a descriptive account of the full video, segmenting the full

video with timings and descriptors, selecting a section of video, writing of a detailed narrative account, development of the graphic score, and pattern identification.

The intention throughout was to respond to the third research question, which asked how an analysis of musical-social processes within the trio might contribute to a greater understanding of the phenomenon. This was the objective driving the activity of microanalysis (Trondalen and Wosch, 2016). On reflection, I would suggest that each stage of activity revealed new facets of the trio. As such, cumulative impressions, rather than definitive understandings, were reached by the end of the microanalysis.

This was perhaps fitting with the research orientation itself. I was not seeking clarity or finality in the Preliminary Study, but rather to open up areas to pursue in the next phase (Ansdell et al, 2010). My intention, in Bortoft's terms, was not to focus, downstream, on '*what* occurs', but rather to remain looking 'upstream', at the '*occurring* of what occurs' (2012, p. 95). In light of this, I would argue that the most meaningful analytic activity of the microanalysis was the development of the graphic score. This enabled me to attend to video in close detail and, by working slowly with pen on paper, allow the material to emerge in graphic form. The focus of the analytic work could be said to be upstream, at the level of process, rather than on the downstream of product. It was in labouring on this that, on reflection, the richest aspects of the analytic work appeared.

Summarising the Data Analysis Process

In the previous pages I have traced the chronological sequence of the data work, outlining the activity involved in the generation of the two data sets, A and B, and the relations between them. The analysis phase raised particular areas of difficulty which I have highlighted here. I have also sought to demonstrate not only how I considered and worked with analytical sticking points, such as the umbrella focus (Table 3:7), but how such difficulties informed the next steps in the process.

The two data sets both originate from the primary data source of the video recording of the music therapy session. From this source, two distinct sets of findings have emerged: five integrated themes arising from the interview analysis and the final table of patternings from the microanalysis process. The multi-layered graphic score serves as a composite document of the two processes, drawing together written text of both participants and myself as researcher, with musical notation in a visual representation.

Although not planned in advance, the integration of words and music in the graphic score services to represent the integration of the study's different aspects, drawing the parts together in adding depth to the emerging understanding of the phenomenon as a whole.

3.8 Discussing Findings

Revisiting Research Questions

The preliminary study aimed to further an understanding of everyday, situated music therapy practice with a child when a parent also attends. By investigating a single case, I intended to explore in depth, but with an open stance, the phenomenon of the trio, examining the ways in which the trio revealed itself, and also testing methods by which it could be investigated (Smith, 2004; Ansdell and Pavlicevic, 2010). These lines of enquiry were articulated in the three primary research questions, reiterated here:

- How do a parent and therapist describe the experience of music therapy with a child in which a parent is also present?
- How might these descriptions inform an understanding of the phenomenon of the music therapy trio?
- How can an analysis of musical-social processes within the trio contribute to a greater understanding of the phenomenon?

Introducing the Discussion

In keeping with Bortoft's understanding that the whole 'is to be encountered by going further into the parts' (1996, p. 6), in presenting the discussion that follows, I use the five integrated themes (Table 3:13) as a structural framework. Within this framework, I expand on the findings, exploring them in relation to theoretical perspectives, particularly those of emergence and collaborative emergence (Sawyer, 2003, 2006). As a reminder, the five integrated themes are expressed as follows:

- The trio appears through the parent and therapist sharing a focus on the child
- The trio appears through the differing perspectives of parent and therapist
- The trio appears through collaborative processes
- The trio appears through parent and therapist sharing a focus on the finding of a parental role

- The trio appears through changing forms, person, and place

My argument is that the trio appears through a dynamic interplay of person, place, and time. This interplay does not only occur at a singular level between the three individuals involved. The trio also comprises three pairings: child-parent, child-therapist, and parent-therapist. Each of these pairings has a third, linked person, whose position and role in the trio varies, depending on the nature of the relationships. A further level of interplay emerges in relation to key figures and places outside the music therapy room: family, friends, and other professionals are vital forces in the shaping and appearance of the trio. At the heart of the trio, however, is a concerted attention on the needs of the child attending therapy. It is here that the discussion starts.
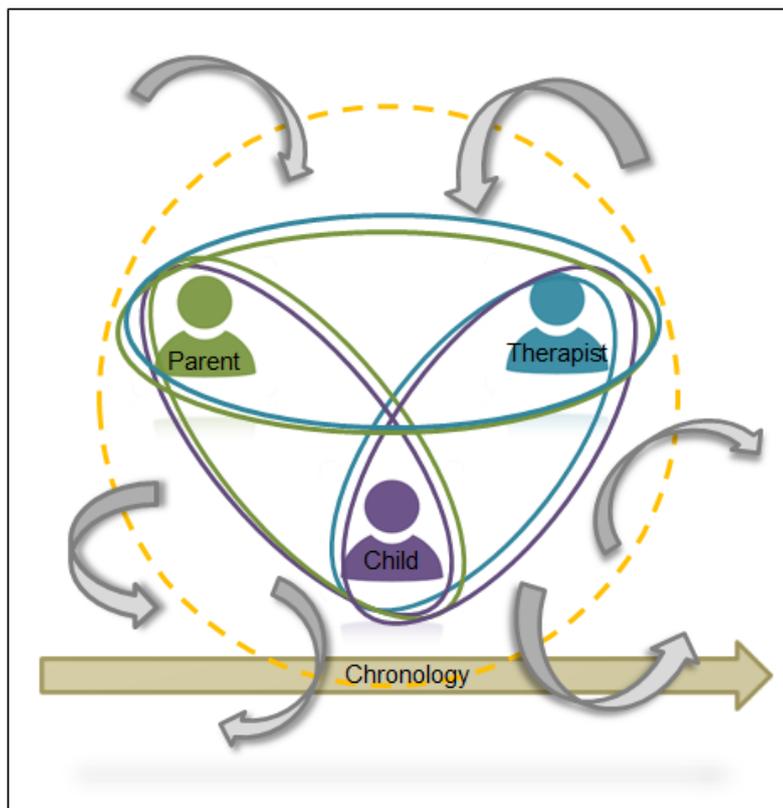
Figure 3:5 Representing Layers of interplay in the Trio

1. The Trio Appears through Parent and Therapist Sharing a Focus on the Child

That a child and their continuing growth and development would be the focus of both parent and professional in music therapy is appropriate given the nature of the

healthcare setting. The CDS is a provision for children with developmental difficulties, and therapeutic interventions offered within it have a prevailing focus on the child's development. This focus is shared by both parent and therapist, the trio coming into being through attention on the child's needs, difficulties, and potential.

Particular areas of difficulty experienced by the child are revealed through music therapy activity: for example, managing activities ending or, as his mother describes, withdrawing into sensory self-stimulation:

> Sometimes Barney will get very drawn in by particular things, like toys and instruments. So here I was thinking he's not engaging so much in what's around him because he's worked out that there's a vibration coming off the bell which he can put to his mouth. (P, 289-295)

Both therapist and parent are alert to the ways in which the child's difficulties manifest themselves moment by moment through the sessions' events. In addition, however, music therapy activity also provides a lens through which both parent and therapist perceive the child as developing over time. Sessions offer opportunities, as the therapist comments, to 'see what he's doing that he wasn't doing' (Th, 60). Time, in both the past and present of music therapy, becomes a way of seeing change. As the parent says of the child's growing ability to use his fingers to pluck the guitar strings:

> That again, he's learned from music therapy, which, because we're trying to encourage his fine motor skills, it's brilliant. He used to just flick stuff, he'll actually single them (the strings) out. (P, 51-54)

Assessing needs and evaluating change may be an integral aspect of being either the child's parent or therapist. Both, from their particular positions, might observe a child's needs and development keenly, if differently. For the therapist, this would be a usual part of music therapy practice if the parent were not present. Parents, too, would clearly have vested interest in considering developmental changes in their child. This raises a question then as to whether – and if so, how – ongoing evaluation of a child's strengths and difficulties occurs differently when the parent is present in therapy.

I suggest that the parent's presence in music therapy enables both parent and therapist a distinctive view of the child. The child, as a complex, developing, relating individual emerges from a backdrop of being seen in relation to another. This backdrop provides a means of checking, or confirming, a view on the child as they appear. As the therapist comments:

> That moment there when he looked up has been kind of one of
> the key differences I think in this block…there's a kind of smile
> on Mum's face when he does that, because previously it's been
> very hard to tell what his awareness is of other people playing
> with him or being around him. (Th, 97-100)

The significance of the child's look up is understood by the therapist's interpretation of the 'smile on Mum's face'. The parent's smile provides confirmation, as it were, of the child's growing awareness of others. The same process of triangulation occurs from the perspective of the parent. The parent remarks:

> In this session it started, he's actually vocalising as well, they're
> both singing to each other. I remember this session, it was
> really lovely 'cos he'd not done this before…this is when it's
> first starting, where he's responding to other people other than
> my husband and I. (P, 94-104)

The observable interaction between child and therapist provides a measure by which the parent gauges the child's increased responsiveness to those beyond the parental couple. As the child's social circle expands and is enriched, so too is the parent's understanding of the child in seeing him engage with the therapist. Music therapy with the child within the trio, as opposed to in a pair with the therapist, can be said to afford particular experiences for both parent and therapist. The presence of the two adults expands their experiences of the child, both 'reading' the child through the person of the other.

The extent to which such observations and experiences are shared between therapist and parent is, however, less clear. For instance, in watching the video at interview, the parent offered rich, detailed descriptions of the child's growing interactivity over time, reflecting freely on changes she had observed. The degree to which the therapist might actively seek to hear a parent's observations during the course of therapy is unclear. I suggest that the intimate, nuanced attention to detail which a parent brings when with their child in therapy could be immensely valuable, in practice, to the therapist.

Thompson (2012b, p. 75) comments on the 'process of knowledge sharing' between therapist and parent underpinning a family-centred approach in music therapy. Although she does not clarify how such 'knowledge sharing' might happen, either inside or outside the session, the notion suggests a practice stance that values parental wisdom. In adopting such a stance, the emphasis, I would suggest, lies less

on knowledge as a commodity to be traded and more firmly on a practice approach that values the process of sharing in and of itself. Given that the focus of both therapist and parent is clearly on the child themselves, such an approach may further enrich the experience for child and parent. It may also forge a partnership between therapist and parent through which both shared and differing experiences may be managed.

2. The Trio Appears through the Differing Perspectives of Parent and Therapist

While parent and therapist share a focus on the child, further complexities are brought to the appearing of the trio through their differing perspectives and the priorities that drive those perspectives. I wish to clarify here what I mean by 'perspectives'. If the therapist and parent are considered to be holding perspectives *on* an event, this positions the trio's activity as a removed, distinct event, on which participants have a view (Mol, 2002). I suggest that such perspectives are not only brought to bear on events 'out there', but that those perspectives serve to generate events themselves. It is through those perspectives that the activity of the trio itself comes into being. In this discussion, while I do refer to individuals having perspectives on events, such references are informed by an understanding of the active nature of perspectives.

I have suggested previously that the opportunity to witness the child in therapy might hold intrinsic value to the parent (Flower, 2008). This idea appears to be borne out in the findings of this study. The parent, for example, reflects on the experience of watching the child in therapy:

> It's just nice to watch how he responds and see what he's doing.…because then I'm the third party, I'm not the one doing the therapy.…But it's nice sitting there and watching, seeing how he responds, 'cos you can really see that in here. (P, 269-276)

Being a 'third party' offers the parent a valued vantage point from which to view her child's the activity and interactivity. Valuing the perspective of 'sitting there and watching' creates a tension, however, with the drive to encourage more overtly active parental participation which is often described in music therapy literature as vital (Allgood, 2005; Warren and Nugent, 2010; Thompson, 2012b). Thompson, for instance, suggests that for children with social communication difficulties, parental participation might support the child's emerging skills and the developing parent-child relationship.

As a 'third party', the parent may not appear to be an active participant. The therapist's intuitive response may be to find explicit ways to encourage greater participation. As the therapist here comments, at some points it seemed necessary to 'perhaps ,just initiate her coming in to it a bit more' (Th, 120-121). At times in a therapeutic process, encouraging overt involvement may be appropriate, particularly if there is concern that a parent may feel excluded from the play between therapist and child (Woodward, 2004; Levinge, 2011). I suggest, however, that 'sitting there and watching' can be understood as a dynamic parental activity in itself. In other words, that watching, attending, and witnessing activity, and reflecting on responses, the parent is indeed actively involved. Such involvement demands recognition as valuable in its own terms.

The task for the therapist, then, is a delicate one. Encouraging active musical involvement may not always offer the parent the optimal experience, nor, indeed, make the best use of their presence at any one time. An approach that considers and values a spectrum of parental involvement, with sensitivity to unfolding events and relationships within the trio, is called for here. Such an approach requires balancing itself with a further perspective that the therapist brings to the trio; that is, a concern with the parent and child pair as a relational unit in itself. This is not a concern that has been explicitly raised by the parent.

Over the course of therapy, the therapist has observed how the child's growing physical independence and social interactivity has created opportunities for shared play between parent and child, commenting that, 'it would be, it has been, rare I guess in the sessions for Barney and his Mum to be involved in something directly together' (Th, 292-294). Her knowledge of the pair over time informs her perception of the potential fragility of the emerging musical relationship between parent and child. As the therapist notes:

> I imagine that Mum playing with Barney in that way might be
> quite difficult for her to know how to keep it going or how to
> sustain it. (Th, 302-304)

The therapist expresses an intention to support the pair as they begin to play more together, 'giving them a bit of a framework to play as part of' (Th, 301). The graphic

score (Appendix 8) demonstrates the ways in which that support is offered. I include here an example, taken from the graphic score, to illustrate this point (Fig. 3:6).[22]

The notation begins at a point on the video (9:57) when the therapist has introduced beaters for the child, parent, and herself. The child drops the beater and uses his hands to sound the drum, playing throughout as therapist and parent alternate in playing with him. As the parent begins to play (9:58), the therapist almost immediately pauses, resuming as the parent herself pauses (10:01).
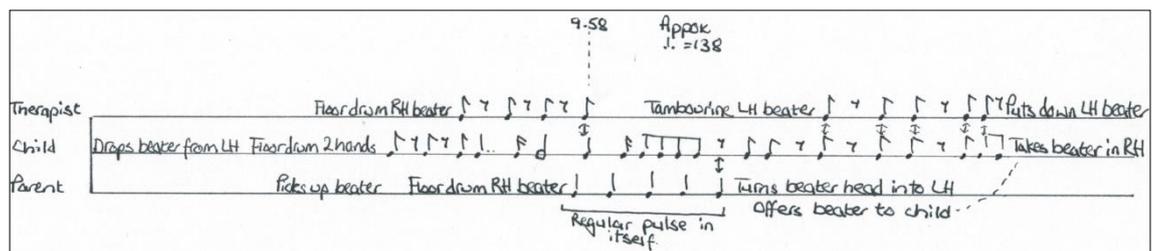
Figure 3:6 Alternating Drumming - Pattern E

On analysis, the therapist can be seen to make almost instantaneous responses to the parent's actions, moving from playing with the child to musically 'giving way', foregrounding the action between parent and child, before stepping back in again (Thompson, 2014). The alternating pattern is identified as Pattern E (Appendix 9), described as 'music alternating between pairs'. A comparable example is found between 10:14 and 10:19, at which point the therapist's singing as the child drums alternates with the parent and child drumming.

In both instances, the rapidity of response mirrors equivalent processes in jazz improvisation. In complex, fast-moving improvisatory playing, multiplicities of musical possibilities are presented at a pace that demands rapid, creative, responses (Sawyer, 2003, 2005). Sawyer (2003) argues that a conventional understanding of creativity, which held processes of ideation and evaluation as separate stages, is problematic in understanding such improvisatory processes. The pace and complexity of the creative

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[22] For a fuller, contextualised view of the extracts used in this chapter, please refer to Appendix 8, Graphic Score.

act, he suggests, demands that ideation and evaluation be considered as occurring simultaneously, as 'constant, ongoing components of the creative mind' (p. 174).

The processes of ideation and evaluation may differ in the classical ensembles, given that performers generally play from a written score (Williamon and Davidson, 2002; McCaleb, 2011). Players remain alert, however, to the finest moment-by-moment shifts made by others, and the need for minute adjustments in response. McCaleb (2011, p. 6) argues that such processes, emerging in real time, cannot occur through intentional communication, but rather through attunement, performers 'pulling' information towards them on which they act.

A closer inspection of Figure 3:6 reveals possible processes of ideation and evaluation within the therapist's activity. Two distinct creative ideas appear: first, drumming with the child, and, second, pausing to allow the parent-child pair to sound. 'Pulling' on the information given by the parent's actions, the therapist shifts from one idea to another. Yet underpinning the ideation and informing a reading of the parent's actions, is an evaluative process itself grounded in a broader aim. The therapist's expressed intention to support the parent-child relationship becomes a marker by which she evaluates and gauges her own activity, effectively choosing to step back.

Considering this only from the therapist's perspective, however, allows for only a partial reading of the moment-by-moment musical-social processes within the trio. It is clearly not only the therapist who is engaged in generating or evaluating ideas. As Monson (1996, p. 27) comments on the jazz ensemble, musicians are constantly 'making musical choices in relationship to what everyone else is doing'. In music therapy, as in jazz, it is necessary then to consider the trio as an emergent, collaborative phenomenon.

3. The Trio Appears through Collaborative Processes

The process of microanalysis enabled the collective, creative work of child, parent, and therapist in music therapy to come to light. In particular, the creation of the graphic score (Appendix 8) provided the means to uncover the detail of the collaborative processes which themselves constitute the trio.

The extract selected for microanalysis contained the lengthiest passage in the whole session in which therapist, child, and parent played simultaneously. Identified as Pattern F (Appendix 9), and notably for its singularity, the three 'sound' together for roughly three seconds. The extract from the score included here (Fig. 3:7), covers 10:03 – 10:10 in order to provide context.
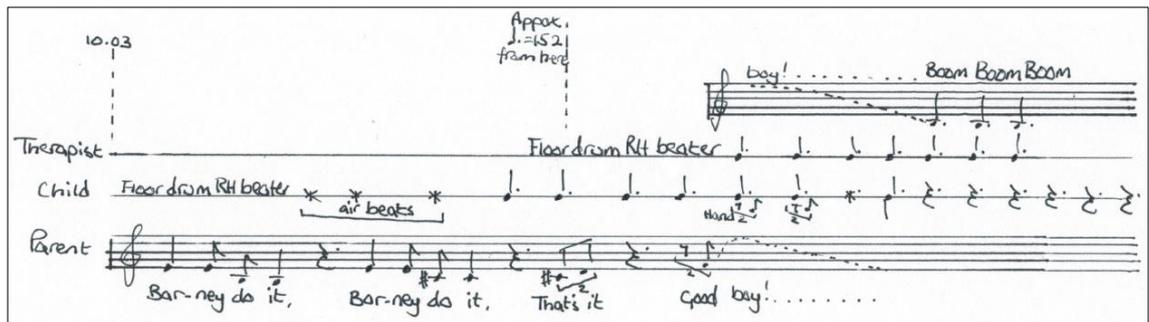
Figure 3:7 Collaborative Processes - Pattern F

The main activity is between parent and child, the parent encouraging the child's use of the beater on the drum by singing 'Barney do it' (10:03). As he begins to beat, she voices an affirming 'That's it' (10:05). The parent's vocalising culminates in an expansive upward and downward sweeping 'Good boy!' The child stops drumming as the parent's vocalisation ends.

This episode between parent and child could convincingly stand alone: a shared, cohesive event which emerges between them before fading away. The event is expanded, however, through the therapist's activity. The therapist mirrors the activity of both parent and child, beating the drum with the child while picking up and closely matching the parent's vocal phrase (Wigram, 2004, p. 82). When both parent and child stop, the therapist adds a further three drum beats, reinforcing them vocally, singing, 'Boom, boom, boom', as though to round off the episode before pausing herself (10:10).

This is a finely tuned collaborative event, emerging initially from the parent offering rhythmic and melodic impetus to the child's playing. In turn, the therapist appears equally alert and responsive to the actions of parent, child, and the parent-child pair. In contrast to Figure 3:6, the therapist's musical responses do not shift between the pairs

of therapist-child and parent-child. Rather, by mirroring the play of parent and child (drumming with the child, vocalising with the parent), the therapist both interacts with and affirms their separate activity. In doing so, the possibility of a greater whole emerges, in which all three pairs sound at once. It is in the sounding of the parent-therapist pair through their shared vocalisation that a novel element appears, bringing a new perspective on collaborative processes in the trio.

Collaborative Emergence within the Trio

Sawyer proposes the notion of 'collaborative emergence' to account for collaborative processes within creative groups (2003, 2006, 2012). He describes it as the process by which a 'group's properties and outcomes emerge from individual actions and interaction', which may have been difficult, if not impossible to predict in advance (2012, p. 63). In this example, the properties of the musically emergent child/parent/therapist whole are greater, not only than each individual could produce alone but also than the sum of the activity of those individuals.

As suggested previously (Fig 3:7), the parts that make up the whole do not only comprise the individuals within the trio, or the interplay between them. Rather, the three possible pairs within the trio might also be seen as parts, interacting both within themselves and, across levels, with the remaining third party. The notated example above (Fig. 3:7) suggests the complex layering of individual action and multiple interaction through which the greater emergent whole both appears and recedes.

Thompson and McFerran (2013) describe comparable practice with a child and parent. They note the collaborative nature of improvisatory processes in music therapy, commenting:

> At every moment in the music making, each person is impacting on what will happen next, and the role of leader or follower can morph into the other in an instant. (Thompson and McFerran, 2013, p. 20)

I would argue that, within the music therapy trio, such 'impacting' is not only the result of individual action. Rather, the interplay between and across pairs within the three, must also be seen as contributing to the emergence of unfolding events in the moment. A difficulty arises, however, in considering how such unfolding, collaboratively emergent events are to be understood by those within them. I suggest that this presents particular difficulties within the configuration of the music therapy trio.

Collaborative Meaning Making within the Trio

 One particular episode within the session vividly highlighted issues of meaning making by parent and therapist in music therapy. This occurrence provides the opportunity to consider this from an individual perspective, but also in terms of collaborative meaning making. The episode in question is too lengthy to include in the main text, but it occurs between 10:16 and 10:42 in the graphic score (Appendix 8).

As the episode begins (10:16), parent and child are using beaters on the floor drum. As they begin to play, the therapist picks up the guitar. The child turns his head towards the guitar, and as the therapist strums, he drops his beaters and reaches toward the guitar. As he does so, both therapist and parent laugh, the therapist singing/speaking, 'Oh dear, have I distracted you?' At interview, the therapist paused the video (10:37) to comment:

> I remember feeling quite guilty at that point that there was
> potentially something quite nice that had been possible with
> Mum and then I just went for the guitar without really thinking
> about it….and as I watched myself do that just now I think I had
> the same impulse again which was, 'Oh look, something's
> happening that I can support, play more of a supportive role,
> sort of wanting to come underneath it.' But that's not the kind
> of effect, the immediate effect of what happens. (Th, 289-293)

The therapist's intention in introducing the guitar was to 'come underneath' the playing of the parent and child. Her action was one known colloquially within jazz as 'comping', meaning 'to get under the soloist – not over him or on a par with him – and to lay down a carpet' (Berliner, 1994, p. 315). Aigen (2013, p. 11) also comments on 'comping' in music therapy, relating its roots in the terms 'ac*comp*anying and *comp*lementing' to the musical intentions of therapists.

The intention to support the parent and child is disrupted, however, through the child's unexpected interest in, and movement towards, the guitar. As the therapist describes it:

> What happens then is that Barney comes back to it being me
> and him, and him wanting something that I've got, and Mum,
> well she's stuck there with the beater. (Th, 307-309)

Having intended to accompany, the therapist reassesses her actions in the retrospective light of the child's response (Sawyer, 2005). In the child reaching for the guitar, the therapist judges the focus of activity to have swung back towards the

therapist-child pair. Understanding events from this revised perspective, the therapist then perceives the parent to be 'stuck there with the beater', as though abandoned by both child and therapist.

While the therapist may intend a particular outcome from her actions, the degree to which that outcome can be predicted is constrained by the trio's collaborative nature. Sawyer (2003, p. 174) suggests that within improvisation groups, as one individual introduces an idea, 'the other players evaluate it immediately, determining whether or not the performance will shift to incorporate the proposed new idea'. In terms of the therapist's introduction of the guitar, the innovation is open, to use Sawyer's term, to evaluation not only by herself but also by parent and child. Each person plays a part in determining how the innovation might be integrated into the ongoing activity, in a process of what I term collaborative meaning making.

Such collaborative meaning making stems, of necessity, from the distinctive perspectives of the individuals involved. Therapist and parent, while participating in ostensibly the same events, judge those events from their own perspectives. Of the therapist's introduction of the guitar, the parent voices a different interpretation. Commenting 'I got really involved there' (P, 202), she elaborates further on events:

> It's quite sweet because he plays with it (the drum) quite a bit
> but then you can see….his favourite instrument is the guitar or
> piano so instantly he wants to play that, but then he remembers
> he's got that to play with too. There's so much to do! (P, 202-
> 205)

The parent views the introduction of the guitar in terms of the child's expanding activity: the introduction of the second instrument creates a dilemma, in which he needs to make a choice. The dilemma is described positively by the parent: being offered and managing choice is seen to mark a further developmental step. This is not an aspect highlighted by the therapist, and as such it speaks of the divergent and potentially problematic ways of looking that both parties bring to events. Each participant's contradictory account compounds this further. The parent reflects on her own activity, commenting, 'I got really involved there,' a comment that contrasts starkly with the view of the therapist, who describes the parent as 'stuck there with the beater.' The same events appear to be understood quite differently by the parent and therapist. How can this be understood?

I propose that collaborative meaning making happens, as Sawyer suggests, through musical processes, in which the 'performance will shift' in response to innovations (2003, p. 174). As ideas emerge within and through the trio, they are considered, adopted, discarded, or reshaped variously in an unfolding collaborative process. Furthermore, if, as previously suggested, ideation and evaluation are considered as 'constant, ongoing components' within an individual (Sawyer, 2003, p. 174), there may be an equivalent creative process within the trio of parent, child, and therapist. As ideas emerge from and between individuals, pairs, and the three as a whole, they are also considered, understood, assumed, or discarded through the same dynamic web of relationships. And within each moment of collaborative meaning making is contained the seeds of collaborative emergence through which subsequent material might appear.

There is a limitation, however, to the suitability of overlaying the music therapy trio with the jazz ensemble. This lies in part in the discrepancy between the intentions which underlie collaborative processes within both. Within the jazz ensemble, for instance, Monson (1996, p. 26) suggests musicians 'take as their goal the achievement of a groove or feeling', aiming to bring their parts 'into a satisfying musical whole'. Sawyer (2005, p. 4) also notes that within jazz improvisation 'the performance is its own goal'. This may also be the case within music therapy. Aigen (2014, p. 65), for example, notes that many individuals may also be 'motivated primarily by the desire to engage in music: this is their goal in participating in music therapy'.

For the trio, the opportunity to 'engage in music' may indeed be a goal in itself. Certainly, the parent expresses her delight at their shared playing, laughing as she says 'I got really involved there!' But perhaps the trio balances the achievement of a 'satisfying musical whole' with other goals and intentions. For the parent, specific development achievements for the child appear key, together with her enjoyment of witnessing those achievements. While the therapist shares a developmental perspective, a further implicit intention of supporting the shared play and developing relationship of parent and child appears. A particular difficulty appears in considering how differing goals or intentions are managed within the trio's collaborative processes, given that they appear to create divergent understandings of events.

Music therapy practice within the CDS has an explicit remit: to support the child in relation to their physical, cognitive, communicative, social, and emotional development. There is a clear understanding within the service that working towards the fullest

possible developmental outcomes for the child happens not in isolation but by considering the relational world of the child and family (Wood et al, 2016). However, working explicitly to support the parent-child relationship is not usually considered or discussed with parents as a primary intention of therapy.

In comparable settings, music therapy carries the clear aim of enhancing the quality of the relationship between parent and child (Gilboa and Roginsky, 2010; Thompson and McFerran, 2013). Indeed, recent music therapy research within autism suggests that the development of close parent-child relationships may lead to improvements in a child's developing communication skills (Thompson, 2012b, p. 164), or their own capacity to become 'more attuned to' the communications of a child (Gottfried 2016, p. 170). If continuing research suggests that an overt focus on the parent-child relationship in music therapy might contribute to the child's development across other areas, this could hold significant implications for the way music therapy practice occurs both within the CDS and more widely. A reframing of music therapy with both professionals and parents would be required, informing the ways in which the intentions and processes of therapy might be discussed and negotiated. As it is, the study suggests that the therapist foregrounds the parent-child relationship, even though it appears less clear that the parent is actively seeking support in this area. Their understandings of shared events differ, in accordance with the lenses through which both view events.

In terms of an ongoing process of collaborative meaning making, such differing views may not be significant. Collaborative meaning making might not indicate unified agreement on events, their meanings, or implications. It may, rather, enable a way of understanding the trio that allows for multiple, differing interpretations of the same events. The collaborative element may lie in the potential bringing together of differing, even conflicting interpretations. Achieving this in practice presupposes an ideological approach to practice that does not afford one set of meanings greater legitimacy than any others. Such an approach presents a strong challenge to narratives which suggest tensions arise in practice when parents appear to hold 'their own agendas and interpretations' (Warren and Nugent, 2010, p. 27). I would suggest that the tensions do not arise from the interpretations or wishes of parents, but rather in their colliding with those of therapists. At both professional and everyday practice levels, I suggest that the difficulty may lie less with the agendas that parents may hold, and more with the therapist's unspoken intentions. While the improvisatory work of music therapy may inevitably generate multiple meanings for those involved, it may be that the potential for

collaborative meaning making within the trio is further compromised when intentions remain obscured.   This assumes particular urgency in considering questions of parental roles in music therapy.

4. The Trio Appears through Parent and Therapist Sharing a Focus on the Finding of a Parental Role.

Both parent and therapist share a concern for the parental role within the trio. This is not a concern for defining one or more roles. Rather, it finds expression in terms of the activity through which role finding is accomplished. As such, it is the finding and re-finding of roles, as a dynamic, continuous, collaborative process that appeared through the analysis, and that I address here.

It is usual practice in the CDS for therapist and parent to meet prior to a child starting therapy. Among the practicalities that are discussed at what is referred to as the 'pre-therapy meeting', parent and therapist will generally talk about how a parent might be involved in sessions. With this as a backdrop, the parent describes her initial experiences in sessions:

> I know that when I first started music therapy I was really
> conscious, I don't know why, not to get involved, and to let
> Barney be the one to initiate.…I was quite nervous about that
> at the beginning, so I wasn't sure what I was supposed to do.
> And I guess it must just depend on the parent and the situation.
> But because Barney was happy I just let him do it. (P, 140-
> 147)

The parent's initial finding of a role emerges from her experiences of the child and therapy. It is shaped by her reading of her child as being 'happy', and by a reliance on the therapist as she waits 'to be told to do things'. However, an overarching uncertainty is expressed about what she is 'supposed to do'. This raises the question as to whether such uncertainty is inevitable, and what influence that has on the workings of the trio.

Within child psychotherapy, while parents are not generally in the room for sessions, carefully preparing parents for their role in their child's therapy is seen as crucial (Nevas and Farber, 2001; Sutton and Hughes, 2005). Sutton and Hughes propose that therapists 'must know our role and the role of parents', arguing for clarity as to the parts each might play (p. 169). In music therapy, Oldfield (2011, p. 65) has speculated on

whether she might alleviate parents' initial anxieties by saying 'more to parents about what their role will be'.

The tension created here is that in seeking to clarify the parental role in advance, there may be a tendency to frame it in static terms, as though fixed and predetermined. While there may be aspects of involvement which can be discussed clearly in advance, understanding the trio as an emergent whole suggests that the parental role, or roles, may also appear through the shared activity of sessions. As the parent comments on watching video of herself drumming:

> 'As a parent I've got more comfortable in the sessions and knowing what to expect as well, and getting to know Laura as well.…I just remember before that I wouldn't have been confident to do that.…maybe because I didn't know Laura well, maybe because Barney wasn't as engaged and communicating so much.' (P, 211-219)

The finding of a role occurs then through a complex interplay of events: the child's developing skills, increasing familiarity with activity of sessions, and the growing relationships between parent and therapist and therapist and child. Notable here is that the developing therapist-child relationship is itself a catalyst for the increasingly active role of the parent. While the therapist has noted activity within the sessions shifting towards 'it being me and him' (Th, 307), implying a certain degree of exclusion of the parent, again the experience of the parent suggests otherwise. The emerging relationship between child and therapist is one means through which the parent's involvement grows and a further role appears.

The therapist also appears aware of the shifting nature of the parental role, shaping her own approach accordingly. The parent recalls the therapist's part in supporting her own increased involvement in the trio, commenting that 'Laura's incorporated little games where he sees me getting involved' (P, 148-149). The therapist too recollects introducing particular joint activities, as a way to 'just initiate her coming in to it a bit more' (Th, 122). In an approach that echoes Thompson's kinetic notion of 'stepping forward and back' in working with parents, specific activities that 'Mum's brought in' (Th, 144-145) are then incorporated into sessions (Thompson, 2014, no pagination). A flexing of practice takes place, in which the parental role continues to emerge through an active accommodation by the therapist.

Within this particular trio, the therapist works to accommodate the finding of a parental role. Other music therapy trios within the CDS have a different composition: currently trios might be formed by the core pair of child and therapist, together with either a non-parental family member, paid carer, nursery or school key worker, or other CDS professional (Strange, 2016). The therapist may well also consider the ways in which each particular person attending with a child finds a role within sessions, although this has been beyond the scope of this investigation. I would suggest, however, that a defining feature of the trio, as revealed in this study, is the therapist's close attention to the parent-child relationship and the ways in which, through consideration of the parent's role in sessions, the relationship between parent and child might be supported further. How that might be seen to translate when others attend with children would be the work of a further study.

Returning to this research, it appears that a further influential element in the finding of a parental role is physical positioning in the room. The trio's physical positioning also emerges as having an impact on the finding of a parental role. The therapist notes that, previously, the child was not yet able to sit unsupported. To some extent, the parent's role was prescribed by the need for her to provide physical support to him. The implications of this are expressed by the therapist:

> So her role was, in the last block a lot about kind of supporting
> him from behind.…and so it was a lot of kind of me and him
> playing and her kind of being physically supportive rather than
> being involved. (Th, 107-110)

As the child's independent sitting becomes more secure, a greater degree of active parental involvement become possible. What is then possible between the three changes. The physical positioning of the three raises a further issue however. On watching the video, the parent notes that her position, just behind and to the side of the child means 'you can't see the eye contact side of things', referring to the child looking towards the therapist (P, 77). While, by supporting the child physically, the parent is performing a crucial function, this is at a possibly significant cost to parent and child. The parent is unable to see what the therapist sees, in this case the child looking towards the therapist.

This is problematic, not least because of the conflict it raises with the therapist's previously stated intent to support the child/parent relationship. In the parent acting as the child's physical supporter, the therapist effectively, if inadvertently, lessens the

opportunity for child and parent to engage more directly. A perspective that crosses disciplines to musicology is helpful here in considering the potential impact in the music therapy ensemble.

Kokotsaki argues that visual and aural connections play a vital part in the coordination of activity between players within musical ensembles, suggesting that:

> When the players managed to externalise their attention towards the ensemble environment efficiently by achieving effective aural and visual communication with the co-performers, the quality of the ensemble playing was enhanced. (Kokotsaki, 2007, p. 658).

The music therapy trio may not necessarily be concerned with achieving a particular level of ensemble playing. It does, however, emerge through coordinated activity between its three members. What can be seen, and by who, shapes the ease not only with which such coordination might happen, but also the ways in which such coordination, or lack of it, might be experienced. In practice, therapists need to be alert to the visual perspective afforded to each member of the trio, particularly when a child requires physical support. In the first instance, this implies questioning the therapist's view, and the privileged perspective it may afford. While, if discussed openly, there may be mutual agreement on the parent acting as support, at other times it may be more appropriate for another professional or family member to attend to assume that role. This would enable the parent to adopt a different position and therefore, role, in the trio. In such cases, it may also be helpful for therapist and parent to review video of a child's therapy more frequently during the course of therapy.

While the parent's involvement may be shaped by positioning, it is possible to highlight further specific ways in which parental involvement itself shapes the trio's emergence. Particular roles which the parent assumes in relation to the child are illustrated in the graphic score. These include acting as a physical facilitator, offering the child beaters (9:48; 10:01), a musical partner[23] in drumming with her child (9:58–10:00, 10:14–10:18): a musical prompter (10:03–10:05; 10:21–10:22), and singing 'Barney do it',

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[23] Pattern C (see Appendix 9 for descriptions of all patterns), identified as parent and child drumming together.

within a pitched, rhythmic, repeated motif.[24] The parent plays an active part in generating and sharing the child's musical involvement.

Interlinked layers of emergence become apparent here. Not only do the parent's actions support the child's playing as an individual, but they also shape developing play between the parent-child pair. The activity of both individual and pair, in turn, influence evolving events within the trio as a whole. This is most clearly apparent in Pattern N, identified as the emergence of a tonal centre (cf. Table 3:17). The parent introduces a short melodic motif at 10:03 (Pattern M), which reappears in slightly altered forms in the singing of both parent and therapist, culminating in the sounding of a tonic chord at 10:25.

Active musical participation enables the parent to find a role within a trio which, in itself, is not a fixed or stable ensemble. The trio emerges through the activity and interactivity of all those within it, and the parent plays a crucial role in bringing the trio itself into being. As Berliner says of the jazz ensemble:

> Every maneuver or response by an improviser leaves its momentary trace in the music. By journey's end, the group has fashioned a composition anew, an original product of their interaction.' (Berliner, 1994, p. 349)

Parent, child, and therapist all leave their 'momentary trace' in the appearing of the trio. In doing so, roles are found, and in their finding the trio creates itself anew in a collaborative, emergent process.

The discourse of 'momentary traces' with its ephemeral connotations brings to the fore the particular dissonance sounded in considering music therapy as a service in a predominantly medically oriented organisation. The language of traces and even of improvisation can appear at odds with that of assessment and diagnosis. So, too, can discussion of the parent and therapist's collaborative work in finding parental roles jar with the ways in which conventional doctor-patient/parent relationships are accomplished. This aspect of the study in particular appeared to me as suggestive of the distinctive nature of music therapy with a child and parent present, within the wider context of the CDS. I return to this in Chapter 4.

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[24] Pattern M identified the motif's melodic shape, while Pattern K is used to identify the rhythmic trace, also used by the therapist at 10:16-10:17 by the therapist.

Returning to issues of the parental role, this aspect of the study carries practical implications for everyday music therapy practice. At a pragmatic level, therapists need to be alert to the evolving role, or roles, of the parent, within therapy. At the outset of therapy, discussion between therapist and parent may help to alleviate the anxieties of all involved. Such discussions could be informed by an understanding of the dynamic nature of roles within the trio and their evolution over time. Finding ways to review and revisit initial understandings of roles, and adapting them in response to changes within the trio, could be seen as a crucial part of the ongoing, collaborative activity of therapist and parent.

5. The Trio Appears through Changing Forms, Person, and Places

This study has investigated place-specific music therapy with a child when a parent is present. The research design focused on the detail of a single case: a child, parent, and therapist engaging in music therapy in the same setting each week. The findings, however, suggest that the trio is not so easily bounded. Rather, it appears in fluidly changing forms, emerging in relation to people, places, and roles beyond the singular space of the music therapy room. The extent of its continually changing manifestations went beyond those I had envisaged prior to beginning.

I had anticipated that the child's home life would form part of the music therapy experience, and this was indeed the case. Given her observations within therapy, the therapist alludes to the child's home environment, speculating on the ways in which parent and child might interact at home. Connections between activity in sessions, and with the father at home, are made. Commenting on the choice to have two guitars available in therapy, the therapist notes:

> Mum has talked quite a lot about how they have one at home
> and I think Dad plays the guitar, and it's just felt like a nice
> marker for Barney to have them down there….most weeks
> there's a comment about how he's been using (the guitar) at
> home, so perhaps it's something about bringing Dad in a bit.
> (Th, 85-92)

The therapist's use of the guitar represents a 'bringing in' of the absent parent. I suggest that it is not only the father who is brought in here, but also the familial trio of father, child, and mother, for whom the guitar is a familiar and significant instrument. In

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doing so, the music therapy trio changes form: albeit implicitly, it becomes a quartet in which the therapist becomes a fourth member alongside mother, father, and child.

The phrase 'bringing in' appears to characterize the relationship of therapist to the wider family unit and home environment. There is an apparent directional flow in her thinking: aspects of family life are considered in relation to the activity within the music therapy room. This flow is in contrast with that of the parent. The parent's focus flows more fluidly outwards, towards the trio of family life. There is less attention on 'bringing in', and more on the homeward direction. Specific activities from sessions become an apparently natural part of the family's way of being together:

> So we'll sit at the dinner table. If he's banging the table my
> husband would bang the table too, and….we'll do responses,
> respond and communicate. We've learned that from speech
> therapy and watching music therapy. (P, 266-169)

The parent suggests that ideas from sessions are subsequently used at home. This not only occurs through a parent learning by imitation, but rather through being 'able to apply what they had experienced' (Thompson et al, 2013, p. 8). Applying experiences occurs through an active reworking of ideas to fit with people or places elsewhere:

> At home now we play a game with up and down with a cloth.
> And we do a similar song to the one Laura made up….but I got
> the idea from Laura. (P, 325-237)

The idea of the game, originating within the session, has been appropriated by the parent. In its appropriation, a transformation occurs: a new manifestation of the song appears, tailored by, and to, the family in a further emergent process. There is little evidence to suggest that the therapist is aware of this lively process beyond the therapy room.

It is as though there is a degree of permeability to the trio: activity, thought, experiences, and relationships move freely in and out of the therapy room, crossing what could be construed as the permeable borders of the sessions themselves. I suggest that such movement occurs more fluidly because of the parent's presence in music therapy, and that this would be less likely to occur without it. The trio becomes a necessary vehicle for such permeability to manifest itself; to be achieved it is dependent on the parent and child. The therapist is, by the nature of the post, fixed in terms of place, their experiences of child and parent gleaned largely from within the

music therapy session. The therapist's capacity to be part of a free-flowing movement from within to without the session is limited, their activity taking place almost exclusively within the music therapy room. For child and parent, only a minute part of their lives together takes place within the music therapy room; their relationship is largely formed in other places, through other events, and in relation to other people. In being part of the trio, the parent enables the activity and experience of music therapy to move easily out of the confines of the session, becoming intertwined with the family's everyday life.

The parent, therefore, seems to be a crucial conduit, acting as link between music therapy and everyday life in the outside world. The parent knows the child in both contexts: observing changes, noting ongoing difficulties, and using other environments and relationships as a means of measuring growing developmental skills. It might be argued that the same could be true in other trios, such as when a paid carer or school key worker attend. They, too, see the child both within therapy and in the outside world, and they also act as conduit. While there may well be significant overlap, I suggest that it is in the nature of the relationship between child and the third person that a qualitative difference lays. The parent links the trio from the music therapy room directly into the family, and back again, in a way which may not be possible for any other carer.

The parent as conduit, with the capacity to cross the trio's permeable borders enables a reciprocal flow of music therapy activity. There is the potential, therefore, for music therapy to become part of intimate family events and relationships, finding form in newly emerging ways. The parent's natural capacity to cross borders with the child from therapy room to home suggests that it is crucial for music therapists to work closely alongside them with the child. The evidence suggests, however, that the therapist did not necessarily acknowledge or give weight to the parent's distinctive role as conduit. The notion of permeability, of musicing travelling between therapy room and home, became a key finding from the Preliminary Study, which was to trigger the further phase of research.

3.9 Concluding the Preliminary Study

Offering a Brief Summary

The Preliminary Study investigated a single trio, the phenomenological approach characterised by attending to 'the appearing of what appears', leading to the articulation of five themes. I include them here as a reminder before weaving them into the summary of my understanding of the trio and the specific issues raised by the study:

1. The trio appears through the parent and therapist sharing a focus on the child
2. The trio appears through the differing perspectives of parent and therapist
3. The trio appears through collaborative processes
4. The trio appears through parent and therapist sharing a focus on the finding of a parental role
5. The trio appears through changing forms, person, and place

It is perhaps not surprising to arrive at the end of this phase of enquiry and state that the child appears as the focal point of the music therapy trio (1). This is entirely appropriate. The purpose of the organisation, and the service, resides in meeting children's developmental needs. This is the healthcare context out of which the trio emerges. The attention of parent and therapist converge on the child, seeking to meet need, to catch moments of change, and to witness the child in relation to another. In prioritising the child and their development, the therapist and parent find shared purpose, a collective musicing appearing to offer the collaborative means for the three to be together (3).

Yet alongside the narrative of shared intention lies an equally powerful one of divergent purpose (2). Indeed, the trio shows itself precisely through the differing perspectives and intentions of parent and therapist. Often, unspoken, personal, and professional agendas shape and thread together into events, continually informing the meanings being made. This more tangled narrative collides with the apparently simpler story of a clean and clear shared purpose. In this collision, I suggest, significant impediments to the nature of the collaborative processes within the trio can be found.

In part, these difficulties find expression in the uncertainties about the parent's role in therapy, in relation to the child, the therapist, and the activities of music therapy (4). This is preoccupying for both therapist and parent, and while it emerges as common ground between them, it also remains hidden from view, as though it is something each must manage for themselves. This emerges most strikingly in the therapist's implicit intention to support the parent/child relationship.

At a practice level, this raises again the question as to whether families 'know what they are getting?'; that is, what the intentions of the therapist are (Jacobsen and Thompson, 2017, p322). At a professional level, it foregrounds questions of power in the therapeutic relationship and the enactment of an incipient paternalism in which professionals privilege their own understanding of what is best for families.

However, a further facet through which the trio comes into being can be seen that complexifies the picture further. The trio is characterised by its permeability, its activities not contained within the time, persons, or place of the music therapy room, but finding renewed expression in the family home (5). Such permeability appears as a further hidden narrative, achieved by the skilled, intuitive work of the parent in appropriating and translating events across settings.   I would argue that the active, creative processes at work here challenge a conventional therapy-centric view of music therapy. The work of the trio appears not only within the therapy room, under the therapist's purview, but reaches beyond, to the places and people of everyday life of which the therapist knows relatively little.

The trio's permeability appeared as one of the unexpected, and unlooked-for, manifestations of the phenomenon. It was in the unexpected that the investigative impetus leading to the next phase of study was to be found.

Pointing Forward

The Preliminary Study was intentionally exploratory in nature (Smith et al, 2009). My aim was to 'open up' an investigation into the trio and, through the methods used, consider the phenomenon in its appearing (Ansdell et al, 2010; Bortoft, 2012). In doing this, further questions began to arise, which themselves suggested important areas to pursue in the next phase.

The study's findings challenged a view of the music therapy trio as solely concerning the child, parent, and therapist in the weekly music therapy session. The trio, rather, appeared as a dynamic, permeable configuration of roles, relationships, and events. I believed that the extent to which the trio stretched, and the nature of such stretching, warranted further investigation. My suspicion was that it was in the contact with the professional, organisational, and everyday worlds that some of the particular areas of tension and creativity in the trio arose.

Music therapists within the CDS work closely with parents week by week. Together with parents, they discuss, agree, and work towards developmental goals with the child. Such collaborative work is constitutive of the trio's fabric. How though, is that fabric differently created if intentions for music therapy differ, and specifically, if the therapist holds a central focus on the parent/child relationship that is not made explicit? To what extent might such a perspective arise from a professional background or agenda, which gives weight to early relationships but is invisible to parent and child?

There are also questions as to the ways in which the organisational context of the CDS influences the appearance of the music therapy service and the work of the trio. As outlined in the chapter 1(cf. p. 22), a largely medical discourse of assessment, diagnosis, and treatment prevails, which the music therapy service identifies itself with to a large extent. This alignment is challenged, however, by the very nature of music therapy practice. Its improvisatory, emergent, participatory character distinguishes it from the more conventional medical encounter. It also creates a tension with a goal and target-driven approach to healthcare which forms an increasingly dominant narrative. I am left with further questions as to the ways in which the organisational interacts with the ways music therapy is offered and described. More specifically, there is an imperative to consider the impact on the everyday work of child, parent, and therapist in music therapy.

This study's explorations have revealed the trio as appearing through the active work of parent, and indeed child and family, beyond the therapy room itself. In itself this indicates that it is not feasible to understand the trio simply as it shows itself within the weekly context of the session. Nor can it be understood only in terms of the trio's three people. This shift in ways of looking raises particular questions. For instance, where, with whom, and how does the trio manifest itself elsewhere? What is the nature of the parental work in linking music therapy with home life, and how is this understood by the therapist and others? My suspicion, at this point, was that in following a trail of enquiry

beyond the confines of the therapy room, conventional understandings of therapeutic practice as being time, place, and person specific may be challenged, bringing implications for professional practice.

The next phase of study, then, required a different kind of 'opening up'. It demanded that the scope of enquiry be broadened, opening, as it were, the door of the therapy room and following the trio elsewhere. To do this would require reconsidering my research approach, and considering different research methods. I address these issues in the following chapter, which provides a bridge between the two enquiry's phases. In drawing this chapter to an end though, I reflect on the study's methodological and ontological aspects.

Reflecting on Methodology

The study employed a hybrid methodology. It combined VEI as a means of investigating the experiences of parent and therapist in music therapy with microanalysis aimed at exploring how an analysis of musical-social processes might further an understanding of the trio. The challenge throughout lay in linking the two strands of activity together to construct a coherent whole.

Considered alongside the interview material themes, the microanalysis added depth and texture to the emerging picture of the trio, also allowing the two data sets to be speak to each other. The pause points, generated at interview, guided the selection of the extract for microanalysis, pointing towards episodes that appeared to be particularly noteworthy to participants. I sought to integrate aspects of the interview process with the development of the graphic score. I intentionally placed direct quotations within the graphic score, allowing words, activity, and the articulation of patterns as observed within the score, to be considered in the light of each other.

The microanalysis not only expanded findings but also revealed new ones. This was apparent particularly in the section from 10:03 – 10:10 (Fig 3:7) in which a significant example of the complex musical-social activity of the trio appeared. This exemplary episode contained three seconds of activity in which not only each individual, but also each pair, sounded. This brought a key idea to light: that is that musicing makes possible a simultaneity not only of individual voices but also the trio's constituent pairs. This event could not have come to light from the interview material alone, only revealing itself through close examination of the graphic score.

The VEI framework yielded a rich array of material. Viewing video material engaged research participants in a lively process, prompting them to recall events and experiences, reflect on them, and relive them at interview (Henry and Fetters, 2012). The reliving found expression in physical form, the parent in particular appearing animated in watching the video, tapping her foot and moving rhythmically in time with the activity on the screen. On reflection, I would describe such activity not as a 'reliving' of events, but rather as a new 'living' of them, experiencing them as though for the first time. Given the differing visual perspectives for participants between being in the session and viewing the session on video, events were viewed differently or indeed, actually seen for the first time. It could be argued that in viewing video of the trio, the trio itself is reconfigured, experienced differently, and changing once again in form.

Given the logistical requirements of VEI, researchers are advised to use more conventional interview formats (Henry and Fetters, 2012). In this instance, conventional interviews would have deprived the study of some of its particular immediacy. The more usual semi-structured interview brings opportunities for recall and reflection, events and experiences of necessity being described and considered in retrospect. Viewing video offered the possibility of seeing events which, although past, were being played out as though in the present. This appeared to encourage the emergence of new thoughts and experiences, born out of the viewing of events as they appeared on the screen. The dynamic nature of this method appeared particularly apt given the 'upstream' focus of the study, with its attention on the trio's appearing (Bortoft, 2012).

Within the preliminary study, a number of methodological limitations emerged. One such limitation arose through the choice to use existing video recording of clinical material. The scope of the microanalysis was determined in part by the quality and framing of the video. While the video provided adequate material for the project, further detail could have been extracted had it been of higher quality. Equally, one could argue that this kept the study close to the practical realities of the everyday real-world practice being investigated here.

The hybrid methodology, utilising both interviews and microanalysis, also caused a unexpected idiosyncrasy during data analysis. Having watched the video material twice at interviews, I did not then watch it again until some months later, when I began

the microanalysis. I had, however, heard the video material multiple times while transcribing the audio recordings of the interview material. The audio trace was therefore familiar to some degree when I came to the microanalysis. This could only be acknowledged, and while I do not feel it played a significant part in shaping the microanalysis, it did emerge as an unexpected feature of the chosen research design.

Finally, decisions concerning the interview process brought a particular research dilemma to light. The therapist and parent were interviewed separately in the study. I argued this on the grounds that a fuller, freer conversation might be possible without the added presence of the other (cf. p. 74). This was informed in some ways by the wish to explore the trio from different angles of experience, but the decision also carried an ethical element. I felt that potential power imbalances inherent in the therapist/parent relationship might influence the degree to which either party felt free to speak of their own experiences if together. As it was, the therapist voiced concern to me at recruitment that, as researcher, I might be privy to opinions expressed by the parent on a child's music therapy which she, as therapist, might not hear. This spoke of the need to consider issues of power not only as they appear between research participants, but also in relation to the researcher. This was perhaps particularly true given my multiple roles of researcher, practitioner, and colleague at that point. This became a further issue in the next phase of study as my position within the service changed.

Reflecting on Ontology

One further tension arises in reflecting on the preliminary study, and that is the question as to whether the term 'music therapy trio' carries any ontological validity. Can the 'music therapy trio' be helpfully understood as a trio at all? The term arose originally from my interest in piano trios, but how helpful is it to frame music therapy practice with a child and parent as a trio, and what kind of trio might that be? There seems no reason why the parent, child, or even therapist should think of themselves as being part of an ensemble such as a trio. The word 'trio' is used only once in the interview material. That was by the therapist, whose use of the term I would attribute, at least in part, to her knowledge of the study from various presentations of it made within the team at its inception. It is more likely that music therapy is understood as an individual therapy for the child in which a parent is also present, as is indeed the case with other therapies in the CDS. Perhaps the term is only helpful for me as researcher,

and maybe even then as a label of convenience, avoiding the long-winded and clumsy description of 'music therapy with a child in which a parent is also present'.

I have discussed the trio in this study in the light of theoretical frames through which the musical-social processes of jazz improvisation or Western classical chamber music ensembles are understood (Sawyer, 2003, 2006; Berliner, 1994; Monson, 1996; Kokotsaki, 2007). While the theorising of musical-social processes across both genres offered aspects of a 'fit' with the music therapy trio, a significant ontological gap seemed to present itself. That gap lies in the underlying musical-social impetus, or raison-d'être, for each of the ensembles. While Monson (1996) suggests that in the jazz group performers aim towards a 'satisfying musical whole' (p. 26), and Kokotsaki (2007) alludes to the enhancement of 'the quality of the ensemble playing' (p. 658), the setting in which the music therapy trio takes place suggests other intentions, namely the child's developmental needs, as central in bringing the trio into being. Neither do existing theoretical frameworks of music therapy practice seem wholly adequate for understanding the trio in this particular setting, sitting as it does between the conventional dyad and group work. The setting also determines the nature of practice, meaning that models of practice which explicitly seek to support the parent-child relationship may not be an entirely appropriate fit either (Edwards, 2014; Jacobsen et al, 2014).

At the conclusion of this Preliminary Study, I suggest that the music therapy trio, brought into being when a parent attends their child's music therapy, has defining qualities of its own that require particular attention. The music therapy trio within a healthcare context such as the CDS may need to be considered as a distinctive kind of ensemble. As such, it may demand a discrete conceptual framework through which practice can be developed, and theory built.

Chapter 4 : Interlude – Reviewing and Refining

4.1 Introduction

This chapter, positioned at a halfway point in the thesis, offers a bridge between the study's two phases. It begins from the questions raised by the Preliminary Study, which suggested that a further 'opening up' of the investigation was necessary, both to pursue emerging trails of enquiry and to broaden the methodological approach through which to pursue them. In this chapter I make the case for both the expanded area and the methods, of study. I introduce fresh concepts, contextualising them in the broader arena of healthcare discourse, and also introduce new, associated theoretical ideas. In doing so, I point the reader towards the issues and questions posed in the Main Study that follows.

4.2 Emerging from the Preliminary Study – Pointing Forward

At the close of the previous chapter, I posed a question as to the ontological validity of the music therapy trio: can the configuration of child, parent, and therapist be understood as a trio at all; could there be a shared understanding; and if so, by whom and of what? I offered a graphic representation of the complex layers through which the trio could be seen to appear between individuals, within pairs, and between pairs and individuals (Fig. 3:5). This graphic also proposed the trio's fluid permeability, marked by the inward and outward movement of people, place, and activity. I argued that the trio may prove to be an inadequate tool for describing this particular music therapy phenomenon, not least because it constrained it to both person and place. In order to understand the enactment of music therapy with a child and parent in this healthcare context the intention was to remove some of those constraints, and use a wider investigative lens.

What, then, of the heuristic of the trio? In the study's next phase I intentionally set the notion of the trio as a focal point to one side. This enabled the freer exploration necessary at this point in following music therapy 'out of' the therapy room to the places and people suggested in the Preliminary Study. I will return to the methodological detail of this shortly, but mention first a further reason for setting the trio

aside. On reflection, I wondered if I, as a practitioner, had become unhelpfully attached as a practitioner to the trio as a concept, and whether this brought with it influencing assumptions (Stige et al, 2009). Turning the interrogatory spotlight away from the trio as a discrete unit allowed me a critical distance, testing it as a concept further through its absence while open to reconsidering its value at a later date. While, in the following chapters I still occasionally use the term 'trio', I do so openly as a writing shorthand. As such, it should be taken simply to indicate reference to the grouping of child, therapist, and parent.

Turning aside from the detail of the trio was necessary in order to pursue the further 'opening up' suggested at this point. This expansion can be understood in two key ways. First, the phenomenon itself – that is, music therapy with a child when a parent is present – had revealed itself as complex and interwoven. It appeared as both contained within, but also uncontained by, the time, place, and person of the music therapy session. The permeability suggested by the study warranted further investigation in order to explore the extent and nature of the interconnections with other people, places, and events. How, if the trails of the trio were followed, might a complexified understanding of music therapy with a child and parent emerge? And how might such an understanding be used to address the practical and theoretical problems presented in this enquiry?

Second, expanding the area of research interest necessitated extending the methodological frame. The focus on individual experience within the Preliminary Study had made IPA an appropriate investigative approach. This required fresh consideration given the expanded scale of the next phase. I deal with specific methodological decisions in the following chapter, but mention here two orienting principles that anchored the design of the subsequent phase.

From its inception the study was practice-led, concerned with what people did with each other in a particular music therapy service. The focus was on the processes of everyday music therapy and the mechanisms through which it was accomplished. Social science researcher Sarah Pink describes an approach to researching the everyday which conveys this intention vividly:

> The goal of the scholar of everyday life and activism is not to find ways to cut across places and practices where everyday life and activism are played out and examine the flat surface that is left…Rather, she or he should find her or his way

through its unevenness, following those whose lives, actions
and things she or he seeks to understand. It is indeed by
following people, things, representation and narratives that we
encounter the very trails that are important and arrive at the
intersections where meanings and changes are made. (Pink,
2010, p. 34)

Pink's call to embrace the 'unevenness' of the terrain of practice aligned with my own
epistemological understanding and methodological intentions. I set out consciously to
complexify the picture of music therapy; to make it, as it were, 'messy', by pursuing the
trails of action and knowledge that those within and around music therapy generated.

Reading Pink generated a trail of its own, leading me towards the work and ideas of
anthropologist Tim Ingold. Ingold (2000, 2007, 2008a) has a predominant interest in
the relationships between human beings and their environments (2000, 2007, 2008a,
2010). He argues for a dynamic interdependence in terms of how both evolve,
proposing an approach that considers:

[…] the organism-person, undergoing growth and development
in an environment furnished by the work and presence of
others. (Ingold, 2000, p. 4)

The lives of people, and the environments within and through which those lives are
lived are created in mutually influencing processes of generative activity. Neither,
Ingold (2008a, p. 1796) argues, are people and environments to be seen as 'bounded
entities'; rather they comprise an 'entanglements of lines' (2007, 2014). Such lines and
their entanglements constitute what Ingold terms the 'meshwork' (2007, 2008a). As he
describes it:

The lines of the meshwork are the trails *along* which life is
lived. (Ingold, 2007, p. 81, italics author's own)

Ingold's italics emphasise the significance of the trails themselves in an understanding
of the way lives are lived. In placing this emphasis, he makes a clear distinction
between the notion of lines in the meshwork and the network. In the latter, he argues,
lines have come to be seen as 'connectors', linking dot to dot, entity to entity (2007, p.
80). The lines of which Ingold speaks are active, intertwining, and, generative. These
are the trails of which Pink (2010) speaks, and which I was concerned with following
here. Given the intertwined nature of music therapy as it had shown itself to this point
in the study, how might the phenomenon be understood in terms of a meshwork of

interlinking trails? How far might such a meshwork extend, whose trails might be drawn into it, and how might the interweaving of lines show itself?

These questions found a further echo in DeNora's notion of 'slow sociology' as a research approach. She describes this as:

> […] devoted to the cultivation of intimate forms of knowledge
> and to the detailed features of what happens locally, here and
> now. (DeNora, 2014, p. 3)

A clear focus on the meshwork as it showed itself locally, in its unevenness, became the backbone of the next phase of study. The commitment to the people, places, and events of the local, however, needed to be understood in relation to the broader political landscape of public involvement in healthcare.

4.3 Testing out Approaches
Partnership within Healthcare

The Preliminary Study pointed towards the intertwining work of therapist, child, and parent in music therapy.[25] I became convinced that, given its participatory nature, it was not possible to conceive of either the practice of music therapy, or its investigation, without giving appropriate weight to the work of all those within it. This conviction had implications at this bridging point, as I sought to bring the next phase into focus. Contextualising the study in a particular NHS narrative around patient involvement grounded my thinking at this point. I include here a limited review of the relevant literature which brought significant impetus and direction to the research process.

In 1999, Angela Coulter, then the Executive Director of the influential health charity the King's Fund, wrote an editorial entitled, 'Paternalism or Partnership?: Patients have grown up and there's no going back'.[26] Patient partnership, she proposed was 'firmly on the agenda in the NHS' (p. 719). Despite the amount of activity in the area since 1999, in 2012 Coulter reported on the effects as being 'disappointing', citing the

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[25] Figures 3:6 and 3:7 in chapter 3 both indicate the dynamic nature of each participant's activity.

[26] The King's Fund works to improve health and care in England, and espouses a vision of optimal health and care for all https://www.kingsfund.org.uk/about-us

organisation as a whole to be insufficiently patient-centred (p. 4). A recent narrative review further fleshes out the picture of patient involvement during that period, noting the sporadic nature of change and the 'power imbalances' that permeate the involvement process (Ocloo and Matthews, 2016, p. 629).[27] The imbalance of power is commented on forcefully by Gibson et al who describe some models designed to encourage patient and public involvement as being:

> [...] controlled by salaried involvement professionals with committed volunteers being allocated a secondary, relatively impotent and subservient, role in organizational and bureaucratic labyrinths. (Gibson et al, 2012, p. 534)

Certainly, the organisational challenges of building patient involvement are deemed to be complex (Renedo and Marston, 2011; Armstrong et al, 2013; Filipe et al, 2017). Beyond the organisational considerations, however, lie ideological problems with the notion of 'patient involvement' itself (Centre for Patient Leadership, 2013; Seale, 2016). Involvement is often construed as a tokenistic invitation for lay representatives to contribute to existing organisational structures and systems. The emerging concepts of 'patient leadership' (Centre for Patient Leadership, 2013) and later 'shared leadership' are intended to disrupt conventional healthcare dynamics of patient and provider, and signal a fresh approach to designing and offering healthcare (Seale, 2016). [28] Emerging models such as these challenge a status quo, seeking to value and utilise different knowledge, skills, and experiences in creating health and care services (Gibson et al, 2012; Filipe et al, 2017).

From Involvement to Crafting

This broader policy narrative steered the emerging perspective for the next phase. Framing the enquiry as an investigation of parental involvement became problematic. To do so risked presenting therapy in paternalistic terms as something into which a parent might be invited rather than, as the Preliminary Study suggested, something in which the activity is jointly generated with the parent. I needed to find another lens

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[27] Ocloo and Matthews (2016) note the terms variously used in the literature to denote involvement including 'consultation, engagement, participation, partnership or co-production' (p. 327), which may imply greater or lesser degrees of involvement.

[28] David Gilbert and Mark Doughty established the Centre for Patient Leadership, a collaborative venture arising in part from their own experiences as patients over significant periods of time. (www.engagementcycle.org/about-us/centre-for-patient-leadership)

which offered a better ideological fit, and which mirrored more closely the detailed activities of all three in the trio as seen in the Preliminary Study.

Evident within the trio's workings was what could be understood as the 'craftsmanship' of the individual and the individual in relation to others (Sennett, 2008). From a recent music therapy practice perspective, Rolvsjord (2016) has traced the frequent emphasis in literature on the therapist's craft. This is particularly evident in terms of a prevailing discourse of interventions or techniques within a conventional medical model. Rolvsjord argues for a reorientation of emphasis towards the client's craft, described as 'competence and efforts in using music in everyday life, and competence and efforts regarding the therapy sessions and therapeutic process' (p. 561). In changing the emphasis, the therapist's crafting role then shifts from 'the intervening expert' to someone who works collaboratively, seeking partnership with the client. However, examining 'craft', Procter (2014, p. 25) suggests, is often lost within what he terms the 'triumphalist narrative' of the professional expert.

Adopting a practice perspective that considers both therapist and client to be crafting therapy together has implications for the way music therapy is investigated. In an earlier paper addressing questions of what constitutes evidence, and for whom, DeNora argues the logic for an equitable approach, saying:

> A focus on the music therapist's craft as the active ingredient in music's therapeutic effectiveness leads to the symmetrical concern with what the client does….If we are to understand the mechanisms of music's effects, then, it is important to develop a symmetrical focus on both the music therapist's and the client's craft. (DeNora, 2006, p. 90)

The findings from the pilot study suggested that the crafting within the trio could not be understood in individualistic terms. Removing one voice rendered the whole meaningless. Both from an ideological perspective and in terms of exploring further the 'mechanisms' through which the broadest manifestations of the trio appeared, it became clear that a 'symmetrical focus' was necessary. As a research stance, I hoped this would enable me to resist privileging any one particular voice, activity, or role in my investigation, or pursuing an approach that centred the therapist.

Exploring Expertise

During the period in which the bridging work between the two studies took place, I read widely, particularly exploring healthcare literature in areas of parental involvement, participation, and crafting. In doing so, expertise began to emerge as a frequent theme. This sparked a curiosity in me. Could the participatory work of music therapy be interrogated in terms of expertise, and might this offer a way of both acknowledging the activity of all and resisting any grand narrative of singular professional expertise? Guided by these questions, I searched healthcare literature purposefully in order to uncover relevant literature. My focus lay in finding literature addressing expertise across and between professionals and families within children's healthcare in particular. I begin here, however, with some broader thoughts on professional expertise, as suggested through contemporary literature.

A Broader Healthcare Perspective

Professional groups often have particular interest in understanding and defining their own specific areas of expertise. This is seen, for example, in recent papers within community nursing (Dickson et al, 2017) and speech and language therapy (Jackson et al, 2017). This is understandable, given the political imperatives there may be to achieve professional legitimacy, or to create the 'triumphalist narrative' of which Procter (2014) speaks. Jackson et al suggest that, in addition to core competencies, it is when practitioners are 'seen to contribute to the community' that they become known as experts, suggesting that it is in the relational turn that professional expertise comes to be understood (p. 614). Defining professional expertise may assume importance in relation to questions of practice, efficacy, and training, as seems evident in a number of papers in a recent psychotherapy journal (Hill et al, 2017; Reese, 2017; Goodyear et al, 2017). As Goodyear et al comment, 'it will affect how we practice, how we prepare others for practice, and even the quality of care our clients receive' (p. 56). O'Shaughnessy et al stand out as relatively isolated voices, arguing against the notion of an individualised, absolutist therapeutic expertise:

> We struggle to see how expertise can be decontextualized
> from a specific clinical interaction or setting and individualized
> into the characteristics of a single clinician. Said differently, we
> suggest that there are just as many ways of being an expert
> therapist as there are ways of knowing and being in the world.
> (O'Shaughnessy et al, 2017, pp. 95-96).

The authors suggest that it is in the therapist's flexing in response to person, place, and moment that expertise becomes apparent. It is through this responsiveness that the

therapeutic relationship becomes, in Rolvsjord's words, 'something evolving and unfolding between two human beings', dynamic and respectful of what the other brings to the encounter (2016, p. 561).

The Danish psychologist and psychotherapist Ole Dreier, brings a further voice of interest to this discussion. His low-key definition of therapist's expertise is that it consists 'in a general knowledge from which a set of techniques are derived as professional know-how' (2008, p. 3). His research interest is not, however, concerned with those techniques, but rather with the work of clients, both in but particularly beyond sessions, in bringing about change (2008, 2011). That this is the way in which the work of therapy is accomplished is taken as self-evident, given the relatively insignificant amount of time client and therapist spend together each week. As he asks, if appointments last for an hour, 'how then can sessions be so decisive as to trigger everything else?' (2008, p. 17). The clear implication is that clients bring their own 'know-how', or expertise, to the therapy process.

In turning attention to the work of parents and professionals in, predominantly, children's healthcare, the negotiating and contesting of expertise and know-how can be seen to thread through the literature. Parents accrue and develop a wide range of specific skills and knowledge in relation to their child by virtue of being parents. These skills often become particularly enhanced when a child has particular medical or learning needs (de Geeter et al, 2002; Hayles et al, 2015). In contact with healthcare professionals, parents may hold an expectation that they will be included in their child's care, and that their expertise will be valued (Balling and McCubbin, 2001; Heath, 2013). Such an expectation rests on the assumption that, given the often significant amounts of care parents provide at home, they have 'acquired a more personalised understanding of their child's specific needs and condition than the healthcare professionals' encountered at any point (Heath, 2013, p. 90).

Despite the wealth of experience parents hold, there is a widely reported belief that their expertise is still not recognised by healthcare professionals (Kirk and Glendinning, 2004; Smith and Kendall, 2016; Swallow et al, 2013). Swallow et al, in a review of research literature, suggests it indicates that 'parents believe their expertise is not valued by health professionals, and tension and conflict between parents and professionals are often reported' (no pagination) Such tensions are explored by a number of writers who variously suggest the potential threat to professional identity (Heath, 2013), the misalignment of values between parent and professional (Denis-

Laroque et al, 2017), and the inherent imbalances of power within the health and care encounter (Leiter, 2004) as possible contributory factors. Leiter offers a U.S. perspective on the work accomplished between parents and professionals with children with additional needs, identifying the inherent inequalities on which successful collaboration pivots:

> Professionals are expected to create equality in a situation in which people are unequal in terms of power and resources. (Leiter, 2004, no pagination).

De Geeter et al (2002) further comment on the organisational values and ethos within which any interaction between parent and professional takes place. They note, 'the degree to which parents can play an expert role depends to a large extent on how the facility envisages the relationship between parents and staff' (p. 445). The facility, or institutional context, is a third figure, which itself may need to make cultural and training shifts if professionals and parents are to make optimal use of each other's expertise (de Geeter et al, 2002; Leiter, 2004).

When parent and professional work in close partnership with each other, the specific context in which that partnership takes place shapes the ways in which it unfolds (Tourigny et al, 2008; Tourigny and Chartrand, 2015; Swallow et al, 2013; Sabadosa and Batalden, 2014). With a chronic healthcare condition, such as cystic fibrosis (CF),[29] Sabadosa and Batalden suggest that the model of care involves far more than aiming towards the patient being at the centre of care. Rather, in order to manage the condition well, it requires 'the interdependent cooperative work of patients, parents, families and the health professionals who have specialised in one or more aspects of the disease' (p. 93). Of such cooperative work, Swallow et al note the need for a high degree of flexibility required to achieve this in the context of children with complex long-term needs, commenting:

> A particular challenge that professionals identified was the fact that individual parents' situations and possible responses to situations vary from one to the next, and from one day to the next. (Swallow et al, 2013, no pagination)

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[29] Cystic fibrosis is a genetic condition that affects the movement of salt and water from the cells. This results in the accumulation of sticky mucus in the lungs, digestive system, and other organs. www.cysticfibrosis.org.uk/what-is-cystic-fibrosis

The authors report, however, that despite such flux in a parent's perceived capacity to manage offering care, continuing to negotiate how much or little was possible at any given point was still at the core of the professionals' approach.

Such negotiation takes place within ongoing temporal frameworks. For instance, Tourigny et al (2008) suggest that within the context of a children's surgical day centre, frequented by children with complex health needs, time constraints limit the capacities of health professionals to work closely with parents. The child, as experienced through time, becomes a further influencing actor in the sharing of expertise (Swallow and Jacoby, 2001). While professionals begin a 'chronic illness trajectory' only on first meeting a child, a parent's experience of the child's illness has often started a long time previously. In listening to a parent and being able to 'take their concerns for their child seriously', the health professional and parent can begin, even in a first encounter, to build foundations for future contact (p. 762).

Tourigny and Chartrand (2015) suggest that within an in-patient hospital context, clarity is still lacking around issues of sharing expertise and working in partnership between parents and professionals. In noting the absence of clear models, however, they argue forcefully for a simple approach to care, voiced as follows:

> We must partner with the experts, and those experts are the children and families themselves. (Tourigny and Chartrand, 2015, p. 11)

Contemporary Music Therapy Positions

The ideological and pragmatic concerns in sharing expertise within nursing literature find parallels in contemporary music therapy literature. Material specifically addressing music therapy practice with children and families highlights three distinct areas: the expertise of parents and family members (Gottfried, 2016, 2017; Thompson, 2017; Jacobsen and Thompson, 2017); the expertise of the music therapist (Thompson, 2017); and a shared expertise, indicating a partnership approach to therapy (Gottfried, 2016; Jacobsen and Thompson, 2017). An approach in which 'everyone's expertise or lived experience is recognized' suggests equilibrium in practice (Jacobsen and Thompson, 2017, p. 310). As discourse shifts, however, from expertise to expert and back, the sense of equilibrium becomes less stable and more problematic.

A number of authors position parents firmly as experts (Pasiali, 2017; Haslbeck, 2017; Jacobsen, 2017). In asking parents to teach professionals favoured family songs to sing with infants in the NICU setting, Haslbeck suggests that 'they become the expert and we the "students"' (p. 37). Haslbeck's comment highlights a strand running through current practice literature in which music therapists acknowledge the potentially disempowering experiences for families of the expert therapist, and therefore seek to distance themselves from being identified in an expert role (Jacobsen and Thompson, 2017; Gottfried, 2016; Oscarsson, 2017). Gottfried states this strongly:

> We should abandon the expert position, in which we hold the
> insights in our possession and give recommendations to the
> parents, but rather cooperate with each family and tailor the
> course of action to their specific needs and capabilities.
> (Gottfried, 2016, p. 166)

A tension emerges at this point, however, between the apparent disciplinary leaning to resist being positioned as expert, and an approach that retains the 'expertise of the therapist' (Thompson, 2017, p. 93). Jacobsen and Thompson (2017) address this tension explicitly. They propose a model within which the therapist moves along a vertical axis from expert to equal in relation to the system of the family, other axes being formed by a horizontal supportive/directive continuum and a diagonal linking 'part of' or 'outside the system' (p. 325).

One difficulty of the expert/equal model proposed is that any movement is only considered as being made by the therapist. It is the therapist who can 'shift between a given stance', moving from expert to equal (Jacobsen and Thompson, 2017, p. 324). The model implies, therefore, that a family (and it is unclear here whether this refers to individual family members or a larger unit) is in the 'equal' position, being joined by the therapist, rather than moving into an expert position themselves. The model is situated in a discussion of the therapist's role in working with families, which may explain any discrepancy with material elsewhere in the text. The difficulties it presents, however, serve to highlight the contentious nature of the territory. How do music therapists understand their own professional expertise, and the expertise of those they work with? And how might expertise appear and be negotiated, or not, within the fluid dynamic of music therapy with a child and parent? These questions, emerging from current healthcare and music therapy literature gave impetus to the next phase.

Towards a Working Definition

I have deferred, until this point, offering a definition of either 'expert' or 'expertise'. This is wholly intentional: my interest is less in starting with a fixed idea of what expertise is, and more in approaching it by way of what expertise 'does'. As such, I subscribe to the view expressed by Carr (2010), who, from an anthropological standpoint understands expertise as 'something people do rather than something people have or hold' (p. 18).[30] In positioning it as something done rather than possessed, Carr makes the case for it being both interactional and ideological. By this, I understand her to mean that power and perceptions of power are frequently involved in how expertise is understood and negotiated.[31]

While recognising that expertise may be evident in the skills, practices, and knowledge bases of individuals, Eyal (2010, p. 3) notes that 'either way it is about the stuff that they do, rather than their interests and identities' that offers the greatest interest. Eyal and Pok 2011, no pagination), informed by Actor Network Theory, propose that expertise be defined as 'a network of connecting together actors, instruments, statements and institutional arrangements'. Expertise, they suggest, is to be found in what people do, in places, with each other and with things. Considered as a meshwork, how, I wondered, might expertise be enacted along the interweaving trails of people, things, and places of music therapy? Might there even be different kinds of expertise at play, and if so, how might they be understood?

Educationalist, Ann Edwards (2010) proposes that while people may have core expertises, gained through training or experience, it is through what she terms 'relational expertise' that the skills and knowledge people bring interact. Defined as 'an expertise which includes recognising and responding to the standpoints of others', relational expertise offers the connective capabilities through which a shared, expanded expertise is accomplished (p. 2). The Preliminary Study had suggested that the perspectives of others were multiple and not always recognised. With an explicit focus on expertise across all participating in music therapy, I wondered how differing expertise might be acknowledged, or not. Did music therapy afford an environment in

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[30] There is a parallel here with the notion of music as being 'not a thing at all but an activity' (Small, 1998, p. 2) quoted on page 16 of the Introduction. The semantic shift from noun to verb turns attention more firmly towards what people do.

[31] For further perspectives on expertise, see Dreyfus and Dreyfus, 2005; Ericsson et al, (eds) 2006; Collins and Evans, 2007; Collins, 2013; Kotzee, 2014.

which expertise could manifest itself evenly, or might its expression be impeded (Carr, 2010)?

4.4 Outlining the Research Area

Emerging questions, such as those posited above, concerning expertise both in music therapy and in wider areas of children's healthcare warrant attention. Certainly, in music therapy that attention is both timely and imperative. Music therapists are working closely with parents and children, and as the Preliminary Study revealed, differences in intention shape the emerging activity and interactivity between parent, therapist, and child. The musicing work of parent and child, particularly beyond the therapy room, is presently little explored, despite the relatively little time each week spent in therapy. The intention in the next phase of the study, then, was to open the metaphorical door of the therapy room, to widen the scope of the investigation.

In seeking to complexify the phenomenon of music therapy with a child when a parent is present, I intended to widen my exploration beyond that of the Preliminary Study. Informed by Pink (2010), I wanted to find my way through the 'unevenness' of the territory to not only trace the people, places, and activities through which music therapy's work is achieved, but also to unpick, if possible, the meshwork within which they interweave in doing so.

My intention, as traced through this chapter, was to bring a 'symmetrical concern' to the activities, knowledge, places, and experiences of all who participated in the study (DeNora, 2006, p. 90). To this end, I used the concept of 'expertise', meaning the interwoven crafting between people, as an investigative tool. While I did not intend to embark on a study of expertise as such, as a tool it provided the means to give weight to the work of all within music therapy, as well as the means to challenge conventional understandings, particularly concerning professional expertise.

To this end, I set out three primary research questions for the Main Study, articulated as follows:

- What is the range of the meshwork within which music therapy takes place?
- What forms of expertise do different parties in the meshwork contribute?

- In what ways is expertise assembled across the meshwork and manifested in music therapy with a child when a parent is present?
    - In what ways might the musical-social activities of music therapy afford or preclude distinctive opportunities for the enactment and assembling of expertise?
    - What are the implications of an understanding of expertise in music therapy for child, family, the professional music therapy community, and for the wider healthcare network?

Summary

This chapter has provided a bridge between the preliminary and main studies, tracing the reasoning that connects the two. It does not, however, only report on a reasoned process. Rather, I have intended it to demonstrate the activity of 'bridging' the two phases as a lived working-out of possible research routes. This has necessitated considering the shifting focus of the research, from the singular, micro-level of the Preliminary Study, to a broader, multiple approach in the next phase. It has also entailed approaching both familiar and new bodies of literature again in honing specific areas of interest. The bridging work of this chapter then serves to connect the landscape already visited, in the shape of the Preliminary Study, with the new territory of the Main Study that lies ahead.

Chapter 5 : Main Study – Music Therapy as Meshwork

5.1 Introduction

This chapter acts as a mirror to Chapter 3, in which I presented the Preliminary Study. This chapter gives a full account of the Main Study. I begin by outlining the methodological frame, together with a discussion of my own positionality as researcher. I then give a detailed account of the data work, including the gathering of data and the analytic processes. The findings of the main study are presented in detail, paving the way for a discussion of the integrated findings from both phases in the following chapter.

5.2 Revisiting Research Questions

The explorations of the Preliminary Study both opened up the research area and brought into sharp focus the direction of the next stage of the enquiry. The research questions, outlined at the end of the previous chapter and included here as a reminder, grounded this further stage of investigation.

- What is the range of the meshwork within which music therapy takes place?
- What forms of expertise do different parties in the meshwork contribute?
- In what ways is expertise assembled across the meshwork and manifested in music therapy with a child when a parent is present?
  - In what ways might the musical-social activities of music therapy afford or preclude distinctive opportunities for the enactment and assembling of expertise?
  - What are the implications of an understanding of expertise in music therapy for child, family, the professional music therapy community, and for the wider healthcare network?

While using these questions to propel the study, I have also questioned the queries themselves as the research progressed. Did they, for instance, clearly address emergent areas of interest, and to what extent did their language reflect the research needs? I have considered the questioning itself not as an obstacle to the research but

as shedding further light on the process and findings. I comment on this at points later in this chapter and in the next.

5.3 Methodological Perspectives

The Preliminary Study was an investigation of a single trio of child, parent, and therapist within the CDS. The findings indicated that further exploration, broadened in scope but still situated within the context of the CDS, was warranted. As outlined in Chapter 4, the next phase was to have a particular focus on music therapy as permeating outwards, beyond the walls of the therapy room, interweaving with other people, places, and events. The collaborative, emergent nature of the trio, as suggested through the initial study, also demanded attention. Understanding such collaboration as being enacted through the expertise of all concerned provided a further focusing lens in this next stage (DeNora, 2006). In widening the study's reach, I planned to talk with as wide an audience as possible, using focus groups as the main method through which to do this. I intended to invite music therapists, parents, and CDS staff to participate in differentiated groups, which I explain in more detail later in this chapter.

Before addressing the details of data collection in the Main Study, however, I wish to ground it in methodological and epistemological foundations. While broadening the scope of the enquiry, my own research approach continued to be guided by the notion of 'gentle empiricism', as outlined in Chapter 3 (Ansdell and Pavlicevic, 2010; Ansdell and DeNora, 2016). Its underpinning usefulness throughout this study lies in the way it:

> […] calls attention to the ways that researchers can and ought
> to work like attendants, supporting, quietly questioning, not
> butting in, closely observing, dwelling with but unobtrusively
> and always ready to abandon any notion if it fails to mesh with
> what can be traced in actual observation. (Ansdell and
> DeNora, 2016, p. 233)

Previously described as a 'practitioner-researcher stance' (Ansdell and Pavlicevic, 2010, p. 131), the account of 'gentle empiricism' given above could indeed speak of music therapy practice, as I understand it. For me, working in this context, this means a musical alertness to whatever a child approaches me with a curiosity about what

might come and a commitment to moving together, as far as might be possible, from that starting point. This stance is encapsulated well in Brown's emphasis on:

> […] the ability to live in and work with the *musical* relationship, holding the core of the developing work both in creating a musical and emotional environment and in working with particular musical components. (Brown, 1999, p. 192)

My intention throughout this study has also been to 'live in and work with' not necessarily the musical relationships familiar to me as a music therapist, but with what I have seen as the particular phenomenon of the child, parent, and therapist grouping in music therapy. In describing the research, therefore, as phenomenological in nature, it is helpful to outline two specific ways in which I consider it to be so.

First, the attitude shaped my intention to consider music therapy with a child and parent as a phenomenon, to be foregrounded and given close attention. This is not, however, to decontextualize it or treat it as though it is separate from the environment, people, and events in which it shows itself (Dreier, 2008). Rather, it is in understanding the phenomenon firmly within contexts, which may be multiple, that it shows itself most fully. This was my intention in broadening the study to cross contexts, seeing music therapy both 'in' and 'as' context, as well as interacting with other contexts (Rolvsjord and Stige, 2015).

Second, in doing this, I returned to the notion of looking 'upstream' at the '*appearing* of what appears' (Bortoft, 2012, p. 24). Bortoft argues for a dynamic understanding of the phenomenon, which is not understood as a static, reified 'thing', self-evident at the point at which it is observed. Rather, 'the phenomenon is not merely the appearance but the appear*ance. This is the phenomenon: the appearing of what appears.*' (2012, p. 24). I would argue that this is also consonant with Ingold's emphasis on lines, not as connectors of points, but as active, intertwining trails themselves (2007). My intention throughout has been to retain a focus on the appearing, the intertwining itself.

The five key themes of the Preliminary Study were articulated in terms that reflected the intention to catch the 'appearing of what appears', the ways in which the phenomenon showed itself multiplying. In the next phase, the intention again was to remain dynamic in my observing and thinking.

Researching Practice

A particular challenge through the whole enquiry has been acknowledging the tension created by researching an area of practice which has become so familiar to me on a day-to-day level as a practitioner. Research, practice, and increasing managerial responsibilities have needed to find ways to co-exist within me during the course of the study.

In one respect this has been problematic, requiring an ongoing attention to the assumptions and privileged knowledge which I brought to the area (Costley et al, 2010). As Flaubert is purported to have said to his student, Maupassant:

> There is a part of everything that always remains unexplored,
> for we have fallen into the habit of remembering, whenever we
> use our eyes, what people before us have thought of the thing
> we're looking at. (Steegmuller, 1949, p. 60)

It is not only, I would suggest, what others have thought but what we ourselves may have thought of what is being looked at that is potentially problematic. Smith et al (2009, p. 13) describe the need to put to one side, or 'bracket' what they term the 'taken-for-granted world' in order to look anew at the familiar. Given my familiarity with this area of practice, the setting and the people within it, the need to manage this through reflection, writing, engagement, and ongoing discussion, has comprised a thread that has run throughout the entire project.

Questioning Insider Researcher Positions

Investigating a familiar area of practice within the setting in which I continued to work as a practitioner raised particular challenges. While present throughout the Preliminary Study, they came more clearly to the fore in the Main Study due to developments in my working life. In beginning this phase of the study, staffing changes within the music therapy service meant that I also moved into a new role as team lead. This changed my role in relation both to other therapists in the team, whom I now managed and to the service as a whole, given that I was now accountable to a more senior manager in the organisation for the running of the service. A further shift was that, as team lead, I became a potential point of contact for families in relation to their child in music therapy. So, too, for the wider CDS team, in which I noticed a move from largely practice-oriented, child-focused conversations to discussions around service delivery and targets.

The tension of straddling researcher/practitioner positions also manifests itself in writing about the service. Throughout the thesis, but particularly in this chapter, I include explanatory notes about the service. These are often procedural, known to me through my role as a music therapist. They have not become known through the research process, nor, in most cases, have they been specifically discussed by participants. They are clearly part of the existing knowledge that I have brought to the enquiry, and I have tended to use them when writing to clarify, rather than amplify, meanings.

These issues can be considered in terms of the frequently used phrase 'insider research' (Costley et al, 2010; Taylor, 2011; Unluer, 2012; Greene, 2014). Greene defines this as research that is 'conducted within a social group, organization or culture of which the researcher is also a member' (p. 1). For the researcher, the benefits of investigating from 'within' might be clear: knowledge of the research environment and area already exists, as does access to people who may contribute to furthering that knowledge (Costley et al, 2010; Greene, 2014). That was indeed true for me: my 'insider-ness' was what had driven the study originally and made it a feasible project. However, both the knowledge and access which an insider position makes possible can conversely be seen as challenges, potentially creating bias within the study (Costley et al, 2010; Unluer, 2012). Part of the work of the reflexive researcher, whether insider or not, is understanding bias, or ways of looking, as an inevitable part of what any researcher brings to a study (Stige et al, 2009). When acknowledged, these may then be explicitly used as a resource in the service of the study (Aigen, 1993; Ansdell and Pavlicevic, 2001).

Some authors question what they see as the 'either/or dichotomy' of the insider/outsider researcher position (Greene, 2014, p. 2). Considered unfeasibly static, Taylor (2011, p. 5) argues for a more nuanced understanding, given that 'one can never assume totality in their positions as either an insider or as an outsider, given that the boundaries of such positions are always permeable'. I would agree that defining myself as an insider, or this project as insider research, risks losing the more subtle shifts of position in the process. Undoubtedly, I have brought a certain degree of familiar knowledge by virtue of having worked in the CDS for many years. I might also consider myself as an insider with music therapy colleagues, being part of the same profession and working in the same environment. This fails to capture the distinctions between therapists within the service: different training backgrounds and experiences in various work settings have not been part of my experience, and preclude me from

feeling myself to be an insider so easily. The notion is challenged further in considering myself as researcher in relation to parents, children, and other staff members within the CDS. The ways in which I am clearly not an insider are multiple and incontestable. I have concluded that understanding insider-ness is best understood in terms of degrees, or as Greene (2014, p. 2) suggests, a 'continuum', along which there is movement and flow.

Positioning and Voicing

Such movement occurs not in a void but in dynamic relation to all those within the environment in which the research takes place. Those directly participating in the study, together with those less directly involved may find themselves in relational flux with each other, in shifting roles and relationships. The research process brings researcher and participants together, as Alvesson and Sköldberg suggest:

> There is no one-way street between the researcher and the object of study; rather, the two affect each other mutually and continually in the course of the research process. (Alvesson and Sköldberg, 2009, p. 79)[32]

My intention has been to allow for such a mutual influencing, and to understand the research process in these terms. In so doing, I take the 'object of study' not as a thing to be viewed from a distance, but rather as multiple (being the CDS; music therapy within the CDS; the therapist, child, and parent within music therapy) and fluid, by virtue of its various manifestations.

Such mutual influencing circles around again to the parallels of research and practice throughout the study. In beginning the Main Study, I was aware of changes I had made in my practice as a result of my engagement in the research process thus far. I return to this in Chapter 7, and move on now to describe the particular research approach and tools utilised in the study.

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[32] The authors' use of the term 'object of study' here appears in the context of comparing a positivist research view, in which researcher and object remain distanced and 'uninfluenced' by the other. Their subsequent argument for the reciprocity inherent in the relation between the two suggests that reinforcing such a binary subject/object divide is not their prime intention here.

5.4 Grounded Theory

The Preliminary Study had as its focus a detailed understanding of the experiences of one therapist and one parent whose child had attended music therapy. Given the attention in the study to the lived experience of the participants, Interpretative Phenomenological Analysis (IPA) provided a suitable methodological framework for the investigation (Smith et al, 2009; Smith, 2011). The Main Study shifted focus, requiring a methodological shift in response. The focus in this phase was less on the personal meaning making of individuals, but rather exploring the meshwork of music therapy with a child and parent as enacted by people, in places, and through time. Smith et al, in outlining the research areas and questions to which IPA is particularly suited, distinguish it from other qualitative research approaches, including Grounded Theory (2009). Grounded Theory (GT), the authors suggest, provides a useful framework both if the research focus 'is not necessarily (or primarily) psychological', and if the intention is to work towards 'a high level conceptual account' (p. 44). On both these fronts, GT became the approach adopted in this study.

At its simplest, GT can be understood as a 'flexible set of inductive strategies for collecting and analysing qualitative data' (Charmaz, 2003, p. 82), aiming towards the building of theory which is 'grounded' in the data itself (Charmaz, 2003; Corbin and Strauss, 2008; Charmaz, 2014). It has its origins in the work of sociologists Glaser and Strauss (1965; 1967). Their study of death and dying within health settings in the United States, *Awareness of Dying* (1965), in which they demonstrated an analytic approach to, and the production of theory from, their investigations was followed by the publication of their influential text *The Discovery of Grounded Theory* (1967). Glaser and Strauss's work appeared at a crucial juncture in the developing story of qualitative social science research, emerging between a dominant positivist paradigm and a developing qualitative realm which was, as yet, methodologically unfocused (Charmaz, 2014). The development of systematic methodological strategies introduced through GT made explicit previously implicit research methods. Moreover, in developing such methods, Glaser and Strauss proposed that 'systematic qualitative analysis had its own logic and could generate theory', as opposed to only adding to existing conceptual frames (Charmaz, 2014, p. 7).

Grounded Theory, as a reflection of the sociological traditions of both Glaser and Strauss, brought together differing schools of positivism, pragmatism, and the field research approach prevalent at the time. Positioned as it was both in contradiction and

alignment to a conventional quantitative paradigm, its positivist foundations have been critiqued, in retrospect, as one of its weaknesses (Bryant and Charmaz, 2007). Glaser and Strauss ultimately moved apart in their epistemological positions, creating, respectively, objectivist and constructionist models of grounded theory (Glaser, 2006, 2008; Corbin and Strauss, 2008).

The terms 'constructionist' and 'constructivist' have often been used interchangeably in discussion of GT (Charmaz, 2014; Ward et al, 2015). Charmaz adopted the term 'constructivist' in the 1990s in order to differentiate her approach to that of social constructionism as it was practiced at the time. Her intention in doing so was to counterbalance an approach in which a researcher's subjectivity seemed to be removed from the study. As she comments:

> If, instead, we start with the assumption that social reality is multiple, processual, and constructed, then we must take the researcher's position, privileges, perspective, and interactions into account as an inherent part of the research reality. It, too, is a construction.' (Charmaz, 2014, p. 13)[33]

Grounded Theory has become, over the years, a popular methodological choice within healthcare. For example, a search of the CINAHL database[34] using the terms 'nurs*', 'grounded theory', and 'research' in 2017 alone elicited thirty-eight papers, rising to 164 for the years 2014-2017. Its popularity in nursing research can perhaps be understood by the need for a research methodology that offers robust, systematic tools (aligned with the rigorous nature of Evidence Based Medicine), together with a constructivist orientation that allows for multiple, constructed realities (Ward et al, 2015). As Ward says of her own experience of nursing:

> I have come to believe that truth and reality are 'slippery' concepts reliant upon personal experiences and beliefs: the patient's physical body is not nursed in isolation from their mental self, their beliefs, their experiences or their social worlds. (Ward, 2015, p. 451).

While widely used, there is also a strong critique from within nursing research of the ways in which GT is employed (Sandelowski, 2000; Webb and Kevern, 2000; Cutcliffe,

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[33] Charmaz herself notes that her own definition of constructivism and the evolution of social constructionism over time means that the two are more closely aligned than previously (2014, p. 14).

[34] CINAHL is the acronym for the Cumulative Index to Nursing and Allied Health Literature.

2005). As a general criticism, Sandelowski questions the nursing researcher's rush towards the adoption of GT, as well as other frameworks, making a plea for solid qualitative description when what is intended are 'straight descriptions of phenomena' (p. 339). The extent to which studies adhere to GT principles and structures are also questioned, Cutcliffe (2005, p. 425) suggesting that researchers need to be clear when adaptations have been made, and acknowledging when a 'modified GT method' has been employed.

Music therapy researchers have also made use of GT in recent years to research particular phenomena, such as meaningful moments (Amir, 1992), humour (Amir, 2005), and experiences of temporality (Daveson and O'Callaghan, 2011); or clinical areas, such as paediatric neurological rehabilitation (Edwards and Kennelly, 2004) and evaluation within community music therapy (Wood, 2015). Apart from Amir's 1992 study, each of these define themselves as modified GT. Daveson's recent review of the uses of Grounded Theory within music therapy research includes those using the terms 'hybrid', 'modified' and 'full-version' Grounded Theory studies as all comfortably sitting under the GT umbrella (2016). Daveson notes that 'this diversity affords researchers with choice and helps researchers in selecting the grounded theory approach that best fits their area of inquiry' (p. 760).

The use of modified Grounded Theory offered an appropriate methodological choice for this study. It provided a set of methods through which to approach both data collection and analysis. Its inductive approach enabled me to retain an overall 'upstream' perspective within a flexible framework adapted to the research needs of this particular enquiry. One such need was the intention to explore music therapy as meshwork, comprising the interweaving lines of people, place, events, and things (Ingold, 2007). To follow such trails, it was necessary to meet and talk with those I already understood to be part of such a meshwork. To meet with as many as possible, and to enable them to speak with one another, I decided to use focus groups as the main method of gathering data.

5.5 Focus Group as Method

Focus groups are a widely used qualitative research method (Wilkinson, 2003; Krueger and Casey, 2015). They are a way of 'engaging a small number of people in an informal group discussion (or discussions), 'focused' on a particular topic or set of

issues' (Wilkinson, 2003, p. 184). Prospective participants in focus groups are considered, Krueger and Casey (2015, p. 6) suggest, 'similar to each other in a way that is important to the researcher', generating a rich mix of material through their discussion.

The method has gained popularity in healthcare research in recent years (Kitzinger, 1995; Wilkinson, 2003; Clavering and McLaughlin, 2007). Music therapy researchers have also utilised focus groups to investigate experiences within areas of clinical practice (Allgood, 2005; McFerran et al, 2010; O'Callaghan et al, 2013), or to explore developing models or techniques (Gilboa, 2012; Geretsegger et al, 2015; Bensimon and Amir, 2010). Focus groups offer what may be perceived as a time-efficient way of engaging with the people at the heart of a research project (Clavering and McLaughlin, 2007; Jayasekara, 2012). This, Jayasekara suggests, is particularly important when 'the issue being investigated is complex', or when existing knowledge of an area is limited (p. 412).

A key strength of the focus group lies in the depth brought through participants engaging with each other during discussions (Kitzinger, 1995; Macleod Clark et al, 1996; Bradbury-Jones et al, 2009). As Bradbury-Jones et al note:

> In a manner that is not possible in individual interviews, a group allows participants to hear each other's' stories and add their own perspectives and insights as the story unfolds. (Bradbury-Jones et al, 2009, p. 667)

Given my intention to complexify an understanding of the peoples, places, and events through which music therapy with child and parent happens, bringing participants together to share experiences and narratives seemed particularly apt. The same sentiment is expressed pithily by the authors of a study of identity in jazz musicians, who say:

> […] if you create the music in a group, it is worth asking a group about it. (Macdonald and Wilson, 2005, p. 397)

This captured my own wish to keep the research as close to practice as possible. Simply put, focus groups allowed me to invite the people involved in music therapy, at whatever level that might be, to meet and talk about it together.

Bringing multiple voices together is a strength of focus groups, but it also brings specific challenges (Krueger and Casey, 2015). Participants may be acutely aware of how what they say might be perceived both by the researcher, and by the others in the group. As Krueger and Casey (2015, p. 15) point out, from a market research perspective, participants might tend to 'give us a picture of how the consumer wants to be seen by others, as opposed to their actual lives'. This, together with other aspects of participant experience, was an issue to which I sought to remain alert during the study.

In choosing to use focus groups, a further decision concerned the groups' composition. To what degree should either homogeneity or heterogeneity be sought within each group? While homogeneity is strongly advocated by some, what that means in practice is less clear and may even be reducible to meaning that participants have 'something in common that you are interested in' (Krueger and Casey, 2015, p. 79). Generally, it is understood that a study's purpose, together with pragmatic considerations, should inform the compositional choice. Within this study I met with three distinct groups: parents, music therapists, and CDS staff. As such, the groups could be seen as representing a continuum of homo- and heterogeneity. The CDS staff group, for instance, encompassed a wide cross-disciplinary mix and thus, as a group, might be understood to be weakly homogeneous. The parent group, on the other hand, could be considered a more strongly homogenous collective.

Differentiating groups in this way was a decision based on two key factors. First, I wanted to encourage participants in each group to talk in depth about their own experiences of music therapy. Doing this with people sharing some of those experiences would, I felt, allow for rich and lively discussion, which may have been jeopardized in a more mixed group. Second, the organisational challenges of running groups was such that separating the groups became a more feasible way of managing the task. With this in mind, the study can be understood as using a 'multiple-category design', running groups of differing populations (Krueger and Casey, 2015, p. 28). The advantage of this was seen at both the data collection stage, at which I cross-fertilised groups with ideas from another, and in the subsequent analysis. I would argue that this approach was methodologically crucial in creating the complex, multi-perspectival picture of situated music therapy practice with a child and parent.

5.6 Research Ethics and Recruitment

The design of the Main Study included parents, music therapists, and CDS staff as participants. Any parent whose child was currently, or about to begin, attending music therapy in which the parent was also present was invited to participate. Involvement was also open to any music therapist within the service or CDS staff member who wished to take part.[35] The nature of the developmental difficulties and disabilities of children attending music therapy precluded a child's active participation in the Preliminary Study. This remained the case in the Main Study and was, in some ways, an uncomfortable limitation of the research.[36] All necessary approvals for this phase were again gained from both the academic (Nordoff-Robbins Research Ethics Committee) and NHS (local and national) committees prior to recruitment.

The recruitment process was differentiated across the three cohorts. Email invitations were sent to all music therapists within the service, and separate email invitations were distributed to the CDS staff group, inviting interested staff to email back to signal their interest in participating. The initial approach to parents was made informally by the music therapist known to the family. Parents who indicated an interest were sent an information sheet, and I met with each of them to discuss the study and what their involvement might entail. No parents were known to me previously, although this would not in itself have been a reason for exclusion from the study. As in the Preliminary Study, the secure storage of data and aspects of research governance were discussed with all potential participants (cf. Footnote 15, p. 69).

A child's attendance at music therapy in the CDS is a time-bound process. Following a single assessment session, the majority of children subsequently offered individual sessions attend for a period of between six to ten weeks. I wanted to meet with parents towards both the beginning and the end of their child's therapy, hoping to learn from their experiences as they moved through the course of sessions. Of seven parents who were initially interested in participating, three were recruited, all mothers. The fact that no fathers were recruited was not surprising given that it remains

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[35] Differentiated inclusion and exclusion criteria, information sheets and consent forms are included as Appendix 10.

[36] While unavoidable, I do consider this a limitation of the study as a whole. I address the issues raised in involving children, particularly those with more complex needs, in the design and process of research studies in Chapter 7.

relatively uncommon for fathers to attend therapy with their child. The two parent groups were planned, approximately nine weeks apart. One parent was unable to attend the initial group and I subsequently met with her individually (See Fig. 5:1, p. 163).

The music therapist's experience is not time-bound, as for parents, but it is cumulative. Therapists meet, work with, and then end contact with multiple families in a rolling fashion, sometimes over months or years. Two groups were planned with the music therapists, not in order to meet at the beginning or end of a course of sessions, but rather to allow time in which ideas from the initial meeting might develop further. Seven music therapists were recruited, although each group had five participants, owing to staff leaving or entering the service. The staff changes contributed to the timing of the groups, which were three months apart.

By design, the group of CDS staff met once only. I considered that I could gather sufficient material from one meeting for the study's purposes, but also made the decision on pragmatic grounds: gathering participants from a diverse and busy staff team together in time and place proved to be extremely difficult (Wilkinson, 2003). Having recruited nine staff members, achieving nearly complete representation of professional groups, only five were able to attend the group on the day itself; four were unable to meet due to sickness, work pressures, or annual leave. Attempts to bring these individuals together, even into paired discussions, proved impossible. While more difficult to navigate than expected, the practical challenges of bringing staff together signalled in itself something of the organisational complexities within the workplace.

Opinion on the optimal number of participants in focus group varies, six to ten frequently suggested as a rough guide (Kitzinger, 1995; Jayasekara, 2012; Krueger and Casey, 2015). Fewer may limit the range of discussion, while more can mean participants have less opportunity to be heard (Jayasekara, 2012, p. 413). Each group within this study had fewer participants than might be considered optimal. In itself, this speaks of the study's context-specific nature which shaped the number of potential participants across the three cohorts. There were seven music therapists working in the service at the time of recruitment, myself included, thereby limiting the possible group size. Similarly, the intention to recruit parents who were either attending, or about to attend music therapy with their child placed an upper limit on potential numbers. While seven were interested, ultimately only three participated due to other

commitments. With the CDS staff group, my intention was to recruit one participant from each team or discipline,[37] which resulted in nine staff being recruited. While the literature offered guidance on optimal numbers, decisions on participant numbers was effectively shaped by the realities of institutional and family life, and, as such, could be seen as a natural outcome of practice-based research.

Ultimately, nineteen participants took part in the focus groups or individual meetings. These were spread across a six-month period in order to accommodate as many participants as possible. Figure 5:1, below, sets out the group composition, the number of times each group met, and the number of participants attending each meeting. Included in each box is a designated code for each group, used later in citing quotations.
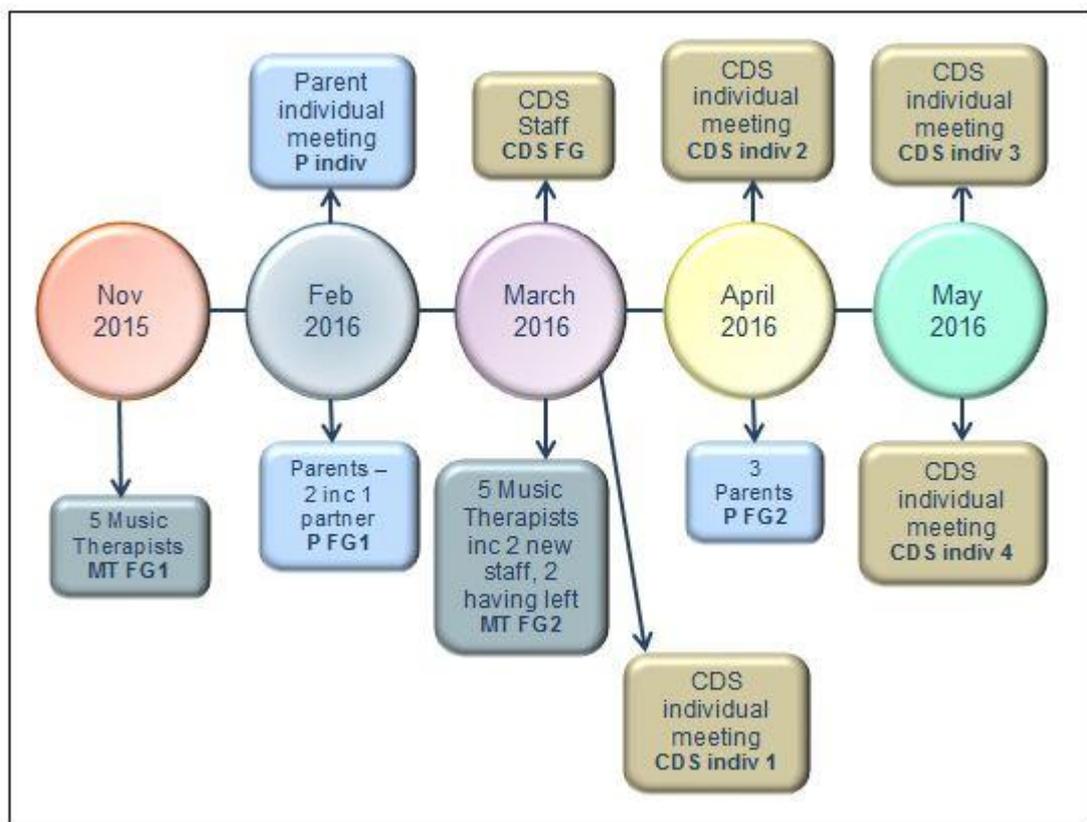

 Figure 5:1 Chronological Flow of Data Collection

[37] This decision followed discussions with service managers concerning releasing of staff to attend the focus group. It was agreed with a number of managers that one member of the team could be given time from their usual workload to attend.

Reflections on Recruitment

Rather than being a purely administrative task, separate from the research process, the recruitment process contained unexpected events that signalled the organisational and relational complexity of music therapy within the CDS.

An administrator in the CDS, whose first name is shared with a clinical psychologist, replied immediately to the email study invitation with the words 'Thanks very much for the email – I assume this wasn't meant for me'. While responding to assure her that I did indeed intend it for her, I was struck by the speed and unequivocal nature of her response. In discussion later, she explained that the shared name meant that receiving her colleague's emails was a frequent occurrence which she always corrected quickly. In this instance her underlying assumption was that an invitation to be part of a research project would not have been directed to her as an administrator. I wondered if various roles within the organisation were perceived to carry greater value than others, and whether this might show itself within intertwining trails as the study progressed.

Recruitment issues also manifested themselves at the point of focus group meetings. As one parent arrived for the first group, the parent's partner, whom I had not met before, also walked in. The parent introduced him, asking 'It's not a problem is it?' She explained that as he often attends music therapy with her child, they had thought it would be interesting for him to come to the discussion. In responding, I was aware of a rapid internal dialogue between myself as researcher and practitioner. As researcher, I knew the partner did not meet the criteria for participation, and if he did, he had not been through the usual discussions prior to giving informed consent. On the other hand, as practitioner, and now team lead for the service, I was concerned that any decision could have an impact on the parent's experience of the service (Dreier, 2008). This was coupled with an awareness of the significant effort they had made to attend the group. In the event, and following discussion with the other group members, the partner stayed to take part in the group.[38] This seemed to be exactly the 'unevenness' of which Pink (2010) speaks, and which kept the focus of the research firmly on the everyday.

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[38] Following discussion with my academic supervisor, and consultation with local and national NHS research ethics bodies, the inclusion criteria for the study were amended to reflect this change. This, of course, added a further layer of complexity to the research process.

5.7 Data Collection

Planning Focus Groups

In planning the focus groups, consideration was given to both venue and timing. Groups were held in the music therapy room of the CDS (Fig. 3:1). Ruff et al (2005, p. 135) suggest the venue should ideally be 'one that is neutral and is not linked to any particular values or expected behaviours'. I was aware that the music therapy room may not have been considered 'neutral' by all participants, including myself as researcher. It is the site of the everyday work of both myself and music therapy colleagues, the space in which supervision and other team meetings are held, the place which parent and child visit for weekly sessions, and into which other CDS staff come for various reasons. Being part of any of these events within the room could be seen to shape the experience of participating in the focus groups. I would contend, however, that no venue, of itself, would be entirely neutral, and that, on balance, the venue's familiarity and convenience, both for those working within the CDS, and for parents travelling to it, made it the most viable option. I did, however, explicitly acknowledge the multiple experiences that I, and participants, might have of the CDS, and the music therapy room, at the start of each group.

The timing of each group was negotiated between myself, the various participants, and the therapists who routinely used the room. My wish to attend closely to the local brought such practical details sharply into focus (DeNora, 2014). Parents' availability was often constrained by childcare needs and the realities of the school day, while the demands of the working day or the nature of part-time working shaped the availability of staff. At each group, simple refreshments were offered for participants, in part as acknowledgement of the considerable efforts made to attend.

Prior to the first focus group meeting with each cohort, and discussed at recruitment, participants were given a handout. This informed them about the general areas for discussion in the group, and invited them to answer a number of questions (see Appendix 11 for sample). The intention in doing this was twofold: for people attending, to enable them to prepare for, and then contribute as fully as possible at the time; and for myself, to be able to shape discussions in response to what seemed important to those attending.

Questions of confidentiality were also addressed at recruitment. It was important to ensure that everyone involved felt safe enough in the group to talk freely without fearing that personal details and potentially sensitive material would be shared beyond the group (Wilkinson, 2003). This was discussed with each participant individually at recruitment, and reiterated at the start of each group.

Discussion areas for each of the three cohorts were planned according to their differing perspectives (see Appendix 12 for sample). While the angling of content for discussion differed, a cohering element was added across the groups through the use of video. In the first parent group, the CDS group, and both music therapist groups, a two-minute video extract of a child, parent, and therapist in music therapy at the CDS was included as part of the activity.[39]

Video within the Focus Group

The use of video in this phase of the study differed from its previous use in the Preliminary Study in which the use of Video Elicitation Interviews provided structure to the meetings with parent and therapist. In the Main Study, the video material provided a creative prompt for discussion, keeping the groups' focus firmly on the activity of child, parent, and therapist in music therapy, while also allowing multiple perspectives to emerge across the groups.

The video extract used was of myself working with a child and his mother, the majority of the extract showing us sitting all together at the piano. The selection of video material to show was guided by a number of interconnected factors. Choosing material in which any of the team's music therapists had been involved was unsatisfactory, given the participation of many of them in the research. I also decided not to use music therapy material from a source outside the Trust, both because of the ethical implications and also because it created a shift away from the local, context-specific level. I chose to use material in which I was the therapist, and approached a family whose child had recently finished a course of sessions. The mother had been actively involved in sessions, and we had filmed frequently, so there was existing video material in which the three of us were engaged in lively, playful musicing. Following discussion

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[39] The video material was used in both music therapists' groups as the group composition differed each time. Watching the video in the second group, whether for the first or second time, also threaded the activity of the two meetings together.

with the parent, informed consent to use video of the child's sessions for the purposes of the study was gained, and together we selected a short extract to play.[40]

5.8 Running Focus Groups

The audio recording of each group was discussed at recruitment, and participants were reminded at the start of the meeting. The focus groups and the individual meetings for those who were unavailable ran as smoothly as could be hoped in a real-world situation. This included events such as the unexpected arrival of a partner, as discussed previously, and the ringing of the fire alarm, which necessitated a brief interlude outside during the second of the parent groups. While I was familiar with running music therapy groups, facilitating groups of this type was unfamiliar, and I wrote personal notes as a way of catching and processing my thoughts and experiences. I include some reflections here, together with brief extracts from my notes, in order to add further perspectives to the research process.

Reflections on the Focus Group Process

The first group was the music therapists, all colleagues, familiar with each other, me, and the music therapy room in which we planned to meet. The group was scheduled to begin at 3.30pm, and I had thought carefully about the practical arrangements for the group, including the numbers of chairs and mugs we would need, and baking a cake the evening before. My notes, after the group, tell the story:

'Had I imagined readying the room (gathering chairs, moving instruments and mats, bringing in kettle and mugs) by myself before 'letting' the group in? I think I probably had. In the event it was all messier than that.

15 minutes before the group, E said to me 'I'm putting the kettle on, do you want a drink?'. T came and sat down in the room at 3.20, asking if I'd had a chance to look at a document. I respond by asking him a question about a family, and we talk briefly.

T had brought biscuits and cake – I hadn't expected that, thinking that I needed to show hospitality. What does T bringing food show? – Investment, support, the need for sustenance, bringing treats for the team. Any or all of these?

What the pre-group mess shows is that, of course, this space is already inhabited by these people – this is their space, which each inhabits differently, and this group is part of the day in

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[40] A notated transcription of the video extract is included as Appendix 13. The child's name is changed on the score.

> this place, in which food and drink is part and parcel of a way of being. And people are used to reshaping the MT room space, moving furniture, choosing chairs, making tea, bringing it in. This focus group room is where the MTs dwell, do, are.'

The place, as in the physical site of research, is inextricably linked with the music therapists' everyday place. As such, people, place, tea, and cake all become part of the place, in what Ingold (2008a, p. 1797) terms a 'zone of entanglement'. As researcher and colleague, I am clearly part of this entanglement. The music therapists, in the pre-group moments, reminded me not just of my own insider-ness, but also their own. This became more apparent as the group discussion began.

> 'Everyone is supervised by someone in the group – including me. Much of the specific content and examples I have heard before, or they form part of everyday questions to me. How awkward was that – it seemed like everyone was <u>bursting</u> with the need for confidentiality, or not to cross boundaries of who knows what about what…And afterwards, putting together in my mind, this group happening two weeks before the Team Lead leaves, two weeks after one of the team has gone on maternity leave, and when there are other changes ahead. Knowledge, power, anxiety scattered all over the place at the moment. I am very much part of, and in the thick of, those anxieties, struggles for knowledge, and tussles of power.'

Roles and the perceptions of power and knowledge held by individuals within certain roles threaded themselves through this group in particular. At times in other groups, I was also aware of a very clear pivoting of my own roles. For instance, in the concluding moments of both parent groups, specific questions concerning a child's music therapy were directed at me: what will happen at the end of the course of sessions, will he be able to have further sessions, and what will happen to the video material recorded during sessions? I felt the shift into being a practitioner and team lead, answering questions and seeking to ensure that parents were well informed about the ordinary processes of therapy.

While the Preliminary Study was, in some senses, inward-looking, parent and therapist discussing music therapy sessions in which they were both involved, this phase effectively opened the door of the music therapy room, turning the focus outward. Participants were invited to join a broad discussion with others, and some staff members were introduced to music therapy in action, by way of the video, for the first time. Surprising ripples were created through the research methods themselves. For example, two weeks after the CDS focus group, I passed one of the participants in the corridor. As we passed she commented on her enjoyment of seeing the child singing

'Hello' in the video clip watched during the group, saying, 'I was singing that Hello song for weeks afterwards, you know!'

Within the second music therapists' group, the 'Hello' song, and its use in the video also prompted thoughts in me about the ways in which the group discussion itself might ripple into everyday music therapy practice. I wrote:

> 'I hear Hannah speak about the Hello, and hear her working something out. I pause to think – it challenges a view of research as one in which therapists speak and I, as magic researcher, take what they say and do marvellous things with it, stirring the pot and extracting the essence for the study. The therapists (and true in other groups too?) may also be taking what is discussed in the group and taking it outside, into everyday life – where like a yeast it keeps working its way through practice and thinking.
> So this is not only me taking from people, but the whole experience of the group may feed – participants may take from the group and make something new.'

Research involvement, whatever ones position, appeared to be generative and mutually influential (Alvesson and Sköldberg, 2009). The activity of research also began to appear to me as another trail in the 'zone of entanglement', in which people, practice, and places intertwined (Ingold, 2008a). The research process could be seen as another interweaving strand.

I was mindful, however, that such strands ensuing from involvement may be experienced as disruptive. One parent related the activity of both the parent and myself in the video to her own experiences in her child's sessions, expressing concern at the differences she perceived. The strength and urgency in her response required a shift in my own, prioritising in the moment my concern as a practitioner and team lead, and seeking to reassure her. In reflecting on it later, it struck in me a note of caution about the ethical implications of the decision to view video. Video material is not neutral, and the ways in which it is viewed may not be foreseeable. While seeking to manage this experience in the moment, it highlighted again the need to consider the potential impact of methodological decisions as thoroughly as possible.

The reflections outlined here were an integral part of the study's data collection phase. They allowed me to consider my position in the research activity, given the multiple roles and relationships in which it was situated. I turn now more formally to the data in describing the analytic work. .

5.9 Data Analysis

A modified Grounded Theory approach formed the basis for the analytic process. The steps taken are outlined below (Fig. 5:2). Given the data sets emerging from the differentiated focus groups, I first worked vertically within the cohort before working horizontally across them. Beginning with transcription, the account that follows describes the steps of the analytic process, culminating in the articulation and discussion of five overarching themes.
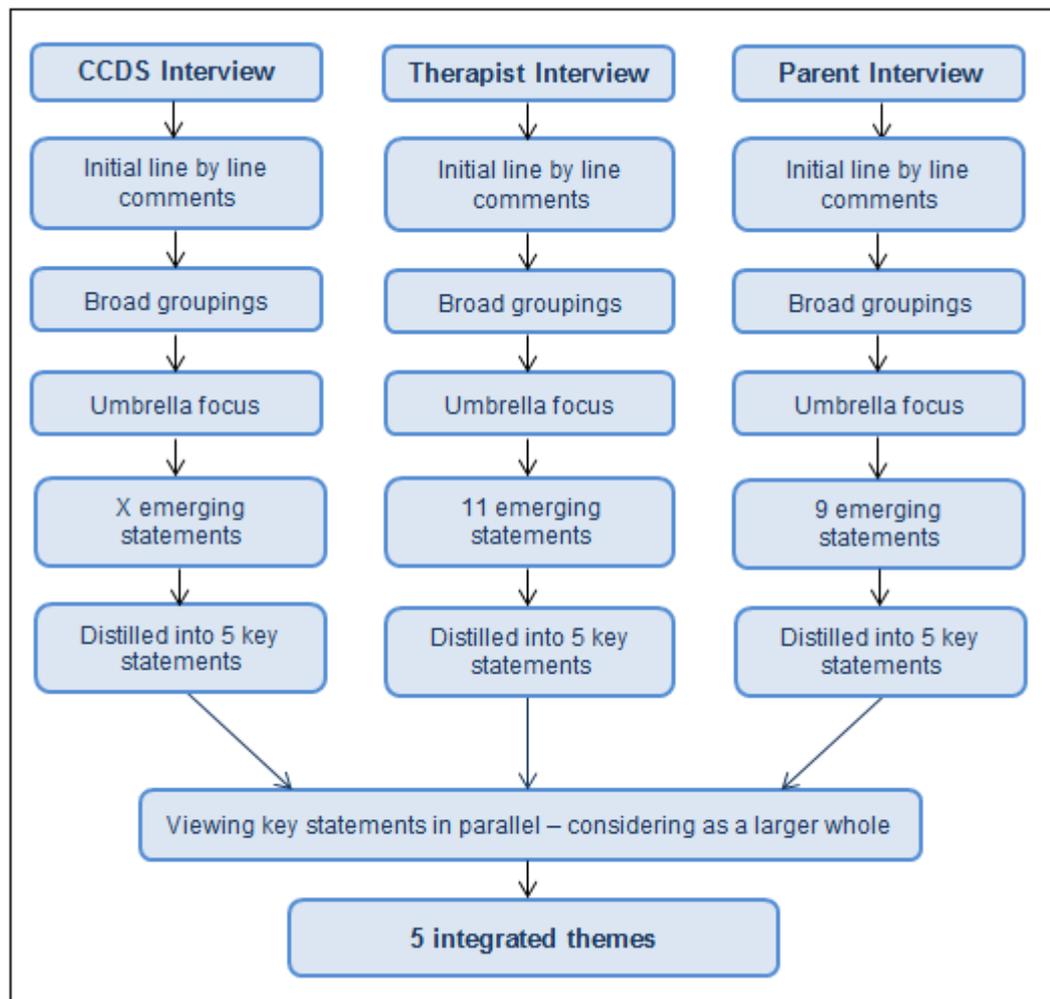

Figure 5:2 Overview of Data Activity

Transcription as an Analytic Step

Following each group meeting I familiarised myself with the material by listening to the audio recording a number of times before transcribing each recording in full.[41] I

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[41] Sample transcripts of each focus group and individual meeting are included as Appendix 14.

completed initial rough drafts before reaching final versions. While lengthy, the transcription process allowed me to live with the material, becoming familiar with the individual voices, the interweaving of those voices, and the fabric of the discussions (Krueger and Casey, 2015, p. 151). While not designed intentionally, the spread of groups across a number of months also allowed me the necessary time to transcribe one event before the next occurred. Understanding the process of transcription as 'a form of interpretative activity' meant that ideas and potential areas of interest arising from the transcription process could inform the planning of forthcoming groups (Smith et al, 2009, p. 74). It also allowed me to feed ideas raised in one group across the cohorts into another in a process of cross-fertilisation.

The level of detail and accuracy within the transcriptions reflected the analytic approach of Grounded Theory (Charmaz, 2006). Transcripts were intended to be read easily, giving a 'feel' for the speaker, while not being reduced in complexity or nuance (Krueger and Casey, 2015). I retained hesitations and repeated or incomplete words in the transcriptions, and included notes of non-verbal material such as laughter, gesture, or movement when their inclusion seemed to add to an understanding of the text.[42] To orientate the reader, Appendix 14 includes a key to abbreviations in the transcripts, together with a graphic representing the participants with fictitious names.

Charmaz outlines the analytic process of Grounded Theory as one which involves:

> […] going back and forth between data and analysis, uses comparative methods, and keeps you interacting and involved with your data and emerging analysis. (Charmaz, 2014, p. 1)

In terms of interacting with the data, from the point of collection on, a distinctive challenge stemmed from the complexifying intention of the study itself. Having met with parents, music therapists, and CDS staff, I needed to work systematically with the material gathered both within, and across, the distinctive cohorts. To do this I used both vertical and horizontal approaches to the data, as represented in Figure 5:3.

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[42] While the full transcripts include repeated or incomplete words, I have reduced these in quotations used in this thesis for ease of reading, unless to do so significantly alters the meaning.
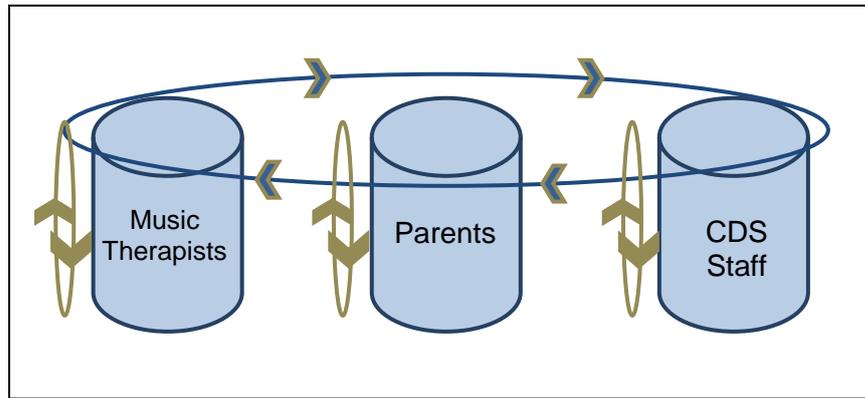
Figure 5:3 Vertical and Horizontal Approaches to Data Analysis

5.10 Working within Cohorts – A Vertical Approach

Working vertically entailed analysing material gathered within each cohort in three stages: repeated, close readings; inductive line-by-line labelling of each transcript; and clustering together of labels within each cohort (Fig 5:2). I worked with Excel worksheets to organise emerging analytic material, and also, at times, with large sheets of paper and coloured pens. The freedom of this latter approach, an example of which is below, complemented the more constraining format of the Excel sheet, allowing me ways to play with the material in a graphic, less text-based way (Charmaz, 2014, p. 218).
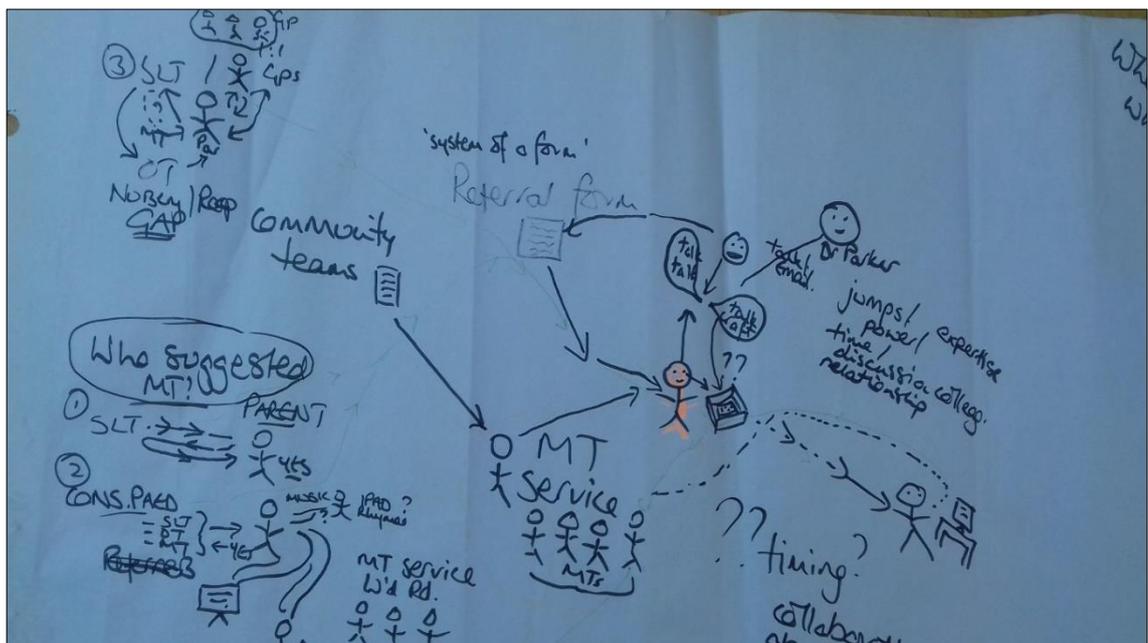

Figure 5:4 Creativity in Analysis

Line by Line labelling

Charmaz (2014, p. 343) describes line-by-line coding in Grounded Theory as a tool for 'assessing what is happening in each line of data and what theoretical ideas it suggests'. I use the term 'labelling' here rather than 'coding'. My intention, mirroring the process in IPA, was to write freely, distilling the content of lines of text clearly.

Figures 5:5.and 5:6, below, are examples of line-by-line labelling, intended to illustrate the analytic process. The first is labelling of the transcript from the individual parent meeting (Par Indiv), the latter from the CDS staff team meeting (CDS FG). The lines on the left correspond to the equivalent line in the transcript to which it relates. Lines with no text relate to periods in which I am speaking in the original document.

170	
171	
172	viewing therapist as 'the professional'
173	asking for direction from therapist
174	what will be most helpful for child, what will upset him
175	asking how what happens in mt links to everyday life and development
176	how can I help him outside - changes at home, child singing at night
177	mother spontaneously sang and played kitchen equipment when he was upset to distract
178	surprising child out of upset
179	asking how do I take events here and appropriate them to use as strategies
180	
181	
182	
183	
184	following instincts, doing it my own way
185	singing, making noise, seemed to help
186	distracted him interrupted upset state
187	unsure if doing it myself would work
	trying out ideas on my own - but is child doing his own learning

Figure 5:5 Line-by-line labelling from Parent Meeting (Par indiv)

	is this a shared perception?
677	
	uncertain of own thinking
678	
	reflecting on own practice - sessions go more or less well
679	
	note own achievement or lack of it in sessins
680	
	notices emphasis on my 'own' achievement
681	
	questions perception of mt
682	
	is there something favourable in every session
683	
	not necessarily dependent on therapist's actions and achievements
684	
	but arising from achievement of child
685	
686	
	uncertainty of own thinking
687	
	something positive in every mt session
688	
689	is positivity wished for in multi-disciplinary meetings
690	there'll always be something' from mt to contribute to team meeting
691	
	other therapies have end goals

Figure 5:6 Line-by-line Labelling from CDS Focus Group (CDS FG)

In generating labels in this way, I did not intend to reduce the text into a concrete, static entity to be dissected. I intended, rather, to retain a sense of the text as an albeit limited representation of lively, spoken words, uttered in relation to those of others, within a particular time and place. At this point, and throughout the analytic process, it was necessary to zoom in and out with the analytic lens between parts and whole: words, phrases, lines, paragraphs, transcripts and beyond (Bortoft, 2012). Nor did this only relate to textual considerations: circling between the individual and group created a further part/whole dynamic to be navigated.

Clustering Labels

Having generated a large number of labels, I clustered these together under loose headings. I include an example below from the analysis of the CDS staff group (see Fig 5:7 below). These 'cluster headings' are in the right-hand column, and labels in the left. My use of the terms 'clustering' and 'cluster headings' differs from Charmaz (2014, p. 184) for whom clustering is a graphic 'prewriting technique' through which ideas are trialled. At this point, clustering labels into headings provided a way of reflecting further on the emerging material within each cohort.

677	is this a shared perception?	professionals may perceive the involvement of music therapy differently	
678	uncertain of own thinking	professionals may perceive the involvement of music therapy differently	
679	reflecting on own practice - sessions go more or less well	professionals question their own part in sessions being more or less successful	
680	note own achievement or lack of it in sessins	professionals question their own part in sessions being more or less successful	
681	notices emphasis on my 'own' achievement	professionals question their own part in sessions being more or less successful	
682	questions perception of mt	professionals perceptions of the distinctive nature of music therapy	
683	is there something favourable in every session	professionals perceptions of the distinctive nature of music therapy	ach
684	not necessarily dependent on therapist's actions and achievements	professionals perceptions of the distinctive nature of music therapy	ach
685	but arising from achievement of child	professionals perceptions of the distinctive nature of music therapy	ach
686			
687	uncertainty of own thinking	professionals may perceive the involvement of music therapy differently	
688	something positive in every mt session	professionals perceptions of the distinctive nature of music therapy	
689	is positivity wished for in multi-disciplinary meetings	music therapy brings positivity to CDS team	
690	there'll always be something' from mt to contribute to team meeting	music therapy brings positivity to CDS team	
691			

Figure 5:7 Labels and Cluster Headings (CDS FG)

Reflection

Charmaz (2014) stresses the centrality of comparative methods within Grounded Theory. Comparisons are made 'at each level of analytic work': data with data, data with emerging concepts, and concepts with concepts (p. 132). While formally working vertically, I became aware that I had, informally, begun a comparative process as I moved across the data sets of the three cohorts. Even at the read-through stage, some material struck me as more, or less, engaging. For example, while the material of the first music therapists' group (MT FG1) was heavily procedural in content, detailing administrative and organisational processes, the content of the initial parent group (Par FG1) was strikingly intimate and experiential in tone. Such qualitative contrasts offered confirmation of the value of including multiple voices in the study, and further hinted at the complexity that such multiplicity might bring.

5.11 Working across Cohorts – A Horizontal Approach

A more explicit comparative process began in shifting planes to work across the horizontal. I began here by comparing cluster headings from the three data sets.

Comparing Cluster Headings

Comparing cluster headings allowed me to tease out distinctive qualities of each set, while also exploring connections between them. I used specific activities as a means of approaching the material differently. One such approach was to draw together the three sets of cluster headings into what I called key areas. Thirty-two key areas were identified, which are presented below (Fig. 5:8). These are represented without any intention to privilege one over another, but rather to lay out the material's broad scope.
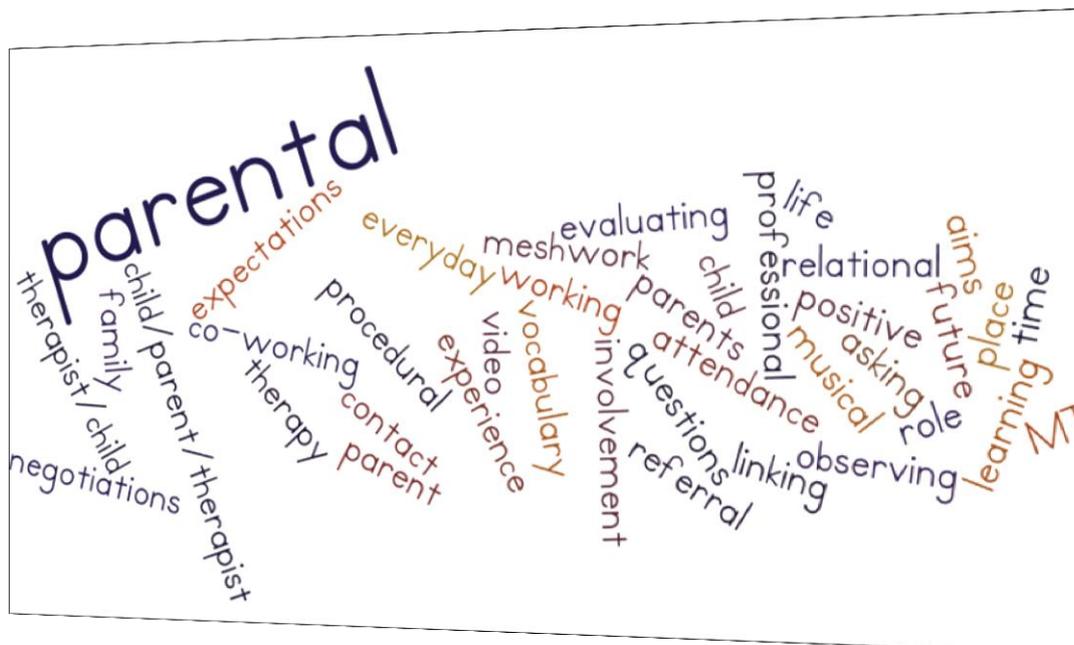
Figure 5:8 Identifying Key Areas

The key areas offered a broad view of the emerging landscape in which certain features were brought variously into focus. These included the *institutional processes* of music therapy (procedural, referral), and its overt *activities* (evaluating, observing, musical, video). It also highlighted the *relational* (working with parents, parental attendance, involvement and role, co-working), the *experiential* aspects of music therapy (music therapy as a positive experience), and the *connecting* of therapy with everyday life. This exercise offered an intermediary stage in the analytic process, allowing me to look across the material as a whole and bridging the activity of clustering labels, with the next steps of working towards statements.

Working Towards Emerging and Key Statements

In working from cluster headings towards emerging statements, the task was to raise the analytic level from the descriptive to the conceptual. Within Grounded Theory, this may signal the articulation of categories, in which commonalities are sought across groupings, and abstracted into an analytic concept (Charmaz, 2014). I chose to mirror the language of the Preliminary Study's analytic stages and have retained the terms emerging statements, key statements, and integrated themes from this point on in doing so.

Nine emerging statements were articulated at this point (Table 5:1). I did not consider these statements to be discrete and exclusive in nature, but rather as analytic

groupings between which overlaps could be assumed to occur. In this sense, the use made of the term 'statements' here is similar to that of 'categories' within other Grounded Theory studies in which authors refer to interlinkages (Webb and Kevern, 2000, p. 801), interconnectedness (O'Callaghan, 2007, p. 276), and categories that 'coalesce' (Charmaz, 2006, p. 3). The statements are dynamic in nature, in movement with each other. At this point, and in keeping with the 'upstream' approach, it was the process of considering what was being stated, rather than the fixing of the statements themselves that was important (Bortoft, 2012). The statements, together with the sources from which they are drawn, are included as Appendix 15.

1.	Music Therapy in the Child Development Service is a distinctive intervention within a complex meshwork of people, places, activities and services.
2.	Relationships between CDS professionals, children and parents evolve over time and are contingent on role, expectations and perceptions of need.
3.	Discussions between multiple parties over time underpin a child's pathway through music therapy.
4.	Expectations of multiple parties generate activity and shape the experiencing of music therapy.
5.	Music therapy is enacted through a fluid interplay of relationships between child, parent, and therapist.
6.	A parent's knowledge, experience, aims and needs serve as often covert influences throughout the music therapy process
7.	Parental involvement in music therapy sessions is negotiated, fluid, and unpredictable
8.	Parent and child act as hinges between music therapy, the wider network, and everyday life.
9.	Time becomes a frame within which experiences, activities and changes are held.

Table 5:1 Nine Emerging Statements

The emerging statements retain and reflect the material's multi-perspectival nature. Within them, a shifting scope of magnification can also be seen. Statements 1–3 speak of the organisational level, in this case the CDS, and music therapy itself as a component part of healthcare meshwork. The lens then zooms in, in 4–7, towards the detail of the specific activities of music therapy with child, parent, and therapist, before panning out again, in 8, towards the everyday life of child and parent beyond music therapy and the CDS. The final emerging statement, concerning the underpinning temporal framework, stands alone yet may intersect with any of the previous eight.

In one further iterative cycle, and to ensure that coherent links could be made through the analytic process, I returned to the unique lists of cluster headings from each data set, placing each of them within one of the emerging statements, and sourcing evidencing material with transcript code and line number (Appendix 15). In doing this, a number of duplications in the cluster headings were identified and removed. I also distilled the emerging statements into six key statements, in the light of revisiting the original material at this point (Table 5:2).

Music therapy in the CDS is a distinctive intervention within a complex meshwork of people, places, activities and services.

Relationships between CDS professionals, child and parents evolve over time and are contingent on role, expectations and perceptions of need.

Music therapy is enacted through a fluid interplay of relationships and events between child, parent, therapist, and others.

A parent's knowledge, experience, aims, and needs shape the music therapy process.

Parental involvement in music therapy sessions is negotiated, fluid, and unpredictable.

Parent and child act as hinges between music therapy, the wider network, and everyday life.

Table 5:2 Key Statements

Having worked inductively with the material until this point, I now turned the focus outwards. I considered the research questions again, of which I include a reminder here.

- What is the range of the meshwork within which music therapy takes place?
- What forms of expertise do different parties in the meshwork contribute?
- In what ways is expertise assembled across the meshwork and manifested in music therapy with a child when a parent is present?
  - In what ways might the musical-social activities of music therapy afford or preclude distinctive opportunities for the enactment and assembling of expertise?

I also returned to the findings and theoretical frameworks of the Preliminary Study, together with the emerging areas of theoretical interest in the current phase. The intention to follow the trails of music therapy's meshwork, together with a detailed,

parallel focus on the expertise of all involved, provided anchor points for reconsidering the key statements. Ultimately I arrived at five themes, which I term 'integrated' given the horizontal analytic work across the three data sets of parents, music therapists, and CDS staff (Table 5:3).

- The Child Development Service as a complex, fluid meshwork
- The distinctive functions of music therapy within the meshwork
- Music therapy as a series of improvised exchanges
- Parents as strong co-producers of the music therapy process
- Child and parent as conduits between music therapy and everyday life

Table 5:3 Five Integrated Themes

Having worked through the series of analytic steps to reach this point, the focus now shifts again. In the remainder of this chapter, I present each of the themes in turn, returning to the people and narratives at the heart of the study in illustrating each section. While making reference to theoretical ideas when appropriate, I intentionally do this lightly, allowing the material to speak for itself, and leaving more detailed discussion to Chapter 6.

5.12 Considering the Themes

In presenting the material theme by theme, I do not intend to consider the findings as 'packaged' into component parts, but rather to consider the whole 'as it is expressed within the parts' (Bortoft, 2012, p. 14). There is inevitable leakage across themes, which, in itself, can be taken as reflecting the trails and permeability of music therapy with child and parent. These trails are further suggested through the multiple voices reflected in these findings. In writing, I have sought to find a balance between attending to distinctive voices, while allowing for connections and cohesiveness when it appears.

In this process, certain voices come to the foreground and recede again. For example, in honing in on the detail of music therapy sessions themselves, the voices of CDS staff members become, understandably, less prominent. In itself, this speaks of the

mobile nature of the phenomenon: child, parent, and therapist in music therapy move in and out of the view of others, with no one individual having a purview across the whole terrain. Whose voice is heard at any one point, then, becomes part of the overall picture which has emerged through the data work.

In this account, I present the themes in order, as they are listed below.

- The Child Development Service as a complex, fluid meshwork
- The distinctive functions of music therapy within the meshwork
- Music therapy as a series of improvised exchanges
- Parents as strong co-producers of the music therapy process
- Child and parent as conduits between music therapy and everyday life

5.13 The Child Development Service as a complex, fluid meshwork

The CDS is an overarching title for a grouping of children's healthcare services, which include music therapy. It operates as a constellation of separate services, which, together with the children and families who use them, constitute the CDS's 'zone of entanglement' (Ingold, 2008a). The CDS has two main objects of activity: identifying and diagnosing a child's developmental difficulties and needs, and enabling a child's development through the provision of medical and therapeutic support.

Given the differing needs of children, various services within the CDS may have contact with a child and therefore family, at any one time. For many children, their journey through services begins from a focal contact with a paediatrician, who acts as conductor, directing families and professionals towards each other. As the paediatrician explained when asked what services she had in mind when first meeting a child:

> **M** – Physio, occupational therapists, speech and language therapists, clinical psychology, music therapy, [clinical, clinical, yeah!]
> **CF** – [You're ticking them off on your fingers!]
> **M** – Clinical nurse specialist, plus or minus the social worker, depending on the disability of the child. So you kind of have a, ok, what am I going to, what are the different people that I'm

> going to need to send this child to, who need to be aware of the child, yeah. (CDS indiv 3, 211)[43]

The specific needs of an individual child trigger movement and flow along the lines of the meshwork. Child and by implication parent can be understood as moving towards and away from different services and, in doing so, moving in and out of contact with staff. Staff themselves are also actively engaged in this process, continually adjusting their actions in relation to others, having more or less contact depending on their involvement with any one child.

1. The Dynamic Work of Roles

The meshwork is generated through people in differing roles interacting with each other and with things. I use the term 'things' here in line with Ingold (2010, p. 96) who suggests things be considered not as fixed, but rather as a 'going on', in dynamic relation to other 'goings on'. Perceptions of power and notions of implicit power become contributory elements in this process. In describing the referral process to music therapy, the lead music therapist speaks explicitly of these underlying currents:

> **T** – Dr Parker referred someone by email last week, a little girl who's very young, one and a half, almost two, just been diagnosed with ASD.[44] She came to see me on Friday saying 'I'm really concerned about this little girl, I think she needs some help from your service'. So, she emailed me her letter as a paediatrician, and I've accepted that as a referral without the need for a referral form so sometimes there are people who jump the system as it were and I think that's interesting.
> **CF** – And how do you decide that, in that instance, the system got jumped?
> **T** – Well, I think it's, you know there are elements of power in this, you know in terms of perceived power in the team […] I suppose those situations are very few and far between now. You know, I think mostly nowadays we have a system where referrals are made….within a system of a form, you know, holding the information you know in a helpful way across services. (MT FG1, 60)

While there is a standardised referral process,[45] the meshwork also appears to come into being through flexible activity. Such activity is contingent on histories of working

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[43] In all quotations individuals are anonymised through the use of an initial (Appendix 14). As in the Preliminary Study, CF refers to me.

[44] Autism Spectrum Disorder.

[45] See referral form within Appendix 2.

relationships, and the freedom to circumvent conventional routes that particular roles and relationships enable. The question of 'perceived power' is itself potent, being used in this context by someone in a senior role. It raises issues of whether others within the team are equally free to navigate the 'system' spontaneously, to choose when to use a referral form, or not, and how such knowledge might be gained. An implicit power differential is contained in such questions.

Individuals' perceptions of their own particular role and status in the network also affect the degree to which they feel themselves to have the agency to act within the network. This resonates with the administrator who assumed the invitation email was not intended for her (cf. p. 164). CDS administrators, for instance, by the nature of their role have often transient, but powerful periods of relating to parents, forming the first point of contact with the CDS, and at times managing acute distress, as this administrator describes:

> **W** - When the parents come here and they seem to have a meltdown on professionals here, I get them on the phone, and I hear them saying, 'I'm at home with this child, this child is not interacting'. Like yesterday I had someone say, 'He's not going to school anymore, school have excluded him, he has, he doesn't see his friends, he's crying all the time, all day at home, because he's at home, but he can't go to school', so you get all the parents, and then, and I have to tell them 'I'm afraid you've got another seven months to wait'…..So, I'm like 'oh my God', you know I struggle with that a lot, I struggle with that a lot, and I keep telling, when I have my one-to-one with my manager, and I even told my new manager, and I said 'I need you to come up with a story for me, because I really am struggling with the parents having to wait'. Like, now they'll have OT.[46] By the time of OT, the child can get to do a few things, by the time they wait to get on the physio list, the child has almost lost the skills that they've learned but then, you know, at the end of the day, it's all staffing issues and there's nothing you can do….And all the time the parents, they're literally crying on the phone about the wait.
> **C** – Mm. So, when you take those phone calls then, what do you do with that? And who do you talk to about that?
> **W** – Mainly colleagues and everyone in the office, and we all talk about it (CDS FG, 572)

While not responsible for, or even necessarily cognisant of, the waiting times for various services, in such situations administrators act skilfully, effectively counselling parents in distress. In doing so, there is an acknowledgement that, in their role as administrators, there is little sense of agency to be able to effect change. While

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[46] Occupational Therapy

demands may be made that a manager 'come up with a story', it is in the informal, office-based contact with peers that experiences are shared and support is found. An imbalance of agentic power emerges here, which highlights a conventional hierarchy between senior staff and those in administrative or more junior roles. An easy acceptance of this imbalance is challenged, however, through the narrative of skilled, though often invisible, work of caring evidenced here.

2. The Dynamic Work of Parents

Skilled, relational work underpins the work of the CDS. It functions along the lines of relationships continually being made, developed, suspended and ended. Multiple relationships form between child, family, and CDS staff over time; each contact with a new service involves child and parent relating to different people, doing various things in multiple places.   Managing such shifting terrain demands a high degree of flexibility for the parent/child pair. In moving between services, parents become gatherers and holders of knowledge and experience about their child's journey through the CDS. The paediatrician outlines the detail she might seek to elicit from a parent:

> **M** - So ok so, you've met all these different people, how have you found things, what are the main things that you have as ongoing issues, what have you heard _____ (*name)* to say. Ok, you've met with this person, what did they say, what was your impression, you've met this person obviously, what's your understanding of what's going on, and then, how have you found the different sessions you've been to, what are you doing at home as well, so have they given you any tips that you're continuing at home, and things like that. (CDS indiv 3, 234)

While the paediatrician may be considered a weaver here, drawing together a cohesive narrative of their child across various encounters, it is the parent who is the supplier of the yarn. The expectation is that the parent will produce the narrative with which the paediatrician can work, threading the child's story together through people and activities within the CDS, extending to home life as well. Parents are not only participants in their child's healthcare, they are active generators of it, as the picture created in any one encounter is passed on to other professionals within the mesh.

The Parent-Professional Relationship
If the work of the meshwork is founded on relationships, then the pivotal relationship in that process is the one which emerges and recedes between specific health professional and parent over time. From a professional's perspective, a key intention

in engaging with a parent lies in enabling and supporting parental involvement in a child's therapy. Active parental involvement, in physiotherapy, occupational, or speech and language therapy is seen as optimal, although what might constitute such involvement, and the factors which might inhibit or enable it, are perceived to vary across disciplines. A physiotherapist, for instance, said this on involving parents:

> T – I think it does depend on the child and what's maybe wrong with them or, you know, how, whether it's a long term difficulty they have that, I guess it's trying to explain over time that that's the sort of picture really, and maybe take the cue from how they are as to how much you get them involved and how comfortable they are so, like Frances said, whether they even get on to the floor or not you know is quite a big thing because not all of them do, whereas for some people it's very natural just to sort of sit and play, and I guess it is more, it's more challenging when they don't want to do that. (CDS FG, 363)

This therapist's approach to involving parents actively in sessions is shaped by a reading of the child and their needs, together with a sensitivity to how involvement might be experienced by a parent. Even when the planned therapeutic activity needs a parent's involvement, professionals are alert to potential reticence, as the speech and language therapist describes:

> R – And I guess it depends on what it was that we were working on, obviously, and what approach we were using, but, sometimes we would sort of do a bit of a session with a child, you know, whether it's singing, or a 'what's in the bag' activity or whatever, so it would be more sort of like, one-to-one, with Mum observing, and then perhaps Mum could have a go at sort of doing similar activities…. But sometimes the parents are a bit reluctant to do that in the sessions, and they prefer just to go home and do it themselves…. I think they kind of feel a bit maybe in the spotlight a little bit.' (CDS indiv 4, 272)

The idea that parents may 'prefer just to go home and do it themselves' speaks to a further strand of the parent-professional relationship within the CDS. Good working relationships are seen to enable the pair to work with ease within therapy sessions. However, a further underlying intention of professionals in working closely with parents is to turn the focus of therapy outwards, away from the therapy room itself and towards everyday home life. The activity of sessions is not intended to remain in the therapy room but to be integrated into everyday life. The parent is perceived to be crucial in this process, as the physiotherapist comments:

> T - What we're aiming for is to try and get them using all the ideas and learning how to work with their child at home or at

school, or, but I do think that's quite personal as well to parents and not all of them are maybe from a, certainly families from different backgrounds, different countries, they have a different idea of, you know, what that might mean, and some places feel that, as I say, you go and have a session and come away again, and I think they struggle more to understand that therapy isn't just a *thing*, it's a way of like adapting their lifestyle or their child's, you know, day to day and it kind of crosses over into kind of tasks that they do throughout the day, and it's not just about one thing. But I guess that's what we aim with parents, but I think it varies depending on their character and how maybe open they are. (CDS FG, 352)

Understandings of child development, healthcare, and parental involvement all intersect with cultural assumptions and values for all involved. This therapist touches on the difficulties that such intersectionality can present and the dilemmas raised in addressing them. While a dynamic integration of therapy activity with that of everyday life, brought about largely by parents, may be an underpinning intention of professionals, it cannot be assumed to be a shared intention. Personal preferences and sociocultural assumptions about therapy – what it entails and who it involves – are deemed to influence the ease with which this integration may occur.

In considering the CDS as a fluid meshwork, then, the child emerges at the centre of the mesh. It is around, across, and through the child that the mesh's lines are woven. In such work, the parent appears as an active generator – conveying information, managing often painful experiences, and bearing frustration – and expected, through this, to link therapy work with home life. How are parents to understand all that might be asked of them, both within sessions or at home, and are there unchallenged assumptions as to the capacity that any one parent or family may have to take on what seems to be expected of them? Where, too, does music therapy as a service within the CDS, find its place in relation to these questions?

5.14 The Distinctive Functions of Music Therapy within the Meshwork

1. Timing Music Therapy

As a service, music therapy is perceived as offering distinctive functions within the wider organisation. These perceptions vary according to the particular perspectives afforded through person, role, or knowledge. Music therapists themselves speak of the attention paid to timing the offer of therapy with a child as differentiating the service from others:

> **H** – I think that's something you hear us as a team say more than most other teams, about, this idea of timing and, well we might have a referral, that doesn't necessarily mean now's the time to do something with that you know in terms of offering music therapy. It might be that we hold off while another therapy takes priority and then we offer. You know, so yeah, it's something that I think we, I hear us, as a team say more than other therapies, I think. (MT FG1 105)

There is a sense of organisational flow and movement in this process; music therapists position themselves in relation to other services, as they also position themselves around a child, seeking to understand the present priorities for a child and family. At times this also means working to manage the anxieties of both families and other professionals.

> **M** – I've got a particular child I was talking to our Clinical Specialist Nurse about, and she was just so, kind of, 'Well, the child's got this, this, this and this', and listed a long line of input, because at the moment it's just immediate, 'they really need help with this, they really need help with that'…. there was just an overwhelming amount of urgency about this child and it was sitting down I think talking about 'Ok, so what's the most urgent matter now?'. Actually, it's that the child's safe and thinking about the level of appointments, the level of input from a range of professionals that the child was having, and thinking about timing, I think, was that was the hardest, when it was we're not saying 'We're not going to accept, it's not that we're not going to accept the child, but let's think about the child and the family, where they're at right now and, you know, how music therapy might fit into that picture in a helpful way'. So that was a difficult conversation I felt. Opening up a bit more thinking rather than 'this child has this, this, and this needs'. (MT FG1, 91)

Adopting a child and family-led flow such as this may result in music therapy being offered further down the timeline than originally envisaged. Holding and working with such an overarching time frame is held in tension with the organisational strictures of targets for maximum waiting times, which can become a driving factor in offering a service. It appears as though one function of the music therapy service, at least as perceived by music therapists, is to consider the interplay of the parts of separate services with the broader whole of meeting the child and family's needs.

2. Experiencing Music Therapy

The distinctive nature of music therapy is also to be seen in the ways in which it is experienced. A child attending music therapy is observed by the receptionist, for instance, to be more relaxed in waiting for their session than when attending other

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therapies. In part this is ascribed to the building's geography. As one administrator said, 'they can hear like the other child on the drum and they can't wait to get in' (CDS FG, 484). Music therapy is felt to be something that is eagerly anticipated. CDS staff perceive the sense of a child being at ease as having a direct influence on parents, who are seen as being more at ease themselves when attending music therapy, as opposed to other therapy sessions, with their child.

In part, CDS staff perceive the ease and enjoyment that parents are felt to experience in attending music therapy as resulting from the less direct emphasis placed on achieving specific therapeutic goals for a child in music therapy. As a staff member comments of families known to her:

> **R** - I think for *our* parents there is that, you're always focusing
> on the next thing, the next thing, and actually maybe in music
> therapy you're able to sort of undercut that a bit, and you help
> the parent kind of find pleasure and enjoyment in what they're
> achieving, in what they can achieve, just like that, rather than
> always sort of be looking at, yeah goals and what they should
> be achieving. (CDS FG, 761)

Within the meshwork, music therapy sessions are valued for the positivity and pleasure they bring parents. The child's present achievements and the parent's experience of their child in that moment are valued as significant features of what music therapy affords in this context.

Music therapy is felt to be broader, less specific, and yet more inclusive in what it offers child and parent. This is understood by one staff member in terms of the focus on goals that appear to permeate cross-disciplinary therapist-parent negotiations:

> **F** – [There's] probably something positive to come out of every
> music therapy session… Whereas with OT and physio we have
> this goal, and with speech, the child isn't achieving that goal
> and that will be the focus of the family's interactions with us, 'oh
> but they're not walking, oh but they're not talking, oh but they're
> not holding a pencil', whereas with music therapy, I've a feeling
> it may come down to these goals, that's kind of my feeling, that
> maybe they're slightly broader and encompass more, so that
> there's often a lot that you can see and talk about in a positive
> way. (CDS FG, 666)

I would argue that the positivity spoken of here is less concerned with the breadth or flexibility of goals and more particularly related to the ways in which music itself works in sessions. Music itself appears as mobile, crossing developmental areas to be

realised through movement, sound, gesture, and looks, both intentional and unintentional. In music therapy sessions, then, there is always action: something is always happening or appearing. It is, I suggest, because of this distinctive emergence that ease, pleasure, and positivity also become experiences frequently associated with music therapy. If goals appear to be flexible and broad in scope, then this is also a reflection of the mobile, mutable nature of the way music itself works.

3. Music Therapy as the Golden Thread

The positive affordances of music therapy are not only perceived to affect child and parent. The CDS team frequently work with children and parents who are colloquially termed 'complex families'. Complex families can be understood as having multiple needs in addition to those of the child, whether in socio-economic, psychological, or physical health terms. Such families are perceived, at times, as having difficulties engaging with CDS services or attending sessions regularly. Music therapy is noted for its adhesive qualities, being described by staff as 'the glue that holds it together for the families' (CDS FG, 805). The suggestion here is that families appear to privilege music therapy sessions and attend regularly. This is perceived by CDS staff to be beneficial in relation to the services they are then able to offer. Other disciplines attach themselves to music therapy, seeing children in joint sessions in order to link activity and appointments together.

The idea of the 'golden thread' was incidentally introduced by a senior manager in the Trust, who, as part of their induction, attended a joint therapy group for children with complex needs. The group, known as 'Music and Mayhem', was run with parents/carers, physiotherapists, music, occupational and speech and language therapists. In informal discussion following the group, the manager commented that music seemed to be 'the golden thread'. It threaded together the various developmental areas of the child, but it also pulled people in the group together into a lively, purposeful whole. That it was termed 'golden' spoke of its unique quality. As a descriptor of music and music therapy within the meshwork, it is perhaps a more helpful term than 'glue'. While 'glue' implies two or more entities being fixed into place together, the 'golden thread' speaks instead, to use Ingold's terms, of the lines along which people, things, and events interweave (2007). This retains a dynamic quality, reflecting again musicing's emergent nature.

Music therapy is also perceived to offer a threading function in the intertwining of a 'complex family' and the CDS team at particular points of meeting:

> **F** – I always have noticed, and I say this without judgement or anything, but if we're at a team meeting….and it's a really tricky family, that's when people ask 'are music therapy involved, are music therapy going to come?' (*sounds of assent*) … it's almost like you guys will defuse the situation
> **W** – Oh good, make sure, make [sure they're coming]
> **F** – [Make sure they're coming]. That does happen. I never really thought about it until now but it is, and it's always the complex families, not necessarily, not necessarily the complex *children* Claire, but the complex families. (CDS FG, 665)[47]

In the often highly charged environment of such meetings, the music therapist is seen to act as a 'defuser', lowering the tensions in potentially inflammatory situations. Although not pursued directly at the time, the comment raises questions: what might music therapists be perceived to do which either creates the impression of, or actually defuses tension? Why might this be particular to music therapy?

I suspect one answer is to be found in the notion of music therapy acting as an unfolding, linking thread. It may be that the improvisatory, musical skills that underpin the music therapist's approach are brought to bear on potentially dissonant situations. Common ground is found, and threads are formed. But perhaps the emergent nature of music therapy also comes into play here. Music therapists are perceived as working with a looser medium and style, positioned at the edge of the medical establishment. This perhaps carries distinct advantages, allowing them to position themselves with neutrality across the borders of conventional organisational structures and parents.

Having begun with the CDS as a complex meshwork, and the music therapy service as performing distinctive functions within and through it, the focus of the findings now shifts. The lens now zooms in on the detail of the practices, people, things, and places of music therapy as enacted in this setting. Here, the mesh becomes more tightly woven as attention turns more closely to the work of the child, parent, and therapist.

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[47] The term 'complex needs' is frequently used within children's healthcare. The NHS website states that 'if a child has been diagnosed with an illness, disability or sensory impairment that needs a lot of additional support for them to live day by day, they might be described as having "complex needs"' (https://www.nhs.uk/conditions/social-care-and-support-guide/pages/parenting-children-with-complex-needs.aspx, 2017). In this setting it is often taken to mean a child who lives with multiple, overlaying areas of need.

5.15 Music Therapy as an Unfolding Series of Improvised Exchanges

Given the organisational context, the procedural elements involved with a child starting and ending music therapy echo those prevalent within this particular healthcare culture. A series of specific events scaffold the music therapy process with a child and parent: the initial assessment session, the pre-therapy meeting prior to a child beginning a course of therapy, and a post-therapy meeting as it ends. These act as anchoring events, the form and content of which remain, to a certain extent, stable. Within such events, however, and subsequently within sessions themselves, the improvisatory, emergent nature of the music therapy encounter manifests itself variously.

1. 'Let's go for it' – Managing Expectations in Music Therapy

Music therapy with a child and parent present is laden with expectations. These permeate the whole music therapy process, are multiple, and are often unspoken. For parents, whose focus is clearly on their child and seeking out the support they feel them to need, expectations have a particularly focused quality. One parent said, on learning of the possibility of music therapy:

> **N** - 'When you hear something new, 'specially for, like Eddy, I want something quick in. I'm waiting for something, miracle to happen, you know, maybe this, this is my expectation.' (Par FG, 142)

Without specific knowledge or experience of music therapy, expectations are raised by the offer of a new therapeutic intervention. At times, word-of-mouth recommendations from other parents become the authoritative foundation for such expectations, as this parent explains:

> **O** - So I did a little read on music therapy, about how Chelsea and Westminster, you know they're so big about music therapy and how it helps autism, autistic, *and* children who have speech difficulties, so I thought, you know what, this probably would be the best because he loves music… I've heard a lot of successful stories, like a lot of success with music therapy. I was with a parent who was with Chelsea and Westminster as well, she has an autistic boy, she said that her son started saying *words*, after the fourth and fifth session, so all that, you know, so if that can work, why not, let's go for it. (Par FG1, 30)

Expectation, in the form of hope, carries significant force. It brings the possibility of the miraculous, and of specific developmental change. It is a force that may not be spoken of, but which may underlie the initial meeting between child, parent, and therapist in the

assessment session. This session carries its own weight for the therapist, for whom expectations are entwined with a sense of professional responsibility:

> H – I certainly feel professionally a bit vulnerable at that point because there's so much unknownness going on. *You* don't know this parent, this parent doesn't know *you*, you don't know the child, the child doesn't know you, you don't know what the music's going to sound like, you've got no prior experience to go off, you've, maybe you've had some contact with professionals who've told you how they've been but you don't know what your meeting's going to be like, and are you going to say the right things in the right order in the right way that's going to be helpful for the parent to say, and then not overload them and da-da-da (*laughs*), and it can go on like that (MT FG1, 310)

The therapist anticipates the interweaving of relationships, knowledge, musical activity, and language that is about to happen. Yet at times their anticipation is inadequate, as when the family group who arrive unexpectedly includes siblings, bringing further layers of complexity to the situation:

> L - thinking back to that unknownness, you don't know how many people are going to arrive for the assessment, so the days when there are other children, who are not really old enough to understand that they're to sit and watch and not necessarily join in….I think that is about managing the children's needs, as well as the child who's being assessed… It's quite nerve-wracking, and challenging. (MT FG1, 350)

The 'unknownness' spoken of here is multiple; while the music therapist is familiar with the place, things, and potential activities of music therapy, the child and parent are, at that point, unknown. This is not to say that the therapist will have no knowledge of them, but that the knowledge they do have has been generated at a distance, through discussions with others, reading referral forms and reports, and optimally, having telephone contact with parents. For parents, the 'unknownness' of the activity, the therapist, and the place itself, may be compounded by the unfamiliar vocabulary that surrounds music therapy. This is evident both in terms of describing musical instruments, 'there's this massive thing with beads in it' (Par indiv, 241), and by grasping a new therapeutic terminology. As one parent noted:

> O - The whole idea is the child is like, I forgot the terminology, is it something that you follow the child's lead? Yeah, kind of it's the child's approach, you go with the child, that's the whole concept about music th-, that was what I was explained. (Par FG1, 106)

Into the potential disadvantage created by unfamiliarity with therapy's technical language, the parent brings a unique advantage to the music therapy encounter: that is, their knowledge of and relationship with their child. However, expectations of what their child will do, and how they might manage the novelty of the music therapy situation, may well be challenged, as the child responds in unanticipated ways:

> **P** - I sort of go, 'oh wow, look Sam' and then I sort of sit down here, and then he sort of come over and stood next to me, and then she [the therapist], from what I remember, had the guitar, and just sort of started singing, and then playing on the piano as well, and he just *straight* away got stuck in. He was *bang*ing the drum, and it even really surprised me, because I sort of felt 'he knows how to do the drums, he knows',… I was sort of really blown away like, 'how did he know', you know I sort of realised 'you're not a baby anymore', you know, you *are* learning, you are picking up things. (Par indiv, 112)

It is not only the immediacy of the child's response that surprises, but the nature of his response. The expectation both of the child's knowledge and skills is confounded in the musical moment. This, in turn, prompts the parent to question her own knowing of him and her own sense of needing to readjust her expectations in the future.

Music therapists bring an alertness to the expectations and assumptions that a parent might bring to the early moments of therapy, such as the assessment session. The notion of music making itself is considered as potentially problematic in generating expectations for parents about its performative associations.

> **H** – And I wonder if the word music puts an idea in a parent's head that the child has to perform? So if there is a level of performance that is expected from the parent, from the child, from the parent from the professional, to perform and make something happen which might not occur when you go for a physio appointment for example, there's not the same, I don't know, cultural associations perhaps with their assessment. (MT FG1, 362)

This layer of concern is not mirrored in the parents' expectations of their own role in music therapy, a more pragmatic request being for a therapist to 'tell me if you want me to come in' to the activity of the session (Par indiv, 226). I return shortly to address questions from a different angle regarding perceptions of the child and the notion of their performance in sessions.

In terms of a therapist's expectations of a parent, physical appearance in itself creates expectations. One therapist described 'reading' the degree to which a parent might

themselves expect to be actively involved in their child's therapy through the parent's dress and appearance:

> **H** - There was one Mum that I worked with who she came and she was very businessy in her dress. So she looked very smart, and I thought, 'oh well, her position in the room is going to be sitting in the chair, and that will be her position'. Her appearance suggests that. And she, as soon as I thought it, she immediately contradicted it because she took off her stiletto boots and got down on the floor, and got really stuck in. And I thought that was just brilliant actually … it was a really nice reminder to me that you can never assume what a parent may or may not want to do, or how they might want to engage, and it sort of showed me how much she was prepared to put aside in order to *be* there with him. (MT FG2, 293)

While expectations are woven between therapist and parent, and quite possibly child, those of others around the child also contribute to what can be a heightened state of alertness at the start of the music therapy process. These expectations may be felt to emanate from healthcare colleagues, as this music therapist describes:

> **M** – I think there's also that level of expectation I feel from sometimes from other professionals like, 'Gosh, this child just doesn't, doesn't engage at all in speech and language therapy, I mean they're just not, they're not engaged in anything', but you know, 'oh music therapy, oh yeah, they love music, they'll definitely love it'. And they come in and it's the pressure you almost feel to engage that child sometimes and when they don't, when they don't engage to start with, or at all, it's quite a pressure I sometimes feel to make sure. And you've got to kind of, you know, as you said, *park* that anxiety and that expectation of others that the child will, will engage in a playful way. (MT FG1, 324)

A thread appears, through which a professional's experience of a child leads to a coupling together of the child, the child's love of music, and an expectation of what music therapy might offer. The music therapist is alert to the pressure implicit in this thread, which may be understood in two distinct ways. First, there is pressure on the individual therapist to demonstrate how music therapy, as an intervention within the organisation, might engage a child. This carries a political angle, as though music therapy as a profession may be granted legitimacy if the therapist successfully engages a child. Second, however, there is an implicit humanitarian, healthcare pressure for someone to do something to engage a child who is 'not engaged with anything'. While alert to such forces, the therapist also strives to set aside all such expectations in order to meet the child as they appear in the moment.

The hope carried by parents into therapy, the anticipation of parental expectations by therapists, and the perceived pressure as others invest in a child's engagement with music therapy, all intertwine in a child's therapy. Expectations are themselves generative, music therapy with a child and parent coming into form as they are felt, acknowledged, and managed between people.

2. 'So how do we make that happen?' – The Work of Talking

The intricate, layered work outlined above among therapist, child, parent, and other professionals is accomplished to a large extent through talking: the referral process, the assessment session, subsequent meetings and the week-by-week routine of therapy itself are all achieved through contact and discussion between two or more individuals. Initial discussions between parents and therapist at assessment are often of a pragmatic nature, involving giving and gathering information, as this therapist describes:

> **M** - So I'd have hopefully had a conversation with the parents before, you know, discussing, you know the rough structure of the assessment…. there's time before to kind of talk a little bit about, you know, how things are at the moment…. just reminding them what the assessment is, what we might be looking for. What would be really helpful in their role as the parent or carer that knows the child very very well…. things that they notice that we don't notice that are more abnormal or whatever for that child to be presenting with. So I think just kind of reassuring them about the expectation and structure of what happens in the assessment, having that time after to kind of reflect on what was seen and what kind of next steps are. (MT FG1, 221)

When a child begins therapy, the 'pre-therapy' meeting bridges the time gap between assessment and therapy, enabling a further exchange of information. Central to this meeting is discussion regarding the parent's expectations of music therapy with their child, and their own involvement in it. While this may involve managing practical details, such discussion may also lead to careful, nuanced thinking between parent and therapist. This therapist recalls discussions with the mother of a child with complex medical needs, whose condition necessitated using oxygen from a portable tank:

> H – We were talking about how that's meant that her and Mum are always in really close proximity. One of the things that Mum wants to work on is developing independence, so there isn't this automatic assumption that Mum's involved in everything this little girl does. And Mum had picked up on this idea of independence and she said 'So, how do we make *that* happen?', and I then asked her what she meant by

> independence…. 'cos I think she'd got very fixed on this idea
> that it was purely about physical independence that, you know,
> she could be out there and her little girl could be in here having
> music therapy with just me and we then ended up having this
> discussion about what independence meant and what it meant
> for this little girl, and, in relation to her mum. And, I think that
> was a new thing for Mum, she hadn't thought about that, and
> she hadn't thought about how she could be in the room but be
> independent. (MT FG1, 403)

The discussion, ostensibly concerned with details of medical equipment and therapy, extends in scope beyond the therapy room to a consideration of the child in the world. What might independence mean for the child, and child and mother, in everyday life? Talking becomes a way to open up possibilities for thinking more broadly, in a way that might be unexpected.

While music therapists often appear to initiate specific discussion of parental involvement and expectations, parents bring to these early meetings information about their child, relating their knowledge of their child in everyday life to the specific setting of the music therapy room. Such knowledge is brought to bear on the usual practices of the therapist, who, in turn, improvises, adapting their thinking and activity in response to the parent's experience.   This parent, for instance, whose child was highly physically active and impulsive, recalled conveying clear messages to the therapist about the room layout and the availability of equipment:

> **N** – Before we started the music therapy we had a meeting in
> here only. On that day I told her, because already she saw him
> and she has idea, little bit of idea but when we talk, I told her to
> make it less, 'cos the first thing when he come, he wants
> everything down, he's asking
> **CF** – [From all over, down from the shelves]
> **N** – (*Gesturing as she speaks*) [that one, that one] yeah, we
> keep telling him 'no' (Par FG1, 161)

Together, parent and therapist work together, opinions and ideas shaping and being shaped in response to the other. Such conversations at the beginning of a child's therapy are mirrored by those as therapy ends in what is termed the post-therapy meeting. Here the emphasis shifts to the sharing of common experiences and knowledge, as gathered through the course of therapy. Throughout the whole process, written documentation, largely generated by the therapist or other professionals, creates a trail of a child's therapy. The written accounts either precede events – through, for example, the referral form document – are utilised at events – such as the music therapy goals-based outcome sheet – or are produced subsequently, as in

written reports.[48]   While noted at this point, I return to a full discussion of the question of written documentation in Chapter 6.

The set events of the therapy process, such as the assessment session and pre- and post-therapy meetings, have structures and guidelines of their own, locally produced by, and for the use of, the music therapists within the service. Therapists use such guidelines as prompts in steering themselves, parent, and child through the encounter. Using these anchor points, the events also have an improvisatory quality to them: their direction, style, and outcomes differ according to the pre-understandings each party brings, as well as the unfolding, relational dynamic between parent, child, and therapist.

That dynamic is shaped by further influences. These include the temporal nature of therapy, and the more concrete, supporting activities through which music therapy comes into form. These influences should themselves be seen as intertwining, and so are not to be considered as discrete in nature. The headings below, then, should not be taken as specific in their delineation, but rather as guiding the reader towards aspects that became foregrounded at various points.

3. 'Time is Precious' – Music Therapy as Lived Time

The work of child, parent, and therapist in music therapy occurs in and through time. Its passing is measured by parents in terms of their current position in relation to the music therapy service. As one parent noted of the waiting time before sessions began, 'yeah, I did wait for a long time. I thought it was just coming like this, but it didn't' (Par FG, 42).

The experience of waiting circles back to the expectations raised for parents at the point of referral about what music therapy might offer a child. Parent's expectations heighten the way time subsequently spent waiting for an appointment is experienced. Once in sessions however, time is experienced as passing quickly, and often

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[48] The goals-based outcome sheet is a document used by therapist and parent over the course of therapy as a tool for discussion about therapeutic aims, and as a representation of change. See Appendix 16.

pleasurably. 'Time is running', as one parent said of her child's sessions (Par FG1, 546).

Music therapy becomes an embedded element in a family's weekly routine. 'Every Thursday at three o'clock' (Par FG2, 518) becomes a stable point in the week, anticipated by parents and often by the child themselves. Parents even see the regularity of sessions as developmentally beneficial, encouraging a child's sense of days and routine, and leading to conversations, as this parent comments:

> **N** – The first thing I do like about music therapy is he is always thinking about the music therapy, and he's asking me about it, which is good for me, because he never asks for things. But now he knows even the days, he knows that every Tuesday he say, 'music therapy?' You know he has PE[49] at school in the morning, and then after that I pick him from school, so he knows, so every Tuesday he's always waiting for me to come to the music therapy. This is a good thing for me to be honest. (Par FG2, 156)

The regularity and familiarity of music therapy holds value in itself. For parents, valuing music therapy brings with it a corresponding valuing of time spent talking about their child, and the events of therapy, with the therapist. In the week-by-week routine of music therapy sessions, however, opportunities for parent and therapist to talk in depth appear to be limited. The perception of time as a barrier in talking together is felt strongly, as this parent explains:

> **P** – They're half an hour sessions, our aim is to get on *time,* you know sometimes we're a little bit late, sometimes it can, time can go like *that,* and I do feel as though I *would* like to ask more questions, or I would like to get a bit more feedback on what you know, like those questions I've asked. You know, is there homework to go with it, is it something I could do at home, but I know obviously time is precious. You get in, session finishes, that goodbye song and that's it, and I always say 'Oh, I'll ask Tara', but then it goes so quick that time, and then you sort of, 'oh, ok, bye', in and out. (Par indiv, 261)

A wish to protect sessions as being 'the child's time', a perception of the therapist's time as 'precious' and therefore not to be wasted, together with the realities of arriving on time and leaving promptly for what follows in the day, all contribute to a sense of time for parent and therapist to talk as being heavily constrained. Limited in this way, questions and comments may be left unspoken, potential linkages of knowledge or

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[49] Physical Education

experience left unmade. This becomes of particular significance in considering how the events of the music therapy session and home environment flow towards and into each other.

Time, as moving on, is felt as courses of therapy are awaited, as they begin, and as they come to an end. While there is a sense of loss of the predictable, if short term, routine, there is also a looking towards the future, as described by these parents:

> **P** – I just take away the experience of it to carry it on the best I can, and I know that, you know, if I need any support, or anything, you're a phone call away.
> **O** – It is ongoing, that's the best thing. You know, with speech and language. Everything here is ongoing that's the best thing, so if you need more you can ask for more. Yeah, that's one of the best things, that you don't go like, 'oh, this is the end, we can't do anything else for that'. No, it's an ongoing thing, which is great. (Par FG2, 810)

In looking ahead, parents appear to link music therapy firmly into place within the CDS as an enduring, supporting structure of services, projected forwards in time. Both music therapy and the wider services are perceived as accompanying a child and family into a future that may as yet be unknown, but in which services and support will be available should they be needed.

4. On Hopes, Wishes, and Negotiating Goals

The pre-therapy meeting provides a structure within which the practicalities of sessions can be negotiated. These include not only making decisions together about times and days for sessions, but also considering together what parent, therapist, and other professionals, may wish a child to gain from therapy. The goals-based outcome tool (Fig 5:9) has been developed by therapists within the service in recent years (see Appendix 16 for full document). While the tool's origins were not discussed in focus groups, my understanding as a practitioner is that it was developed, at least in part, in response to perceived demand that the service demonstrate through written records the discussions commonly held with parents about how music therapy might support a child (Wood et al, 2016). The document is not used by all therapists, at least partly because not all parents wish to make use of it. Its use is currently being evaluated within the service.

Figure 5:9 Music Therapy Goals-Based Outcome Tool

The tool is designed to assist the fluency with which parents and therapists talk together about the aspirations and aims for a child's therapy; however, the extent to which this occurs is unclear. A discrepancy appears as to the extent to which goals are perceived by therapists to be negotiated and discussed, or felt, by parents, to be 'given' to them. One parent described the process of the pre-therapy meeting with the therapist as follows:

> **O** – We had another little meeting, a pre-meeting, we sat down
> and we were given goals, what I expected and what they
> expect, you know there was a whole plan laid out and, and
> then she said maybe every four weeks we're going to do a little
> catch-up and see what Joshi, how he's progressing. (Par FG1,
> 278)

It is noteworthy that this is one of only two occasions when a parent specifically uses the term 'goal'. It is being used here in such a way that ownership of the goals does not lie with the parents. More frequently, parents speak of what they 'want' or 'hope' for for their child. Despite the increasing use of the goal record during the course of the study, therapists themselves referred little to either explicit goals in their work or negotiating those goals with parents. One therapist, on speaking of agreed goals,

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acknowledged that she didn't 'tend to think about them so much during the therapy' (MT FG2, 633). There is a sense, then, in which the formalised language, style, and professional-led use of the tool is at odds with the everyday language and practice of working towards change in music therapy. The use of the goals tool can, however, be seen as having had a specific impact on another activity that forms part of the structure of practice, the reviewing of video with parents as part of the therapy process.

5. 'This is a great moment' – The Connecting Work of Video

As therapy ends, the 'post-therapy' meeting offers a further structuring event when parent and music therapist meet to discuss a child's therapy. Reviewing video of a child's sessions together at this meeting is often a springboard for shared reflections, allowing multiple perspectives to emerge, be felt, and jointly considered. Speaking of watching video with one father who had attended weekly sessions with his child, a music therapist commented:

> **E** - When he saw the video in the post-therapy meeting, he said, 'Oh,' he said 'now I get it, I know you encouraged me to sit back at times and let the child do things himself', and he said 'and I thought I was doing, but now I've watched the video I'm always in there, and trying to', and he said 'you know, if we had more therapy I would sit right back and let him, give him much more time and space'. And it was really interesting him *totally* getting that for himself when he saw the video when, you know, we'd had several conversations about it, and he just had to see it. (MT FG2, 576)

Watching the video prompts reflection on the events at which the parent, child, and therapist had been present (Henry and Fetters, 2012). In reflecting comes an immediate 'I get it' moment for the parent, as reported by the therapist. Although they had talked about the parent's actions during therapy, it is in watching it that events are seen anew and considered differently. This suggests that viewing video earlier in the therapy process might be helpful as parent and therapist find ways of working together in a child's therapy.

The selection of moments of video to watch in the meeting is a process that lies almost exclusively with the child's therapist. But on what basis do therapists decide which moments to select? The introduction of the goal records is seen to influence how a therapist might make selections:

> **L** – I choose video differently now we've got goal sheets. I choose video that links to what the goals were and … I would

often choose 'this is where we started from and this is where we *got to'.* (MT FG2, 628)

The goal tool becomes a template on which choosing video is based, with the clear intention of pointing downstream to show progress. Other therapists appear less concerned with mapping video choices to specific goals, but rather work to consider how a parent might experience watching video:

F– The thing I think more now about is the fact that it's sort of the last images they're gonna be left with about the therapy and there's something about needing to if possible, leave a sense of potential, and potential for growth for further development and a hope for the future, and affirming what the child's done, celebrating like you said. It's the last bit…
H – But I also think if you're with parents who you feel they don't feel like a big change has happened and you think there *has*, then I think that early clip can be really helpful in saying 'I don't know if you remember what the early sessions were like, or how we found that session 2 when it felt a bit tricky, but we're just going to watch a little snippet of that, and then I wanted to show you how the *final* session was', and then see if they can see the difference, and then sort of check in with them, to see if *they* can see the difference, and then it's how far you then have to go in showing them the progress that might have been made. (MT FG2, 635)

Watching the video offers both retrospective and prospective opportunities. Therapist H talks of having video material available from both early and later sessions, her use of them being tailored around her perception of how a parent experiences their child. Looking back provides a way of understanding the present and the changes that are felt to have occurred on the way. But the careful selection of video extracts for this meeting begins from the present, 'affirming what the child's done', and points forwards, suggesting 'hope for the future' (MT FG2, 638)

The meeting between therapist and parent as therapy ends is a complex event in itself, gathering together expectations, hopes, and goals through the focusing lens of video material. In addition to a linear, chronological perspective, viewing music therapy from a past point through the present and into the future, the meeting's gathering point also serves to broaden the focus, viewing the child again within the wider context of the CDS. Initial expectations may be carried forward through other therapeutic input as child and parent move from music therapy towards other professionals. One therapist describes the contextualising work done in meeting with a parent, following a course of sessions that had taken a different therapeutic direction than anticipated:

> **H** – (Thinking about) well why might things not have gone in the way that it was hoped for, …. was that just, you know, things not being quite where they could have been, or, you know…. reframing it somehow, to change the focus of it, so that the parent doesn't feel, like you say, you want them to go away with a sense it's been meaningful, so then changing the perspective of the conversation, so it *is* meaningful. Even if, you know, Mum expected them to play the drum independently, if they can't do that, then thinking about why that might not have happened and how could that be helped in the future, if that's, you know, the goal. (Mt FG2, 663)

The responsibility for selecting video extracts appears to lie solely with the therapist. In pragmatic terms this is inevitable: the video is filmed on a CDS camera and stored securely in the building. Parents only watch it when attending the final meeting. Beyond the pragmatic questions of storage, there is a further question of professional appropriation of the material which is unsettling. It is as though music therapists themselves become the arbiters of which moments are significant, and should be privileged over others. What, then, of the parent's own capacity to recall and privilege moments of their own? As one parent notes, at times the selection of 'wow' moments may coincide between therapist and parent:

> **P** - It was really nice to actually sit down and discuss with her through everything and ask advice, to, you know, how can I go from here? And it was great to get all of that feedback and just her saying the changes in Sam as she saw him grow in the sessions and to pick exactly the video that I felt was like 'wow'. And she's like 'this is a great moment', and I'm so glad we caught it…. that was the big one, that was the one that *I* felt 'wow', you know. (Par FG2, 716)

The parent's experience is one of affirmation, not only through hearing the therapist speak of her child's development, but also through the therapist's selection of a video clip which carried great significance for her as a parent. While this appeared to create a strong connection between the pair, I would suggest it still raises questions as to what might happen if the process was turned around and the selection of 'wow' moments lay in the hands of parents.

6. 'I get to be a big kid' – Navigating Parental Involvement

While the findings to this point are all concerned with a parent who is in the therapy room with their child, this is not necessarily the case for all families. There may be various reasons why parents do not come into the room with their child, and music therapists themselves differ on their positions on this. Some discuss the often practical implications of coming into sessions with parents at the pre-therapy meeting:

> **L** - I think the age of the child has a factor as well, so how much developmentally this is appropriate for them to be without their parent or with them. I think it can also depend on the aims of the work, so one thing that I think music therapy does really nicely is allows parents and children to be together and have that protected time together which doesn't necessarily happen in their roles in other therapy appointments. (MT FG1, 426)

Discussions may involve questions of a child's age or the nature of their difficulties, but also the suggestion that music therapy has a particular role in supporting the parent-child relationship. If that is considered a priority – and in the quotation above it is unclear whether it is therapist, parent or a third person who might deem it so – then parental attendance would be crucial. The expectation of other therapists of parental attendance in sessions is far clearer, and even non-negotiable:

> **T** – I think the basic premise here is that the vast majority of kids we see have parents in the room. I think the ones that *don't* have parents in the room are kind of the exceptions to the rule now, would people agree?
> **M** – I've never seen a child without a parent unless it's at nursery…. I've not had a parent not actually come in, but then I must say I don't often give that as an option. Maybe that's wrong. Maybe I should do (MT FG1, 480)

The exchange above speaks to some extent of a changing culture of practice within the service and the ways in which those changes might be communicated. When I began working in the CDS eleven years ago, parents frequently sat in the waiting room while their child had their music therapy session. As noted in the Introduction, over the years the ages of children attending have dropped, and the complexities of need in many children seen have risen. Both of these factors have contributed to the increased expectation that parents will attend sessions with their child. As a practitioner I have experienced this as a gradual evolution, and suspect that I, and colleagues of longer standing might still consider the possibility that in discussion with some parents and children, a child might attend alone. That a therapist might not, as noted above, often 'give that as an option' suggests that there has been either a formal or informal shift in what might be expected of therapists within the service.

When a parent does attend a child's sessions, the level and nature of their active involvement may have been discussed with them prior to therapy beginning. It is in the everyday activity of sessions themselves, however, that it is worked out in a fluid, ongoing way. A parent's intimate knowledge of their child sits alongside an

unfamiliarity with the activity and the often unspoken norms of music therapy in this setting. The extent to which active involvement might be understood by a parent as being permitted may be unclear, and parents may articulate a wish for clearer guidance as to whether or not to join their child in active musical play. One parent voices her uncertainty in this situation:

> **P** - I don't want to get too intervening, you do as a parent you know? I just wanted to go, 'but you tell me if you want me to come in then, and get involved' and I've always said that to Tara 'anything you feel I should be doing, that I *should* step in, or I shouldn't, *tell* me, you know', 'cos he will want me to be involved, he will give me some sticks and say 'Mum you play the drum' and then I will go and play the drum, just watch him and carry on playing the drum because that's what he's instructed me to do. But you know, I do say, 'look, if you feel I need to be *here* or.' And she's like 'no, no, you carry on', so then I just usually carry on that way. So I don't sit in a chair long anymore! (*laughs*)
> **C** – Don't you? You're up and around?
> **P** – Yeah,
> **C** – [Or down on the floor?]
> **P** – [I don't mind it, I love it!] (*laughs*)
> **C** – Do you? What do you love about it?
> **P** – I get to be a big kid! (*laughing together*) Whacking the drums, next thing, I'm coming up with a tune! (Par indiv, 226)

A delicate choreography is enacted here. The parent asks for direction, based on her understanding of what her child might wish for, and the therapist, in response, seems to encourage the parent to participate as fully as she might want. And emerging from the parent's involvement is her own seizing of the playful potential which she finds for herself within the session, declaring, 'I get to be a big kid!'

The question arises as to what, and whose, are the motives or intentions that drive, or inhibit, parental participation. Music therapists seem to hold in mind a perception of a child's needs as a firm point from which to consider, and frequently steer, a parent's involvement. This may occur in discussion prior to therapy starting, but it may also occur in the moment as a therapist observes a parent's activity, assesses it in terms that may or may not be known to the parent, and acts to shift the focus of activity. One therapist describes their thinking:

> **T** – I think the clue for me often is, you know, I'm listening, I'm listening to the *child*, and I'm listening to the *parent* but my perceptions of how the parent is listening to the child in relation to how I'm listening to the child give me a clue about where I can pitch my aims for the work generally.... If there is a bit of a dislocation there in my listening to the child, and my perception of the parent's listening, then I think it's about reframing your

aims for the work, and that about how you balance the parent's needs with the child's. So I had a Mum who was obviously very distracted in the session, had her mobile phone out a lot and it felt like I was doing my work on my own with her little boy and actually the work to help her involved bringing me and him closer to her and saying 'Right, let's, you know, we'll do this together now' as a way of trying to rebalance that. (MT FG1, 535)

While the therapist, in this instance, speaks of pitching and reframing aims, in the light of experiencing a parent's presence in the room with their child, the extent to which that thinking might be made explicit to a parent is unclear. Rather, the motives for setting out to involve a parent may be ascribed a clinical basis, seeking to support the parent-child relationship. Such motives may remain unknown to parents.

Parental attendance brings with it a perceived demand for the music therapist to consider the needs of not only the child and the parent as individuals, but also the parent-child pair as a unit. This presents, at times, dilemmas for therapists, who feel themselves to be balancing needs and re-evaluating where the focus of their activity should lie at any given time. Specific musical adjustments made at such points are evaluated in terms of how beneficial they may be, and for whom. I include a lengthier quotation here for the sake of the sharp detail with which this therapist considers the musical, relational, and physical activities of herself, child, and parent:

> **E** – So, if there's been something where it's seemed quite natural to involve the parent, you know, something that's definitely a three-way thing, and then the child moves on, … I've been aware of times when I've thought, 'Am I going to move' - not physically but musically - 'with the child, and support what they're doing, or am I going to make the effort to bring Mum into that, even though it might mean losing a bit of what the child's doing?' And I think quite often I've been aware there'll be points where parents will sit back and it will become a *two*-way thing, and I wonder what that's like for the parent after there's *been* a three-way, and whether they're left wondering 'Oh, what should *I* be doing to fit in to this again, it was very obvious I had to play the drum when it came round, what am I supposed to be doing now the child's on the windchimes, and the therapist's there, what am I supposed to do?'…. And there was one particular child…. where when we'd had a three-way it felt as though Mum was really *enjoying* that sense of being together and when the child moved on, Mum wanted to stay and it felt like *she* wanted that musical support and sharing for herself, and I felt quite torn, thinking how do I support both of them, but it felt as though you know, I kept trying to bring it back to the focus on the child for Mum and drawing attention to what he was doing, but it felt as though Mum was quite clearly showing her own needs at that point. (MT FG2, 344)

The forming, dissolving, and re-forming of musical-relational links, the fragility of those links, and the elasticity demanded in maintaining them reflects the complexity of music therapy work between child, parent, and therapist. The therapist describes her own balancing between moments of clear triadic play and others in which the trio pulls apart. At such points, the therapist feels herself to be pivoting between child and parent, concerned to meet the distinct needs of both.

While the underlying purpose threading through the music therapy service is to support the child's developmental needs, the parents' emotional needs of parents and the relationship between child and parent are inseparable from the child themselves. Balancing whose needs are attended to, and how, is an inevitable and shifting aspect of the therapist's work. As a parent, child, and therapist become familiar with working together, a further rebalancing may take place at times, and particularly during longer or repeated courses of music therapy. When parent and child feel at ease with each other in the music therapy setting, the music therapist may feel themselves to be 'almost redundant' (MT FG2, 187). In speaking of this, one therapist suggested that reaching such an equilibrium could signal that a child might be ready to move from individual work to other music therapy formats, such as a group.

Such balancing work in sessions does not, of course, lie with the therapist alone. Parents are acutely aware of positioning themselves in relation to the child and therapist, and are frequently called on to interpret signals being given by others. One parent describes the complexities of managing her own involvement in her son Sam's therapy this way:

> **P** – I just come in and follow sort of Sam's lead a little bit … I can sort of know whether he's really into going or whether it's a 'No, no', and I *leave* it, I step back and leave it to Tara to think 'ok' maybe *she* wants to get him more involved .… that's where I said 'I'll sit here, let's see', 'cos if it's always *me*, that's not what life's going to be about, he's going to be in the classroom, there's going to be a teacher, he's going to have to take instructions from someone else, and let's see how *she* can bring him out of that. (Par indiv, 213)

This parent brings to the session a fine-grained understanding of her child and an awareness of the skills he will need in the future, together with her sense of the therapist's intentions and capabilities. Her own monitoring of the level of her own involvement finds physical expression as she decides to 'sit here', removing herself intentionally from the arena of activity.

Parent's choices about their own physical positioning in the room often appear indicative of their intentions for active involvement in a session. For instance, a parent may join their child and therapist on the floor, or at the piano, if being there might encourage a child's involvement or assist the therapist in doing so. However, stepping away from active involvement and 'sitting here and watching' (Par FG2, 222) is also an intentional act, informed by the frequently expressed wish to see a child developing a relationship with the therapist. As this parent says:

> **N** – I'm very happy to see him communicating with other people, because I don't expect him like that, so, he does listen to her, especially with the piano. He is, I don't know, somehow she connect with him, because when she's singing and playing with the piano, and he's making drum, she try to *follow* him, what he is doing, but he is doing different thing, but they connect each other, I don't know. So, to see him like that is I'm happy just sitting down and looking. (Par FG1, 219)

Keenly observing, the parent witnesses her child coming into a relationship with the therapist. In witnessing, from a physical distance, the musical-communicative activity between them, the child himself emerges afresh to her. There is an argument, hinted at in the Preliminary Study and finding fresh force here, that 'sitting down and looking' is not only the physical position of choice for a parent at some points but can also signal a truly active involvement in the business of being a parent to this child in this place and time.

The question arises as to whether, and how, parent and therapist might talk not only of physical placing in the room, but more broadly of the shifting, fluid nature of parental involvement. At times, involvement may be openly discussed during sessions; 'anything you feel I should be doing, that I *should* step in, or I shouldn't, *tell* me' (Par indiv, 228), as one parent requests of the therapist. The findings suggest, however, that such explicit discussion is rare. More common are continuing processes of questioning, evaluating and adjusting of person and action, all of which constitute a form on internalised negotiating undertaken by both parent and therapist within a session. Such negotiating, and improvisatory shiftings, are informed not by any party's specific goals, but by the underlying intentions that act in some ways as therapy's engine.

In considering the driving forces through which music therapy with a child and parent appear, the focus in the next section now moves more specifically to the work of the parent in music therapy.

5.16 Parents as Strong Co-shapers of the Music Therapy Process

Being a parent of a child with additional needs demands a high level of commitment to pursuing the best possible developmental outcomes for a child. Of her approach to music therapy, one parent explained:

> **O** – Maybe I was too committed for it (*laughs).* I am with Joshi's therapies, I *have* to. It's a responsibility. It is a responsibility and I want him to only get better with this. If that means giving one hundred per cent of time and everything, as a mother, I have to. (Par FG1, 294)

Such commitment takes an emotional toll on parents, although the notion that 'we're strong, we're mothers' (Par FG1, 400), speaks of the emotional and practical resources that are drawn on in meeting the challenge. Certainly, parents bring the most intimate, detailed understanding of their child to music therapy, an understanding embedded in, and seen through the prism of, the everyday events of family life. Small, incremental changes in their child are observed in precise detail and validated by virtue of the parental role, as in this example:

> **O** – Joshi, now, has started responding to sounds. Like there was a time when, you know, I'd tell him, 'Oh look, there's an aeroplane, Dusty Crophopper', it's one of the planes in Disney movies, right? He loves Dusty Crophopper, so I'm relating the plane as Dusty Crophopper. But now when he hears a plane he looks up. Let alone a place, a *helicopter.* And I think it's the music it has, 'cos he wasn't like that before this, he wasn't, *no.* Like, I mean I'm the mother, I observe him better than anybody else, I'm with him 24/7. But now, even when there's like cartoons on TV, like Peppa Pig, he sometimes not even look …. but now he hears Peppa Pig, je just comes out running, looks at the TV, and he *sits.* His focus has improved dramatically. (Par FG2, 80)

As keen observers, parents are constantly evaluating their child as they appear in relation to the world around them. This means that individual music therapy sessions are evaluated as more or less helpful for a child, but more broadly, a course of sessions is weighed up in terms of their overall impact on the everyday life of child and family:

O – I think with music he has developed, like the barber. This was all during music, I mean the time he was having his music therapy. To sit on that chair, Claire, it's a big deal, trust me. I used to be covered with hair. I don't have to do that anymore…. And dentist, like you know he was OK with his mouth open and had to do a check, and his teeth were healthy, that was great. I mean, now you know I feel like it's not been much of a challenge for me to do things and take him out. If that makes sense? Like I feel like there's something coming off my shoulder, 'cos Joshi's getting comfortable or he knows his surroundings. (Par FG2, 825)

The parent brings to music therapy a detailed knowledge of the child in dynamic relation to both music therapy sessions and everyday life. Such knowledge affords authority to how the parent voices the intricate connections made across contexts. The parent knows because he or she is there to witness links and changes. To what extent, though, is that authority sought, or heard, in the usual course of a child's music therapy? Does such linking work feature in music therapy, and if so, how is that accomplished, given that regular discussion time between parent and therapist is at a premium? I return to these questions later both in this and the following chapter.

It appears as though in noticing changes in their child in everyday life, parents clearly consider music therapy as contributing to such changes. Music therapy is almost considered retrospectively as shaping the present. The findings suggest, however, that the lived experience of attending music therapy with a child finds its way into the everyday stuff of family life while therapy is ongoing. This seems to be a fluid, naturally occurring process, but one which may be unspoken, and therefore unknown to the therapist. It may only be in conversation as therapy ends that the parent' work is revealed, as this therapist describes:

M – I think also, sometimes the parents get together aims in *their* heads of what they want of the work without you really knowing. There was a child I saw for ten weeks, and Mum was really reluctant to join in …. it was really interesting then in the post therapy meeting when we had time, just the two of us to talk…. in her feedback she was like 'yeah, no, it's been really useful to see how you interacted with him'. She said, 'You know, this is what we do at home now, we pretend to be you at home and so do his older sisters, they've started to imitate him, and *they* do those things, and it's just really nice to do that at home. Because, you know, that's what I've been doing, I've been watching you and that's what I do when I'm at home now, I copy you.' And I thought, 'Oh my gosh!' From the ten weeks of seeing what Mum was presenting like I would not have guessed that that was on her agenda, her aims for the work. I, my aim for the work was trying to get her involved in playing

with her child but needless to say I didn't know that, you know,
all the other time at home she was assuming my role and
playing with the child like me…. I was quite shocked, I think, by
her response in that post-therapy meeting, 'cos it wasn't what I
had expected at all. (MT FG1, 587)

Two driving and distinct intentions appear to be at work here which need further
unpacking. The therapist perceives her work to be in urging the parent to play 'with her
child'. The parent's perception in sessions, as being 'really reluctant to join in', may
have even confirmed to the therapist the suspicion that parent and child needed
specific support in playing together. The therapist's interpretations here collide,
however, with those of the parent. While the therapist's focus appears to be on the
activity of child and parent within the therapy room, an inward perspective, the parent's
focus is outward, on the child as one of a larger family group. Her appropriation of the
therapist's activities, 'when I'm home now I copy you', has also been extended to the
siblings in an expanding ripple, who also now 'pretend to be you at home'. There is an
active, resourceful musicing at work here by the parent, and wider family, which is only
known to the therapist as therapy ends.

It is at the end of therapy, when, as the therapist notes, 'we had time, just the two of us
to talk', that the distinct lines of intention are brought to light. Implicit in this statement
is that there is a paucity of time at other points in the therapy at which parent and
therapist could have such opportunities to talk. Time becomes a finite resource, as
though owned and limited. If, however, time is perceived as a further trail along which
a child's music therapy unfurls, then the workings of the parent, therapist, and child in
therapy are generated through it. As the child emerges, developing through time, so
too does the work of music therapy. Within this process it is crucial that a greater
emphasis is placed on the parent's experience of therapy and time, through which that
experience and knowledge are given weight, is woven into the everyday fabric of music
therapy.

The fact that a course of therapy is time-bound in nature is crucial in understanding the
imperative for parents to be active shapers of their child's therapy. Parents effectively
play the long game, continually holding a future time in mind while engaging in the
present moment. The present, then, is viewed in terms of longer term projections of
the future with their child:

O – I was being very realistic about things…. It's pointless to
have so many hopes, and say, 'Oh, my kids going to start
talking at the end of the therapy'. No, you just have to go with

> the flow and do things, and be a part of it. And that's helped
> me a lot. 'Cos I kept my expectations, not low, but I said 'D'you
> know, Stephi, we'll just see how he responds'. And he has. So
> can you imagine that half an hour has meant so much? Like
> the change, that Joshi's developed in like ten weeks, twelve
> weeks, with a break in between? So, *maybe* if he would have
> something similar like that in the future that would only bring
> bigger changes. (Par FG2, 467)

An active tension is held between 'being very realistic' about a child's development and imagining a greatly expanded future for a child. Past, present, and futures flow together as part of the parental work of constructing a hopeful future while remaining grounded in past experiences and knowledge, and present realities. It is with the knowledge of this panoramic perspective that parents invest in music therapy with their child, working to mould, however minutely and inaudibly, its unfolding events to best fit their child. This work brings to the fore the entanglements between music therapy and the everyday world in which life is lived, and the mechanisms through which such entangling occurs.

5.17 Child and Parent as Conduits between Music Therapy and Everyday Life

In understanding the linkages between music therapy and everyday life, it is first useful to revisit the notion of music therapy as a distinctive service within the CDS.[50] Amongst other therapeutic services, such as physiotherapy, speech and language, and occupational therapy, linking the work of sessions with home life is of particular concern to professionals. There appear to be clear expectations that parents will continue a child's therapy activities in a structured manner at home. As one therapist explains:

> **R** – From a speech therapy point of view we feel, I don't know,
> there's quite a lot of expectation that our sessions are carried
> forward at home. A bit more, 'Ok, so this is what we're
> modelling, this is what we're working on, but it's about what
> happens at home that's actually going to matter'…. there is
> more of an emphasis on that. (CDS indiv 4, 320)

Across these disciplines there is specificity about the activity 'carried forward' from therapy to home. It is clearly defined and expected as part of the therapeutic process.

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[50] In using the term 'everyday life', I include the people, places, activities, and things which together constitute the lived world of a person, in this instance a child and parent.

This is in contrast to the linking of music therapy activity to the home environment which assumes a more fluid, spontaneous quality. Specific activities or tasks are not given to parents to carry out at home as they may be from other therapies. Parents themselves report, however, the improvisatory way in which activities from therapy appear at home, often at the child's instigation. For example, one parent describes how her child extended use of the parachute in sessions into use at home:

> **O** – He does that at home, takes the blanket…. gives it to me, and sometimes I'm like 'What do you want to do?' And he's like, you know, trying to do that (*mimes shaking the blanket*). … I didn't know what to do at first, 'cos he doesn't talk, so, 'Joshi, what? Do you want me to wrap you, or do you want me to cover you? Are you cold?' 'No'. And then he was …. trying to lift his arm, and then trying to pick up the blanket, trying to lift it up, and like '*Ooh*! OK, it's the *Stephi* game, right, the parachute!' So I tried to do, 'cos it's a little vague, and I tried to do it, so when Karl came that evening, I said to Karl, 'We've got to do this activity with him'. He was so happy, he was giggling, and all over the floor. (Par FG2, 532)

The shared activity detailed here has its roots in the familiar weekly events of therapy. An emergent linking from therapy room to home appears through the child's own initiative. It is as though he imagines the activity into the home, and in doing so he substitutes ones thing for another. The parent then acts as meaning maker, receiving his communication and making the translational link back to the therapist and the therapy room. As a friend is included in the new activity, it is woven through people into a further form.

The 'things' of music therapy take on the 'going on' quality suggested by Ingold (2010). They both hold the potential to be more than they seem, as with the blanket, and to represent the trails across place, person, and experiences, as in the example below:

> **N** – For Eddy, you see we have that guitar at home, exactly the same, and sometime he mention his brother's guitar, and he bring it and say 'music therapy' so I know he remembered a lot of music therapy…. And there is a keyboard at home, sometimes when he does this he says, he mention about music therapy…. So I think he remember what he's doing here but he can't explain….
> **P** – …Sam's got a guitar he never touched as well, and he just comes out and starts singing the Hello song, Goodbye song. And whereas at night, before bed, he'd get quite upset, and quite teary, he just started singing the song… And whereas before he'd cry before bedtime, and he just now picks up the guitar and comes down…. he sings, you know, and just suddenly starts picking up the guitar. (Par FG2, 341)

The child uses instruments and things, meaningful to them, to interweave therapy with the ordinary relationships and routines of home life. In this improvisatory use of the things of therapy, the child's actions appear to signify change. Nor is it only through instruments that change is noticed. Singing, too, becomes a different part of the parent-child repertoire of shared experiences at home:

> **P** – But he's singing more, definitely at night. And, as a distraction, he got a bit upset, I started singing and making sort of with the bottles (mimes tapping some bottles and singing) 'dah-da dah, da dah!'. He was like, 'What?' you know, just sort of distracted his mind from that… I've sort of gone on my own thing of it, as in doing more singing, you know, making sort of the drums, the noise, and that helped when he got quite upset, stopped him from getting into that really sort of upset mode (Par indiv,176)

The highly attuned, emergent creativity described here appears to be a striking example of the fluid permeability through which musicing of child and parent finds expression at home. The child is heard to be singing more, and the parent finds herself spontaneously singing and playing kitchen equipment in response to his emotional state. This is less concerned with the appropriation of a specific activity or instrument, and more with both child and parent dipping, at will, into a shared pool of potential musical-social responses. Parent and child become improvisatory partners in a newly creative way.

How is this flow of activity and experiences understood by those involved in it? In recounting the singing that both she and her son have found themselves doing at home at times of distress for him, one parent speaks of the questions it raises for her:

> **P** – Is it something he *learns* from music therapy, and then it helps, then he does it himself, or is it something *we* input in. So that's my big question if you see what I mean? … *He* learns music and he knows it's relaxing, so that's what he does for himself if he gets upset, or is it more that I bring it in? That's the big question I'd like to ask – I'll have to sit and think about that. (Par indiv, 187)

 The 'big question' interrogates the mechanisms through which music therapy and its potential benefits find their way into the life of the child and family beyond the therapy room. It questions the balance between a child learning and experiencing in therapy, and then applying his learning and experiencing in everyday life, and the interwoven work of parent and therapist in both instigating and contributing to these processes. This is the micro-detail of the finely woven relational meshwork through which music

therapy appears. This is a meshwork in which the whole is indeed greater than the sum of its parts. It is, I would suggest, in the musicing between child, parent, and therapist that the meshwork appears and changes occur.

Circling back to the therapy room, however, a further question arises as to how alert a music therapist might be either to the linking work of parent and child, or to the questioning which a parent might engage in about the connecting between therapy room and home. The findings suggest that music therapists do not, during a course of therapy, actively seek to uncover the processes by which such connecting occurs. When asked specifically about their understandings of the parent's question as quoted above, and how they might consider such questions, these responses were offered:[51]

> **D** – No, no I haven't thought much
> **F** – Teachers yes, and in different settings. That's something that comes up a lot.
> **H** – I think parents *must* think about it, it's whether they then articulate it, and whether they're too anxious about articulating it. Because we often hear the phrase 'Well you're the professional, so I'll just take your lead', and that, and at that point I often say 'Oh no, no, no this is a partnership we're forming here, a working partnership, so I consider you as much a professional as I am, so let's scrap that idea that one knows more than the other because we're both bringing *different* sets of skills'. But I think some parents might feel more comfortable to articulate a question like this, whereas others might only ever wonder and think 'I daren't ask them that cos they might think that I know enough'. And this question also puts lots of expectations out on the table really, doesn't it? The parent's making a demand really, they're saying 'Look, what is this about, I would like some answers, but in answering those answers I understand there might then be an expectation on me as a parent to do something beyond the thirty minutes once a week'. So they're volunteering themselves. (MT FG2, 489)

The active work of both child and parent in linking activities and thinking between therapy sessions and home appears to be not only unseen by music therapists, but also unsought.   While parents may report significant changes to therapists, particularly at the post-therapy meeting, therapists give far less attention to the week-by-week processes through which those changes are achieved beyond the therapy room. In Bortoft's terms, it is as though attention is directed 'downstream', towards an end point, when the 'upstream' flow of week-by-week activity beyond the therapy room could be

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[51] The timeline of focus groups allowed me to cross-fertilise different groups with emergent ideas and specific questions arising from previous groups. In this instance, I provided the music therapists with a typed copy of this specific quotation as a prompt for focused discussion.

considered an integral part of the music therapy process (2012).   If attention is 'downstream' to this extent, then particular questions arise, such as how and where is change understood to occur by music therapists. Moreover, the question as to what a 'working partnership' between parent and therapist means in practice if it isn't manifested in a curiosity about the linking of therapy room with everyday life, becomes of pressing importance in understanding music therapy with a child and parent.

Drawing Threads Together – A Brief Summary

The question of this working partnership and its importance marks the end of this chapter, and therefore of the Main Study itself. In this phase of enquiry, my intention was to pursue the areas of interest raised in the Preliminary Study, specifically by following the trails along which music therapy comes into form through people, places, things, and events. In this chapter, I have presented this phase's research approach, data work, and findings. The findings have revealed not only the complexities of the trails and the meshwork's multi-layered weave, but also detail of what people 'do' with music, and with each other, within and beyond the therapy room. In presenting the material, I have sought to allow for the multiple voices through which music therapy with a child and parent is generated, each of which reveals different facets of the whole phenomenon. The two phases of the enquiry, the Preliminary and Main Studies, can also be considered as revealing the phenomenon in different ways. The next chapter brings together the two phases, integrating them into a distilled whole, which I discuss in the light of selected theoretical concepts.

Chapter 6 : Discussion

6.1 Brief Summary

In the previous chapter, I presented the Main Study's activity and findings. As in the Preliminary Study, the latter phase culminated in the articulation of five main themes. This chapter draws both phases of the study together into an integrated whole. I begin by revisiting the main themes from each phase, creating a synthesis from which I extract three narratives. These are discussed in relation to extant theoretical material, and I make the case for a rethinking of current theoretical and practical concepts in music therapy with children and parents.

6.2 Introduction

In this chapter the level of attention shifts from the specifics of the study's two distinct phases to their integration into a synthesised whole. The shift is grounded in the original, overarching question that has driven this practice-led study: 'How is music therapy with a child and parent enacted within a specific healthcare context?' The focus throughout has been on the processes through which music therapy is 'done', with the intention of uncovering the mechanisms through which it is accomplished by those within and around it.

This investigation has been founded in particular ways of looking. The Preliminary Study focused on the phenomenon of the trio, specifically on its appearance within the detail of the music therapy session. The latter phase broadened in scope, following the interweaving trails of people, places, and events through which music therapy is enacted. While the scope and research methods altered in response to the study's needs, 'gentle empiricism' has provided a stable and grounding research orientation throughout (Ansdell and Pavlicevic, 2010; Ansdell and DeNora, 2016).

Five main themes were articulated at the culmination of both study phases. These are presented alongside each other below (Fig. 6:1). In synthesising them, I propose three discrete but interlinking narratives through which music therapy with a child and parent is enacted: narratives of ecology, emergence, and expertise.   These three interlocking

domains reflect aspects of the main themes, without being tied exclusively to any single theme. I discuss them in turn in the following sections, using the material generated to argue for a reframing of music therapy practice and theory in the field.
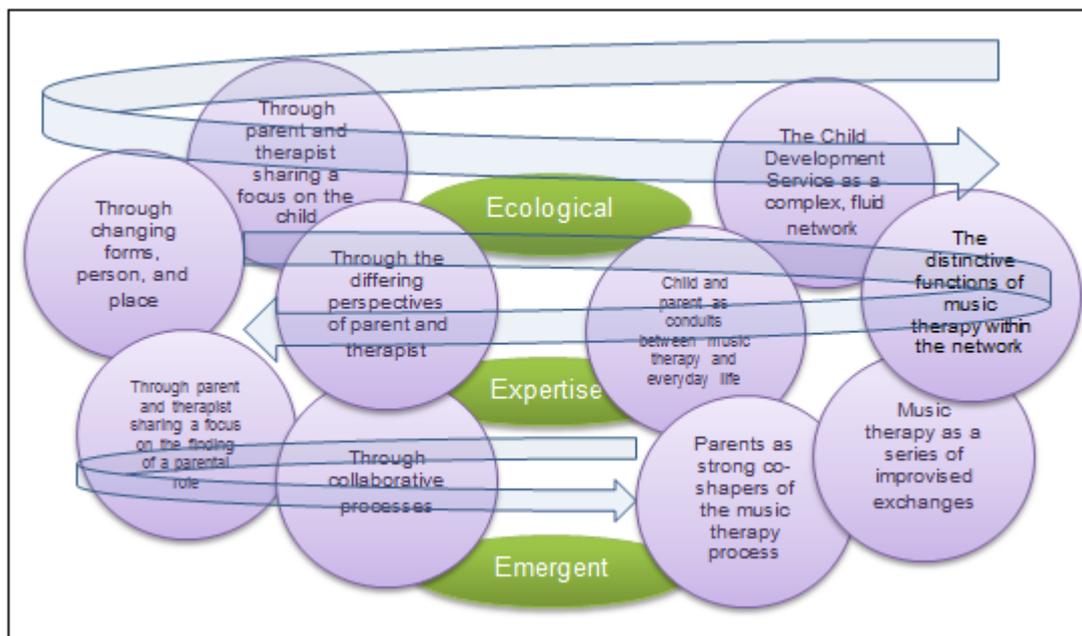

Figure 6:1 Synthesising Findings

6.3 On Ecology

Music therapy is always enacted in context, in this case the CDS's organisational setting. It also functions as context, a meeting ground for multiple influences, and, at any one time, as interlinking with the forces and dynamics found across contexts (Aasgaard, 2004; Rolvsjord and Stige, 2015). The enactment of music therapy is shaped by, and in turn shapes, those contexts with which it comes into contact. Figure 6:2 offers a provisional representation of this triumvirate, which I review further in the following chapter.
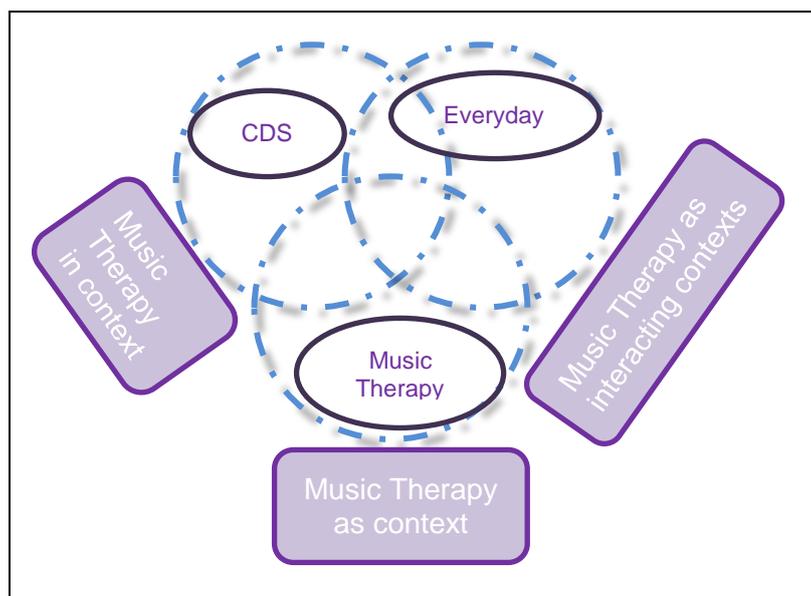
Figure 6:2 Contextualising Music Therapy

The dotted lines of the CDS, Music Therapy, and Everyday, serve as a reminder that the circles do not denote solid boundaries, but rather represent the intermingling, osmotic messiness of life as lived. While the representation is crude, it provides a way of visualising music therapy's interactivity; that is, as interacting both with its organisational host and with the lives of children and families as they come into contact with the CDS and, more specifically, the music therapy service itself.

The concern in this study has not been at the level of the contexts themselves, but rather at the level of what people do, with what, and with whom across contexts. The focus, then, is on the 'meshwork of interwoven lines' as proposed by Ingold (2007, p. 13). Like Ingold (2007, 2008a) the emphasis is not on lines which function primarily as connectors of points. Rather, interest lies in the life of the lines themselves, as 'trails *along* which life is lived' (Ingold, 2007, p. 81, italics author's own). In the complex meshworks of people, places, things and events, the trails of music therapy emerge and interweave. In following these lines, the meshwork's range and ecology becomes apparent.

Ingold (2007) proposes a typology that includes three primary classes of lines: traces, threads; and cuts, cracks, and creases. Here I focus specifically on the first two, using the distinctions Ingold makes between types of lines as a way of considering the music therapy meshwork detail.

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On Traces

The trace, Ingold (2007, p. 43) suggests, is 'an enduring mark' created on a surface by a continuous motion. Music therapy is enacted through the largely formal traces created by virtue of its organisational context (Rolvsjord and Stige, 2015). Processes of a child's referral, assessment, and diagnosis within the CDS leave literal traces. These exist in the form of written documentation, electronic notes, video material, and correspondence with parents and professionals. Such traces map the formal, prescribed paths, often referred to as the Clinical Pathway, on which child, parent, and health professionals embark when a child is referred to the CDS.

The Clinical Pathway is a familiar tool within healthcare, designed to standardise and articulate the events and time-scales involved in assessing, managing and treating specific medical conditions (Kinsman et al, 2010; Rotter et al, 2010). Within the CDS, particular pathways reflect the differing neuro-developmental or medical conditions of children referred. The use of the term 'pathway' is suggestive of movement, of travel along the line of the path. In practical terms, however, such pathways are often more concerned with transport than travel (Ingold, 2007); that is, the focus is on a destination, or series of destinations, be they diagnosis, commencement of treatment, further assessment, or potential discharge. The route, as it were, is mapped in advance, rather than navigated anew.

As the pathway is followed, traces are created in clinical notes, written reports, and correspondence. These serve to evidence actions taken, the resulting inscriptions generating permanent records. Such trace-making is, however, the domain of the few. In the CDS, clinical records and reports are predominantly written by professionals. While such documentation may include, often in detail, the words and wishes of a child or parent, the trace is created and authorised by the professional whose signature is at the end. Creating traces within this medically grounded context is bound up with conventions of professional/patient status and power (Launer, 2010).

The music therapy service adopts many of the administrative conventions of the broader context. Referral forms, assessment reports, and correspondence templates all largely align music therapy as a service with that of the wider organisation. This is apparent in terms of formatting and style, but also in terms of the authorship of written material which remains largely in the hands of professionals. While there has been a distinct shift in recent years towards directly incorporating the views of parents and, to

a lesser degree, children in written reports, such documents are still written and signed by the music therapist. Trace-making in and around music therapy, as in other forms of healthcare, is the domain of professionals. One particular difficulty raised by this imbalance is that it does not reflect the improvisatory, co-created nature of music therapy activity itself.

The formal trails of organisational processes and pathways that pave the administrative way into music therapy are disrupted once child, parent, and therapist enter the music therapy room together. As one therapist said of the moments prior to an initial session, 'you don't know this parent, this parent doesn't know you, you don't know the child, the child doesn't know you, you don't know what the music's going to sound like' (MT FG1, 310). While all first healthcare meetings may involve unknown configurations of people, it is in the interweaving of people with musicing that the strands of the formal loosen to the more informal.

On Threads and Thread-Making

In musicing, by which I mean the broadest span of what people do together with music, emergent, unpredictable actions and interactions appear. In Ingold's terms, musicing is more closely akin to his second class of line, the thread, than the trace (2007). Describing them as filaments, Ingold depicts the entangling of threads either through human activity, as in rope making or weaving, or through processes in the natural world. The spider, for instance, produces threads from its own body from which it forms its web (2008b). Unlike the trace, the thread is not dependent on a surface; it emerges, entangling with other threads in more or less ephemeral ways. Such entangled threads are generated, I suggest, in the improvised interweaving of events and people in the music therapy session.

Here, then, is one manifestation of music therapy as context. It is the meeting point of influential forces, the formal traces of the organisational pathways and processes, and the threads of musicing, characterised by a higher degree of informality and interactivity. The meeting of the formal and informal generates its own particular force, a rupture, or, as Ingold suggests, in a third type of line, a crack, as two forces collide (2007). It is in this rupturing that the distinctive nature of music therapy within the CDS is seen, as the formal is thrown into relief by the informal. But it is also a rupture that generates particular tensions to which I return later in this chapter.

The meshwork of music therapy is not, however, only to be found in activity within the music therapy room. Rather, it extends away from its walls, stretching beyond the purview of the music therapist or other CDS professionals, towards the home life of child and parent. Music therapy is then less 'in context', and appears more 'as interacting contexts' (Rolvsjord and Stige, 2015, p. 8). Following the lines along which music therapy is enacted creates the imperative to understanding music therapy in relation to the various worlds of people, place, and events with which it comes into contact. The notional borders between the music therapy session and everyday life (Fig. 6:2, p. 218) become the ground across which the detail of music therapy's meshwork can be traced.

I use the term 'border' here in keeping with that of Sennett (2008). He proposes the ecological border as a 'site of exchange where organisms become more interactive' (p. 227). The water's edge is one such border, where the dynamic, shifting meeting of land and water offers rich feeding sites for the inhabitants of both. My use of the border is not intended to denote a literal physical site as such, but rather areas where the activities and people of the music therapy session come into contact with the people, places, and events of life elsewhere.

The study has revealed the degree and complexity of musicing between child, parent, and others, beyond the conventional boundary of the music therapy room. This is a level of detail which, to date, has been largely unexplored in music therapy literature. In Ingold's terms, this is perhaps not surprising. It is thread, rather than trace-making activity. As such, it is not preserved in documented form, nor do written traces of it travel back to the music therapy service. The threads of such border-crossing are, however, entangled and intricate. Efforts to understand their intricacy can be supported by drawing on the notion of the 'site of exchange' (Sennett, 2008). It raises questions as to what is exchanged at such sites, by whom, and how?

I argue that it is not music therapy, as such, that travels between therapy room and home. Rather, it is the threads of musicing: what child and parent take to be the essence of music therapy for either or both of them at any one time. These find expression in, for example, the shared banging of the dinner table (P, 266) or the child's introduction of a familiar game from a session (Par FG1, 532). At the site of exchange, the thread of activity comes into being through the things of the site, such as the kitchen table or the blanket. These take on a different life, a 'going on' as they become entangled in a generative momentum (Ingold, 2010, p. 96).

It is not that the activities of music therapy are transported from therapy room to home as complete fixtures. Rather, it is that elements travel there, in intertwining processes through which people, things, and environments themselves change in relation to one another. Thus, what can be done with a blanket is changed, as is the function of a kitchen table.

Ingold (2000, p. 19), in his efforts to erase divisions between humanity and nature states that 'a proper ecological approach' considers the 'whole-organism-in-its-environment'. They are not, he argues, two things brought together, but rather exist as an inseparable, mutually influential whole. To this whole, and for the purposes of this discussion, I suggest that musicing acts as a distinctive generative force within and across such sites of exchange. It threads through and around the movement of people across contexts, itself indivisible from Ingold's 'organism-in-its-environment' whole. Thinking ecologically, then, not only enables a way of looking at how music therapy with a child and parent unfolds, beyond the walls of the therapy room, but more significantly demands a different way of looking. Without altering the perspective, only a partial view is possible. Not only is music therapy's ecological richness lost, but aspects of the second pillar, emergence, are also compromised.

6.4 On Emergence

The thread making of musicing can be understood as emergent in nature; that is, its course is unpredictable, and contingent on unfolding surrounding events (Sawyer, 2006; 2012; McCaleb, 2011). The notion of collaborative emergence, used by Sawyer to account for improvisatory work in creative groups, offers a way of understanding the micro-detail of interwoven musical-social action between child, parent and therapist in music therapy (cf. p. 116). Action between the three appears and coalesces, its emergence highly dependent on what each individual does in concert with others. Episodes of collaborative emergence such as the examples in Chapter 3 (Figs. 3:6 and 3:7), can be considered as an expanded form of the emergent activity within dyadic child-therapist music therapy. The third voice of the parent adds further layers to the emerging musical fabric.

On Constraints
The potential for the emergent to appear in improvisatory groups is moderated by constraining factors. Sawyer (2006, p. 88) identifies two main areas of constraint within jazz improvisation. In the first, the emergent nature of the improvisation itself produces

its own constraints as it appears. What any one individual plays, for example, shapes and constrains, what a fellow musician might do next. A further set of constraints are more clearly imposed by musical conventions of genre and style, or assumed through understandings of cultural or social context.

I argued in Chapter 3, and restated above, that collaborative emergence offers a way of understanding the fine detail of the improvised activity between child, parent, and therapist. In the additional light of the Main Study, however, I find I need to refine this perspective somewhat. I would argue that, while the detail of joint activity within sessions remains distinctively emergent in quality, the degree to which it can be described as collaborative appears more questionable. I suggest two sets of constraints which impede not emergence as such, but the collaborative nature of the collective emergence. These can be understood firstly in terms of implicit intentions and secondly in relation to constraints stemming from professional alignments.

In what ways do implicit intentions constrain music therapy's collaborative nature? A clear finding of the study has been the singular focus which both parent and therapist bring to bear on the child, and their development, in music therapy sessions. This focus is held by both therapist and parent in tandem, with additional, often covert intentions that are largely unspoken. The parent, for instance, privileges the developing relationship between child and therapist, and the therapist focuses on the quality of relationship and experiences of the parent-child pair. While the gaze of both is turned towards the child, each perceives the child in relation to another.
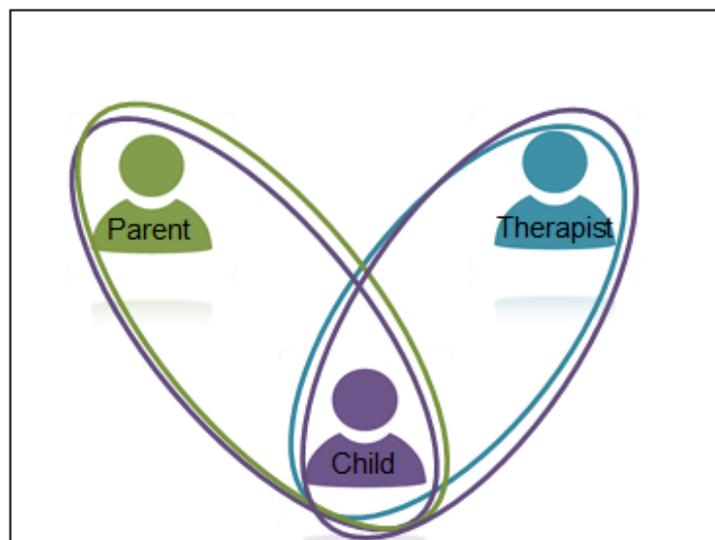

Figure 6:3 Differing Directions of Gaze

Not only do each have different intentions, but their moment-by-moment evaluation of activity is read, as it were, through the lens of such intentions (Sawyer, 2003). When those intentions come to light, often latterly, this appears to be surprising, as one therapist notes: 'Sometimes the parent gets together aims in their heads of what they want of the work without you really knowing' (MT FG1, 587). The blurring of intentions, I suggest, becomes a constraining force in collaborative terms. The extent to which collaboration, co-labouring, can occur when the object of labour is obscured is certainly compromised. Moreover, the obscuring of intention – and I mean here particularly that of the therapist – raises questions about the potential impact at the relational level. As Jacobsen and Thompson (2017, p. 322) ask, ''Does the parent know what they are getting'?'. If the agreement between parent and therapist as to what the purposes of music therapy are is less than frank, then this raises ethical questions about the nature of any agreement between them.

A further constraining influence meets emergence in music therapy as a result of its situation in a specific healthcare setting. The adoption of organisational trace-making tools by the music therapy service collides, as noted previously, with the thread-making of musicing. The development and use of the Goals Based Outcome Tool (GBO) exemplifies aspects of this collision. In recent years the music therapy team have developed the GBO tool with the intention to work more closely with parents in supporting children in music therapy (Wood et al, 2016). It is similar both in form and function to those used across other disciplines in the CDS, frequently forming part of discussions with parents prior to their child starting therapy. Its use is currently being evaluated within the service, and recent team meetings have included lively discussion among therapists not only on its content but also on the diversity of approaches to its use.

While developed in order to help parents and therapists communicate more clearly about what was important to them about a child's therapy, the findings suggest the tool creates a particular linguistic difficulty. The data analysis revealed that while the term 'goals' was used frequently by music therapists, parents mentioned it only once. Parents spoke frequently, however, of 'hopes', 'wishes', or what they 'want' for their child. This is a significant discrepancy. Describing the tool in language that differs strongly from the usual language of parents, positions it whether intentionally or not, within a certain healthcare discourse. In effect, it signifies an alignment with a professional rather than a parental community.

On Formalising

Beyond the linguistic difficulty is a further tension exemplified by the GBO tool. In attempting to formalise or fix intentions (whether they are termed goals, aims, or wishes), a tension is created with the improvisatory, emergent nature of music therapy activity itself. This is an inevitable tension, as Wood describes of aims within individual work with an adult:

> I have mine, Caryl has hers. But a third set emerges in this matrix of purpose. The music we start to make has its own demands. (Wood, 2016, p. 68).

Musicing brings its own quickening and force, generating its own particular demands. When recognised and accommodated, the tension created by this 'third set' dissipates, and any rupture is repaired. The tension persists, I suggest, in the strain between the fixed and formalised and the emergent. How is a musical quickening to emerge into form if form, in the sense of intended outcomes, is imposed too firmly on it. At one level, perhaps music therapists simply need to be clearer about the need to be unclear as to the forms and direction therapy might take once the music begins.

A view from the notional border of music therapy service and host organisation throws a different light on this apparent area of tension. According to CDS professionals, a distinctive function of music therapy lies in the emergence and spontaneity that the 'looser' goals of music therapy offer. Staff across disciplines do not urge music therapy, as a discipline, towards working with children and parents towards goals articulated with greater clarity or tightness. Rather, value is found in the fluid foregrounding and backgrounding of goals, contingent on the emerging activity at any one time. What this can mean for families, as one staff member suggested, is that 'there's probably something positive to come out of every music therapy session' (CDS FG, 665). I suggest that, at the site of exchange, where disciplines meet, the emergent, fluid nature of music therapy activity adds a distinctive quality to the organisational ecology. This significantly enriches what the CDS offers children and families. Perhaps it is to the importance of this ecological diversity that the publicly available information, stating that the CDS is one of a few comparable services to include music therapy points (cf. p. 18).

Currently, however, there is a forceful dynamic created among parents, professionals, and music therapists. Parents do not use the formal language of goals, and professionals argue for a lessened emphasis on fixing goals in music therapy. If

professionals and parents place such value on the emergent, the question is whether music therapists are going against the flow in working to 'fix' practice, and if so, why? Music therapists, it could be argued, align themselves less with these particular proximate voices and more with perceptions of organisational or professional demands. It may be that calls from institutional voices to measure outcomes of therapy, or demonstrate evidence of impact, are perceived to be particularly powerful and require specific responses. The point, however, is that heeding those voices alone risks compromising the distinctive nature of how musicing works not only within music therapy sessions but also more broadly across the institution of the CDS.

Emergence in the Everyday

Emergence appears to flourish more naturally beyond the organisational constraints, at the points where music therapy meets the everyday life of the child and parent. It is here that threads of musicing mix fluidly with the things and people of home life, generating a dynamic flow. In the home environment, of course, the therapist is absent; moments of shared musicing emerge between child, parent, and key others. At times, the musicing in such moments holds strong ties to the activity in music therapy, as when a parent adapts a song sung by the therapist for use at home. At other times, such as a parent spontaneously erupting in music by playing the bottles in the kitchen, the overt connections to sessions appear weaker.

With either stronger or weaker ties to the music therapy source, the child and parent at home weave musicing into their world in active, often unpredictable ways. This active weaving appears to be in sharp contrast to therapeutic approaches that provide activities for use at home (Gottfried, 2017; Schwartzberg and Silverman, 2017). Such approaches may have their pragmatic place, but they present a difficulty that requires attention. The difficulty lies in losing sight of the 'organism-in-its-environment' and the indivisibility of the two (Ingold, 2000); that is, that what a child, parent, and others do with music appears as dialogue between people, place, and things. In trying to imagine, or impose, the form that musicing might take for child and parent in other environments, the potential for dynamic emergence is curbed. As Bortoft puts it:

> This is the kind of thinking which tries to 'get to the milk by way of the cheese', thereby eclipsing the dynamical quality of the organism be-ing itself differently according to the situation in which it is placed. (Bortoft, 2012, p. 79)

Away from the music therapy room, the child and parent show themselves 'be-ing' differently along their lines of musicing. What could be termed an ecological

emergence can be seen as a foundational, largely invisible, layer in the enactment of music therapy with child and parent. To this layer I now add consideration of the expertise through which music therapy appears.

6.5 On Expertise

It is worth reiterating here the approach I have taken to questioning expertise in this thesis. The focus has been on the enactment of expertise, in other words, how it is done, and continues to be done, between people (Carr, 2010: Eyal and Pok, 2011). This approach echoes Carr's premise that 'expertise is something people do rather than something people have or hold (2010, p. 18). However, while attending particularly to questions of how expertise is done, I would argue that the core, specific expertise of individuals or groups needs to be acknowledged (Edwards, 2010).

Acknowledging a core expertise is particularly important given my intention to bring a symmetrical focus to the activity of all concerned with a child's music therapy. Expertise is ideologically weighted, often privileging particular groups or individuals as experts (Carr, 2010). This is certainly a familiar trope in literature concerning children's healthcare, in which professional rather than parental or children's expertise is given weight (Balling and McCubbin, 2001; Leiter, 2004; Heath, 2013). A symmetrical focus on expertise allows recognition of the specialist skills, knowledge, and experience gained either through professional training, or through parenting and caring for a child with additional needs. It also includes the unique expertise each child brings, irrespective of their additional needs, manifested by being themselves in the world (Flower, 2008). This is not to discount the tensions which arise as, and when, expertise is contested, but it is to acknowledge the multiple, core expertises which, in music therapy, turn outwards to meet and interact with others.

This is the relational expertise of which Edwards (2010) speaks, expertise being jointly negotiated between people as they work together. Sennett (2008, p. 246) rather elegantly refers to such expertise as 'sociable', intending the same outward facing position. Both stress its improvisatory nature, as it is co-created and recreated moment by moment. The intention has been to follow the improvisatory, emergent nature of expertise between people. In this sense, and informed by Ingold, I have reviewed the research question in the Main Study that asks: 'In what ways is expertise assembled across the meshwork?' Ingold (2007, p. 74) is critical of the notion of assembly,

arguing that it centres attention on the connected point rather than on the dynamic work of connecting. On reflection, to ask in what ways expertise is 'conducted' retains a focus on the lines of travel themselves. The relational, sociable work of people in a tangling of expertise then remains central.

Conducting Expertise

The ways in which such tangling occurs can be understood both at an organisational level and within the detail of music therapy activity itself. At an organisational level, the formal administrative trails surrounding music therapy provide largely predetermined procedural paths. CDS professionals hold varying degrees of knowledge about music therapy which they bring to bear in discussing music therapy as a therapeutic option with parents and music therapists, and in subsequently completing a referral form. The relational work is, to a large extent, predictable and unproblematic. Such formal trails are open to disruption, however. The usual referral process is subverted, for example, and a senior clinician able to 'jump the queue' (MT FG1, 64) when a personal approach is made to the lead music therapist about a child in particular need. The response is improvised, the relational taking precedence over the formal as two professionals work to resolve an urgent situation.

As one clinician noted, 'elements of power' are instrumental in this process. Both parties are able, by virtue of role and status, to exercise a high degree of relational agency in their actions (Edwards, 2005, 2010); that is, they possess the capacity to shape their thinking and action to that of the other, drawing on their expertise to work together fluidly. The extent to which such fluid working can occur is compromised, however, when relational agency is reduced. This is evident, for example, in an administrator attempting to respond to a parent in distress on the telephone, but unable to effect the actions which could offer help most directly. In such instances, the expertise of staff who feel themselves to lack the agency to effect change for children and parents turns sideways, towards colleagues and managers. In often covert, and occasionally subversive ways staff who feel themselves to hold less agentic power work across organisational hierarchies to influence the actions and thinking of those who do.

What, then, of activity within the music therapy room? To what extent is relational expertise evident within a session with child and parent? The training of the music therapists within the service is representative of a number of UK training courses. As

such, practitioners bring varying theoretical and practical perspectives to their work. However, underpinning the work across the service, as outlined in Chapter 1, is a relational emphasis; that is, it is through the co-creation of shared music between child and therapist that each comes to know the other, meanings are made, and developmental shifts may occur (Brown, 1999). As it is most frequently described in literature, the therapist's expertise lies in connecting the improvised music they might offer with the movements, gestures, and sounds of the child with whom they work. This speaks of the therapist's expertise in approaching the work, but it is insufficient in understanding the relational expertise of child, parent, and therapist in music therapy together.

The microanalysis presented in Chapter 3 (Figs. 3:6, 3:7) provided a detailed account of the intricate relational work by which the three move in and out of musical contact with each other. These episodes demonstrate movement and fluidity between the parties, but also reflect the ambiguous intentions underpinning the activity. Therapists attend closely, in music making, to the child, while also prioritising the activity and relationship of the parent-child pair. As one therapist reflected, ''Am I going to move' – not physically but musically – 'with the child and support what they're doing, or am I going to make the effort to bring Mum into that'?' (MT FG1, 348). Parents, on the other hand, privilege the child's activity and the formation of the child-therapist relationship. As one parent comments, 'I can sort of know whether he's really into going or whether it's a no, no, and I leave it, I step back and leave it to (the therapist) to think, 'OK, maybe she wants to get him more involved'' (Par indiv, 213).

As mentioned previously, the blurring of intentions acts as a constraint in relation to emergence. It also threatens to inhibit both the core and relational expertises through which such emergence appears. Neither parent nor therapist can utilise their specific knowledge or experience fully. Nor is a relational expertise, dependent on the capacity to align thinking and action, easily accessible within such ambiguous conditions. This presents a surprisingly compromised picture of the sharing of expertise within music therapy, which challenges what can become a grand narrative of collaboration and partnership.

Towards a Woven Expertise

Across the border, from therapy room to the child in everyday life, a different, more active relational work takes place. Child and parent, singly and jointly, appropriate, translate, and transform what musicing affords in more or less complex ways (DeNora,

2000; Ansdell, 2014). Appropriation occurs in simple, precise terms; for example as a parent adapts a song from therapy for use in the home. It also takes more oblique forms, as a parent finds themselves spontaneously singing and improvising on household objects in response to a moment of distress in their child.

Appropriation is not only the parent's domain. The child, too, initiates activities in the home, the origins of which are traceable to the therapy room. The creative appropriation that the child effects in, for instance, substituting the session's parachute with a familiar blanket at home, speaks of an imaginative expertise itself. The subsequent interaction with the parent (cf. p. 213) demonstrates the relational, intersubjective work that unfolds between them. The child appropriates and parent and child make a translation, which ultimately leads to transformation. There is a coming together of experience, knowledge, intention, and skill that finds form in a woven expertise. Through such weaving, the form that emerges – what they do together – shifts from being a replica of the session's activity. Rather, it is actively reshaped, making a distinctively new event in and with this environment, while still retaining clear links to its origins (Dreier, 2008).

The woven expertise of the parent-child pair shows itself in the active partnership through which they seize music's affordances, interweaving them into the places, things, and events of everyday life. The therapist herself is physically absent from their musicing, but their actions and presence may infuse the threads of activity that ripple into the home. The emerging narrative of skilled crafting by parent and child runs counter to more conventional music therapy views on the movement of activity and experience between therapy and home. This brings a robust challenge to the therapist-centric accounts that are more commonly heard.

Within the broader CDS services, the movement of activity from therapy to home is clearly driven along a therapist-parent axis. Therapists provide parents with programmes, suggest strategies, or comment on those already being practiced by parents. This may be entirely appropriate in some instances. For example, in physiotherapy a particular exercise to improve leg strength may be recommended, and may need to be carried out in the same way whether in the clinic or in the home. To draw on Ingold's ideas, the exercise, individual, and environment can be separated. An outcome, rather than a process, is foregrounded, which the therapist drives through by way of the parent and child.

A parallel therapist-parent axis is to be found in parts of the music therapy literature in this field. An outcome of therapy may be, for instance, that parents gain specific skills or are invited to use particular ideas at home (Baron, 2017; Gottfried, 2017). Some authors go further, proposing that a therapist might 'educate parents about adapting interventions to use at home' (Schwartzberg and Silverman, 2017). While there may be a cultural variance in the professional practices described here, in each instance the impetus for threads of activity from therapy to home originates with the therapist. On the basis of this enquiry, this is problematic and presents a partial perspective.

It is not through the therapist's direct impetus that musicing travels from therapy session to home. To argue that it is propagates a narrative of professional power and expertise which I contest here. It is the child and parent who both actively appropriate, translate, and transform musical moments in their environments to their own ends. This is an angle that is not currently represented in music therapy discourse. I suggest that the narrative needs to shift away from a therapist-centric perspective on the permeating work of music in the home, to one which more clearly reflects the creative work of parent and child.

On Hidden Expertise

In accordance with this, I argue for one further manifestation of expertise in music therapy with a child and parent, that of a hidden expertise. The woven musical-relational expertise of the child and parent at home and in everyday life remains largely unknown and unanticipated. Indeed, what parent and child do with music seems to rouse little curiosity from the therapists who work so closely with them. The site of exchange – the active edge where intermingling of multiple influences occurs, and where parent and child do new things with music – seems to be unfamiliar territory for music therapists.

There are pragmatic concerns to be raised here. The amount of time spent in sessions, in relation to the amount of time spent elsewhere in the week, is miniscule. There is a limit, then, to what can be shared of everyday life in sessions (Dreier, 2008). While this calls for further investigation, my suspicion is that the pragmatic is not the only obstacle. I suspect that there is a general lack of attention, or more specifically a limited awareness of a lack of attention, to the level and detail of experiences which emerge in the home from events in therapy. The absence of attention creates a further rupture in the flow of knowledge, skills, and experiences which may otherwise flow

more fluidly between home and therapy. In this rupture, the potential for a richer, shared expertise within the trio of child, parent, and therapist is also compromised.

6.5 Reframing Music Therapy

Thus far in this chapter I have proposed three interweaving narratives through which the enactment of music therapy can be understood: ecology, emergence, and expertise. These narratives, as evidenced in this enquiry, carry a combined weight that makes the need for a theoretical and practical revision of practice compelling and urgent. In the following section, I lay out the constituent details of such revisions.

Positioning Practice

Music therapy with a child when a parent is present can be understood as occupying a distinctive space between conventional therapeutic configurations of individual or group work. Returning to the local music therapy context of this study offers a way of understanding the need for a revised positioning of practice.

Within the CDS, music therapy is offered to children in the form of individual or group work. While there are variants within these offers, such as length of a course of sessions or type of group, individual or group work form the two conventional alternatives. As such, therapy is either dyadic, with an emphasis on the therapist-client relationship, or group-based, with the greater social emphasis which working with peers offers. To what extent can the music therapy practice of seeing a child with a parent, as investigated here, be understood as either of these configurations? Can it really be presented, as indeed it currently is, as individual music therapy?

When understood within the particular context of the CDS, an argument can be made for it to be considered as individual work. In this context it is the child and their developmental needs which are the focus of attention. It is the child who is referred for music therapy and whose developmental needs are forefronted in therapy. Both parent and therapist clearly approach therapy with those needs in mind. The therapy then is firmly conceptualised in relation to the individual.

And yet it also differs significantly from a conventional understanding of individual work. It is not enacted through the usual therapist-child dyad. Not only is the parent present in the therapy room, but the intentions and actions of therapy are inevitably shaped by

their presence. More significantly, the parent, with child, forms the vital connective tissue that links home life with therapy, extending the usual borders of therapeutic work.

If not individual work, what then? The size of the configuration and the focus on the needs of one particular individual mean that a model of group work is not applicable. Nor can it be described explicitly as family work. While the study reveals the implicit intention therapists may have to support the relationship between parent and child, more explicit systemic work falls beyond the remit of both the music therapy service and the wider CDS.

Music therapy practice, as investigated in this enquiry, occupies an indistinct, mobile space between each of these conventional frameworks. The difficulty of pinning it down to a more precise position lies, I suspect, in the relationship between those frameworks and the apparently elusive nature of music therapy in this area. Music therapy with a child and parent present is not singular and therefore easily fixed. Rather, it consists of multiple sets of practices enacted between shifting configurations of people in different places. Musicing stretches out of, and into, the everyday life of child and family. Mobile and mutable, the ways in which music therapy appears resist fixing or reducing into one particular framework.

Describing Practice

The multiplicity and mutability of practice is manifested in the slipperiness of the language used to describe it. There is 'dyadic music therapy' (Gilboa and Roginsky, 2010), 'family-based music therapy' (Pasiali, 2013), 'family-centred music therapy' (Thompson, 2012a), and a 'family model of working' (Wood et al, 2016), to name a few. Throughout this enquiry I have resisted these terms, sticking somewhat obdurately to 'music therapy with a child when a parent is also present' in my effort to stay as close to the phenomenon as possible.

At this point, I suggest that the phrase 'music therapy with a child and parent' offers the most straightforward description of the situated practices discussed in this thesis. This resists bending or fixing the complex meshwork of practices in to any one position. However, such simplicity of language does not indicate a simplified conceptualisation of music therapy. Rather, I propose a framework posited on an 'ecological attitude', through which expertise and emergence are inextricably threaded.

6.7 Toward an Ecological Attitude

An ecological turn within music therapy is certainly not new. Well before the emergence of the community music therapy movement, key music therapists expressed their understanding of the individual in relation to interlinking personal, musical, and sociocultural worlds (Alvin, 1978; Priestley, 1975; Ruud, 1998). As Ansdell (1997) proposed 'ecology' as a metaphor for music, and therefore also music therapy, Bruscia was also describing what he termed the 'ecological area of practice' (1998, p. 229). This, he suggested:

> […] expands the notion of 'client' to include a community,
> environment, ecological context, or individual whose health
> problem is ecological in nature. (Bruscia, 1998, p. 229)

An 'ecological approach' in music therapy, then, is described as one in which the focus is on the promotion of health not only for an individual, but within or between the surrounding interlinking contexts. Connections are understood to be dynamic, change in one implying change in the other (Bruscia, 1998; Stige and Aarø, 2012; Wood, 2015). Wood describes it thus:

> The ecological approach assumes that in musical experience
> the person can be formulated as both individual and
> communal, and that music itself is also similarly multi-valent,
> being manifest both in the individual and in the collective milieu
> in which it is situated. (Wood, 2015, p. 54)

Community music therapy holds an ecological perspective as an underpinning tenet (Ansdell and Pavlicevic, 2004; Stige, 2002, 2004, 2017; Stige and Aarø, 2012, Ansdell, 2014; Wood, 2016). Stige and Aarø list an ecological approach as one of seven characterising signifiers of community music therapy.[52] By this they mean recognising and working with the mutually influential relationships between individuals, and the various groups and community networks in and around which they move. Considering music as ecology itself is also central to this approach (Stige and Aarø, 2012; Ansdell 2014). Music itself appears as one of the threads, along which people do things with other people in different places.

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[52] The authors propose an acronym, PREPARE, the letters of which denote key qualities of community music therapy: Participatory, Resource-Oriented, Ecological, Performative, Activist, Reflective, and Ethics-Driven.

Within the field of music therapy with children and parents, a number of key authors refer more specifically to an ecological approach (Gottfried, 2017; Thompson, 2012a, 2017b, 2017c; Jacobsen and Thompson, 2017). Its roots are traced from systems theory towards the development of family-centred models of care, characterised by a turning from an expert-led stance towards an approach focusing on 'family participation and collaboration' (Thompson, 2012a, p. 109). Seeking to work collaboratively both with parents and caregivers (Thompson, 2017b, 2017c), and more explicitly with the family system itself (Gottfried, 2017; Jacobsen, 2017), becomes a feature of an ecological approach in practice. As such, supporting the relationship between child and parent in music therapy may take precedence over that between therapist and child, while the development of the child is still a key focus of therapy (Thompson, 2014).

The ecological approach, then, can be understood as an overarching term denoting a broad range of socio-culturally oriented practices. Within the clinical field of children and families, it appears to take on particular meaning, suggesting specific intentions to collaborate with, and support, parents, children, and families. On the basis of this enquiry, I propose the notion of the ecological 'attitude', rather than 'approach', as a more helpful term to use. Attitude suggests a position, a point of view, or even a state of mind. Akin to Arnason's 'improvisational attitude', the ecological attitude signals a way of thinking and perceiving, rather than necessarily doing (2003, p. 134). Similarly, West (2016, p. xi) argues for a 'therapeutic attitude' in mental healthcare, reasoning that 'once the attitude is struck', the approach naturally follows. The essence of the ecological attitude I propose lies in positioning oneself, as it were, upstream, holding the ecological in mind, and expectant of it appearing. From such a position, an approach may then be manifested by way of particular intentions or actions. To begin with the action or intention, however, is to begin too far downstream, arguably becoming more concerned with doing than thinking. The distinction is a fine but important one. If considered, then, as a way of thinking or orienting oneself, the ecological attitude carries with it ramifications for the ways in which music therapy practice with a child and parent is understood and enacted.

De-centring the Individual

Within community music therapy, an ecological approach has signified a shift away from a focus on the individual as client (Wood, 2015). Conventionally, Wood argues, music therapists have placed the client at the centre of music therapy work, whether

within the dyad or group. An ecological approach, he argues, does not 'primarily centre the client', but accepts that the contexts in which music therapy takes place are fluid and dynamic (p. 44). Relationships among individual, families, and wider groups constantly configure and reconfigure themselves, the place of the individual shifting in doing so.

The institutional context in which music therapy in this study sits exerts a strong influence on the positioning of the individual. The CDS's remit, in offering healthcare to children with developmental difficulties, generates, and indeed demands, a centring of the individual. This is the institution's core purpose. Music therapy within such a context necessarily reflects this purpose: a child ostensibly attends music therapy because of the additional needs they are seen to have. Indeed, the focus of both parents and music therapists clearly converge on the child's specific developmental needs and changes over time through music therapy. A centring of the individual is both unavoidable and imperative.

Such centring becomes problematic however if it precludes an equivalent de-centring; that is, if the understanding of the child in music therapy is reduced to their condition, developmental phase, or even their weekly activity in the music therapy room. Holding the child in mind as active across layers of relationships with people and places enables a significant shift in perspective. It allows a view of the child as acting with agency, appropriating and transforming music's affordances. In doing so, the child draws on both their own expertise and that of of others in generating events and experiences in everyday lives. In this field, an ecological attitude brings a reconsideration of the borders between therapy and everyday life. As such, the child's agentic, musicing characteristics as seen beyond therapy can be considered to be present within the music therapy session itself.

De-centring the Music Therapist

An ecological attitude in this field demands a further de-centring, that of the music therapist. In terms of activity within the therapy room, this is not a new idea. A sensitivity to accommodating the relationships within the room is present in current thinking, frequently in terms of the therapist making way in the moment for parent-child activity (Drake, 2008, 2011; Thompson, 2017b). If the borders of music therapy open, as I suggest, following the musicing lines created by child and parent in the home, then such interactivity necessarily occurs beyond the therapist's sight. The centring of the

therapist, in terms of their actions being perceived as pivotal to the stretching musical meshwork, is necessarily challenged.

Sawyer argues that no single musician determines the flow of a performance in jazz groups (2005). Rather, music is co-created in the moment through the partners' collective contributions. This is a familiar and recognisable phenomenon within the micro-detail of the music therapy session. What, though, of the collaborative, creative musicing beyond the session, which is largely invisible to the therapist? The therapist is not only absent from such activity but inessential to its occurrence. In Sawyer's parlance, the therapist is not the single musician who determines the flow of this particular everyday life performance.

As the musicing of parent and child travels out of sight, the therapist is naturally de-centred. Their active involvement in the days, hours, and weeks between sessions is impossible. Thinking ecologically cultivates an understanding that action ripples through different people and places, emerging differently shaped as it does so. It also necessitates an attitude, parallel to that at the micro-level, in which the therapist steps away in order to centre more squarely the parent-child pair.

Repositioning the Parent and Child

The therapist's capacities for both action and knowledge are constrained by the limits of conventional practice. It is the parent and child who, together, move between contexts, and through whom the interlinking work of border crossing is done. The work of observing, witnessing, evaluating, attending, translating, and transforming are all integral strands of the generative work of parent and child in music therapy.

In the themes resulting from the Main Study I described parent and child as 'conduits' between music therapy and everyday life. A conduit is usually understood as a channel, along or through which something passes. On reflection, a more apposite word would be 'conductors'. 'Duct' has its roots in the Latin, 'ducere', meaning 'to lead or bring together', while 'con' means with, or together.[53] I would argue that parent and child lead music therapy together, that they act as its conductors. The effective and

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[53] https://www.etymonline.com

intricate crafting through which this is achieved, however, remains largely in the background, unseen and untraced.

Within a conventional music therapy frame, often confined to the time, place, things, and persons of sessions, there may be limited perceived need to understand the conducting work of parent and child. This is not to suggest that neither parent nor therapist are concerned with sharing information, knowledge and experiences. Rather, it is to propose that the nature of such sharing is currently strongly determined by the language and form of the traditional therapeutic frame.

If the borders of music therapy in this field are conceived of less as static, and more as 'active edges' then exchanging knowledge, experience, and activity can occur with greater fluidity and ease (Sennett, 2008, p. 227). If therapists centre parent and child as conductors, then music therapy might mingle more fluently with the interlinking contexts of a child's everyday life. At this point, practice may become more truly collaborative.

6.8 Toward a Framework of Practice

Having argued for the child, parent, and therapist to be differently centred or repositioned, those arguments can now be drawn together. I propose here a fresh way of understanding music therapy practice with children and parents within a healthcare context such as the CDS.

Music Therapy at the Edges

The study has revealed that music therapy practice with a child and parent within the CDS is constituted of multiple, interweaving lines. Along these lines, music therapy is enacted, its people, places, things, and events entangling as they emerge. Such entanglements create particular tensions, which themselves contribute to the evolving phenomenon.

At the heart of practice lies a relational tension, created through the inherent instability of the triad of child, parent, and therapist. Comprising shifting configurations, relationships between individuals and pairs emerge and recede continually. These are themselves viewed differently, depending on any one particular perspective. One such perspective is created by the contextual setting of music therapy, within the CDS's

organisational structures and formalities. Music therapy, as a service, sits on a cusp between the organisational norms of service delivery and discourse and the loosened language and activities of musicing through which it is accomplished. In this sense, the music therapy service itself can be understood as operating at a border, as between therapy and home. It may be one, however, in which exchanges are less freely sought, or where the edges are less overtly active. Finally, expertise becomes a dynamic force which drives music therapy's musical-social action. This, too, creates its own tensions, as certain expertises, or ways of expertising, are awarded greater legitimacy or visibility than others.

Actively Adopting Tensions

To date, the conceptualisation of music therapy practice with a child and parent has largely negated or appeared to resolve such tensions. I would argue that they have done so by strengthening the conventional boundaries of therapeutic practice in a number of ways; that is, by privileging the work of the therapist with the child, and considering the parent as an adjunct, albeit highly valued, to the activity of the therapist-child pair. An emphasis on the child's development as evidenced in relation to the activity of sessions, rather than everyday life remains strong as does an alignment with the formal structures of host organisations and professional bodies in documenting and communicating events. Such an approach reflects aspects of what has been termed the 'consensus model' of music therapy (Ansdell, 2002; Pavlicevic and Ansdell, 2004). This is an approach characterised by its emphasis on music therapy as largely dyadic, its concern being with the psychological rather than wider socio-cultural life of the individual and the specifics of time, place, and person.

This enquiry challenges the validity of such a conventional, bounded frame of practice, but I also argue that such a frame cannot be discarded altogether. The music therapy practices investigated here are firmly rooted in individually focused work, centred on the child's developmental needs. There is much of value in existing theory and practice in this field that informs this work's everyday realities. The nature of the organisation, its structures and conventions, and the services it offers however anchor the therapist in a specific healthcare place, unable to witness what happens elsewhere. What has not been clear until now is the extent and nature of the child and parent pair's activity beyond the therapy room. It is particularly in the light of this that the framework for practice must stretch beyond the conventional towards the ecological thinking found most readily in community music therapy. An ecological attitude can then emerge not

only in relation to practice, but also to theorizing. Concepts and approaches might not be seen as exclusive, but rather brought together in fluid exchange as the active edge of borders (Sennett, 2008). To do less, in terms of either practice or theory, is to risk obscuring the fullest narrative of music therapy as enacted by children and parents, in favour of retaining familiar professionally privileged constructs.

My argument is for an approach that actively adopts the tensions through which everyday music therapy practice in this area emerges. A hybrid approach is needed to manage such tensions. This holds together music therapy as necessarily individualised and developmentally specific, with an emergent, communal, informal counterpoint. These facets can be described through a set of identifying characteristics (Fig. 6:4).
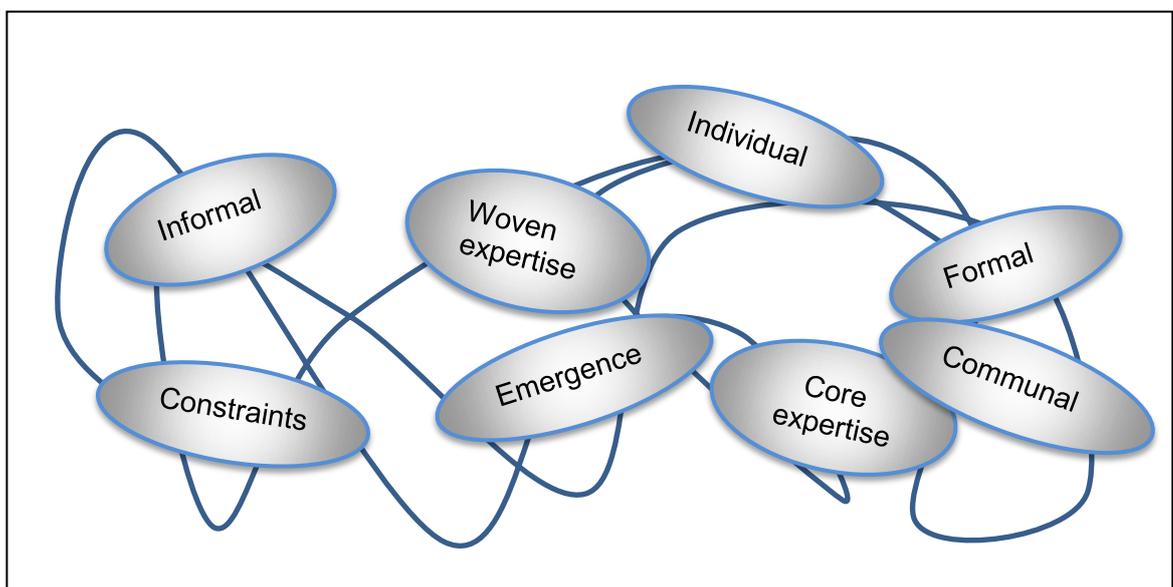

Figure 6:4 Identifying and Interwoven Characteristics

The characteristics are not intended to be read in any particular order of priority, or to fall across a spectrum. Rather, in the enactment of music therapy, each of these characteristics comes to the foreground and recedes again at any one time. They are, in effect, characteristics, not fixed positions or destinations, and as such, they are more or less revealed through the active line-making work of people in music therapy.

Neither are two differentiated groups of characteristics suggested. To do so creates an unhelpful binary, which, at its crudest, presents the formal and individual in opposition to the informal and communal. Presenting them as one hybrid set links them closely together, but allows them to interfere with each other. As the formal, for example, meets the informal in the discussion of a referral, or the emergent erupts in the use of

bottles in the family kitchen, so the complex, messy trails of music therapy become apparent. It is along these trails that the work of music therapy is accomplished. It is these same trails that need to be followed in developing theory and practice with children and parents.

This argument carries implications for thinking, practice, and training, both in the music therapy profession and more widely. These are addressed more fully in the following chapter, but they raise some key points here in drawing this discussion to an end. On the basis of the study, a revised approach to music therapy practice and theory in this area is required.   This involves loosening the hold on the conventional perception of the therapist's singular skills and knowledge without an equivalent acknowledgement of those of parent and child. This brings with it an imperative to resist a concomitant professional urge to attribute changes in a child too quickly to the music therapist's work, or to music therapy as contained in a single weekly session. It demands a new appreciation of the parent and child's crafting and a deepened acknowledgment of their ongoing relationships and worlds. The enquiry also challenges notions of what music therapy might be understood to be and the compromises inevitably made as a profession continues to seek legitimacy and status. The question becomes with whom, or what, does the individual music therapist, the music therapy service, or the profession align itself at any one time? Such realignment towards the child, the parent, and their wider world appears to be both timely and necessary.

6.9 Reflecting on the Trio

What, then, of the music therapy trio – the grouping of child, parent, and therapist – with which I began? Throughout this thesis I have used the term largely as shorthand, implying the cluster of three. However, I am left with questions concerning the trio: is there a trio, does the notion carry any ontological validity, and to what extent is it helpful to think of music therapy with a child and parent in terms of the trio?

A music therapy trio certainly does appear at times. The week-by-week activity of a child in a music therapy session is largely accomplished in the room by the threesome's collaborative efforts. However, holding too tightly to the trio as a concrete configuration potentially risks losing a sense of the grouping as both more and less than a trio. Even within the music therapy room, it reshapes itself into differing pairs and individuals in a state of continuing flux. This instability is made more pronounced

by the occasional attendance of others (making it at times a quartet, quintet, or more). Beyond the session, in the wider meshwork of home and family life, the music therapy trio assumes different forms. Without the therapist it appears as a duo but gathers others into itself to make other, mutable ensembles. And even when the therapist is absent, their presence may still be felt in those groupings. The trio, then, is perhaps most useful as a metaphor. As such, it offers a way of thinking about this peculiarly distinctive music therapy phenomenon. It speaks of the active configuring and reconfiguring through which music therapy with a child and parent is achieved.

6.10 On the Unasked Question

This enquiry has had a firm practice orientation, with a clear intention to investigate the processes – the workings – of the child, parent, and therapist in music therapy. It did not set out to answer questions as to why parents might attend with their child, accepting the fact of attendance as a reality of everyday practice in the CDS. Parental attendance was, and continues to be, often a question of practical necessity. The child's age, their particular difficulties, or the therapist's need for a parent's help in working with a child all contribute to make parental attendance vital. In this light, the trio becomes a configuration of necessity, enabling a child's therapy to proceed smoothly and safely.

This enquiry has revealed the nature, extent, and intricacy of a parent's activity in their child's music therapy. This activity, stemming from their intimate knowledge of the child, shows itself in the music therapy room, beyond it in situations of everyday life, and in the work of linking the two. It is in the expertise of their work that the unasked question as to why parents might attend therapy with their child finds at least a preliminary answer. The trio emerges, then, not only as a configuration of necessity but, ultimately, a configuration of choice.

Chapter 7 : Conclusions

7.1 Introduction

This enquiry began with questions of a specific area of everyday music therapy practice within a particular setting. The study has explored the ways in which music therapy with a child and parent is enacted, both through the detail of a single case and session and as it appears beyond the therapy room. This chapter draws conclusions from the enquiry as a whole. In it, the findings are related to existing knowledge and practice, both within the clinical field and more widely. In doing so, the study's implications for music therapy practice, theory building, and research are considered, aspects of which are generalizable across related healthcare disciplines. The chapter concludes with reflections on the quality of the enquiry as a whole.

7.2 Drawing Conclusions

My main conclusion, at the end of this study, is that music therapy with a child and parent can be seen to be enacted along multiple, interweaving lines of people, places, things, and events. Understood as a meshwork, its interlinking lines variously influence, propel, and constrain the ways in which music therapy appears. While it cannot be understood only in terms of what takes place within the therapy room itself, the sessions' detail offers an appropriate place to start in relating the findings of this study to existing knowledge in the field.

Within the Therapy Room

Active parental involvement in music therapy sessions has been widely understood as beneficial, specifically in supporting the child's development (Thompson and McFerran, 2013; Kaenampornpan, 2015) and in nurturing the parent/child relationship (Gilboa and Roginsky, 2010; Thompson, 2017c). This study suggests that parents are indeed eager to be actively involved in supporting their child, but that the intention to nurture the parent/child relationship lies more clearly with the therapist than parent. The clear relational intent on the parent's part within sessions is in encouraging connections between child and therapist. In 'sitting down and looking' (Par FG1, 219), parents actively make way for this developing relationship.

'Sitting down and looking' has a further distinctive purpose. The extent to which parents value the opportunity to be the 'third person', witnessing their child participating in music therapy, has been noted previously and is confirmed in this study (Jones and Oldfield, 1999; Flower, 2008). Therapists need to balance the importance of witnessing for parents with the impulse to encourage a more overt parental involvement. Sitting and watching can itself be understood as a form of active involvement. This argument gathers more weight in light of the mobile, mutable nature of musicing between parent and child beyond the therapy room.

Beyond the Therapy Room

The activity of parents in adopting and transferring activities from therapy room to the home environment has been well documented in recent years (Chiang, 2008; Nicholson et al, 2008; Pasiali, 2013; Thompson, 2014; Thompson et al, 2015). There has also been interest in the uses parents make of shared music activities in everyday life with children (Gottfried, 2016; Gottfried et al, 2018). The parent is generally presented as being the main instigator of music in the home. While this study acknowledges that parents indeed act as vital conductors of musical activity across contexts, it also highlights two further aspects of this process.

First, the child appears as an active initiator of musicing within the home. Appropriating activity from the session, the child draws those around them into moments of shared musical play. The child's agency and the woven expertise of the parent/child pair beyond sessions have, however, been largely unknown. The unseen nature of the child's and parent's work finds parallels in literature from music therapy in adult mental health (Rolvsjord, 2013, 2015). The commonality lies in the active linking of experiences and activities that those participating in music therapy do across contexts. This study has thrown particular light on the extent to which the child, and not only the parent, demonstrates such linking.

Second, a further point can be made on the ways in which such linking is achieved. Previous studies suggest that parents are given, or they appropriate, discrete activities from sessions to use in the home (Chiang, 2008; Nicholson et al, 2008; Thompson 2014, 2017c). While this study demonstrated that parents adopted and adapted particular activities, it also brought to light the extent to which musical-social play between child and parent at home appeared as emergent and highly spontaneous in

nature. Musicing erupted, often taking unexpected, original forms, or linking in extremely tenuous ways to the events of a session.

Considered together – the child as a dynamic initiator and the emergent, spontaneous nature of musical-social activity between child and parent in the home – these findings bring clear implications for practice. Acknowledging the creative work of child and parent does not necessarily lessen the need for the therapist's skilled activity within sessions, but it does suggest that therapists retain an expectation of such agency and interlinking work (Rolvsjord, 2015). Given the emergent nature of musicing in the child's everyday life, as it appears in this study, it may be that the need for the therapist to suggest or supply activities for home use is less than previously thought. Perhaps, as Rolvsjord suggests, what is needed is less 'doing' by professionals and a greater recognition of the 'doings' of those we work with (p. 316). Understood in that light, perhaps one aspect of the therapist's work is to raise with parents the possibility of musical spontaneity at home that either they, or their child, initiate within everyday events, and to be attentive to those events informing future therapy sessions.

Considering Intentions

Running through the entire study has been an ontological dilemma; that is, what music therapy with a child and parent is understood to be, and by whom. The clumsy description of 'music therapy with a child in which a parent is also present' that I initially used signified my attempt to retain the practice's inherent ambiguities. Music therapy literature variously describes practice involving children and parents as dyadic (Gilboa and Roginsky, 2010; Jacobsen et al, 2014), or as related to the family unit (Thompson 2012a, 2012b; Wood et al, 2016; Oldfield, 2017a). The descriptors given to practice appear to indicate therapy's intention. In other words, dyadic therapy seeks to support the parent/child relationship, while family-centred music therapy has a concern with the family system as a whole (Gottfried, 2016; Jacobsen and Thompson, 2017).

This study's findings suggest that while the music therapy provision being investigated is not described in such explicit terms, an intention to support the parent/child relationship frequently informs the therapist's actions. This does not necessarily correspond to the parent's intentions. As such, the finding echoes the question 'does the family know what they are getting?' (Jacobsen and Thompson, 2017, p. 322). Here I concur with the authors in stating that there is an ethical urgency to this question, both

in terms of the agreement made with child and parent, and in terms of impeding the potential collaborative work between them.

It could be argued that processes whereby the goals and aims of therapy are negotiated and agreed between parent and therapist preclude such possible ambiguities (Oldfield et al, 2012; Jacobsen et al, 2014; Jacobsen, 2017). On the evidence of this study, I disagree with this on two key grounds. First, that fixing goals, and in a similar vein determining specific roles in music therapy, is problematic because it runs counter to the ways in which music in music therapy shows itself to work. By its nature, improvisational music therapy is 'upstream' and emergent, coming into form moment by moment. As such, it collides with 'downstream' goals and often institutionally-led requirements for measurable change. Second, I would argue that formalising goals is problematic, given an ecological understanding that considers music therapy as 'interacting contexts' of people, place, and things (Rolvsjord and Stige, 2015). What is important, and to whom, ebbs and flows as musicing travels across the active edges of the therapy room and everyday life.

An Ecological Attitude – Repositioning Music Therapy and Musicing

This study has thrown light on the interweaving threads and traces through which music therapy with a child and parent is enacted. Specifically, it has suggested the need for an ecological attitude through which the interplay between contexts of therapy and home, and the activity across them, might be understood (Stige, 2017).

In the field of music therapy with children and families, an ecological approach often indicates a family-centred orientation that understands the child within the family system and seeks to work collaboratively with parents (Gottfried, 2017; Jacobsen, 2017; Thompson, 2017b, 2017c). In keeping with Ingold's description of ecology as 'the study of the life of lines' I suggest that a significant component of an ecological attitude lies in the recognition of the trails created by people musicing in places and with things (2007, p. 103). Grounded in such a premise, the ecological attitude signifies a dynamic, lively quality, poised to follow the musicing of child and parent interweaving with the people and places of everyday life.

Such a stance moves from a notion of therapy itself as being the place where change occurs, or the therapist as the key agent of such change (Rolvsjord, 2013, 2015). Indeed, it suggests that music therapy, in the form of the weekly sessions, may have

assumed greater significance than can be feasible given its limited time within a child's week (Dreier, 2008, 2011). The capacity of activity within the session itself to bring about change appears disproportionately weighted in relation to the broader crafting and skilled work of child, parent, and others in everyday life, the processes of which have been opaque. It is, I suggest, in the revealing of these processes that the imperative to redistribute the weighting afforded to the session itself appears. The representation then of music therapy as positioned centrally, (Fig 6:2, p. 218), interlinking only minimally across a 'site of exchange' with the everyday life of child and family is arguably flawed therefore.

An alternative representation that speaks more appropriately of how music therapy might be understood places the child and family centrally. Music therapy and the wider CDS organisation appear, then, as parts of the whole of everyday life (Fig. 7:1).
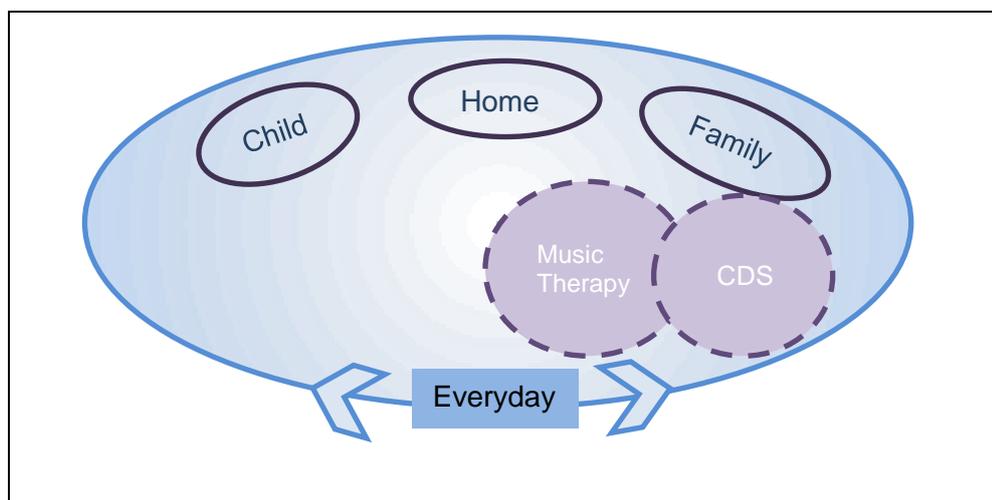

Figure 7:1 Centring the Child and Family

While arguing for music therapy to assume a less central position, the converse can be argued for musicing itself. Indeed, I would argue that the musicing work of child and parent as it trails beyond the music therapy room, and the processes through which that occurs, warrants greater attention than previously afforded. It is in following these trails of activity that parent and child show themselves as active crafters with music, initiating, translating, and conducting in highly personalised ways. Then the child can be defined less by diagnostic labels, or developmental goals to be met, and more as a generator of their own creative, interactive world.

In light of this, I propose that the traditional dyadic model through which music therapy with a child and parent has often been seen is partial and inadequate. If the

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phenomenon of music therapy with child and parent is understood in conventional, hierarchical terms, then too great a privilege is given to therapy and therapists themselves. If understood as a continually forming and reforming meshwork, along which interconnecting lines of musicing, relationship, and expertise meet and tangle freely, then the work of child and parent is privileged. In this sense, their work is considered on a par with that of the professional, hierarchies are resisted, and a changed point on which to base practice is found. From this point, the study's wider implications can be discussed.

7.3 Implications as Entanglements

To consider implications is itself to extend further the lines and trails of the enquiry. The word has its foundations in the Latin *implicationem,* pleasingly meaning 'an interweaving, an entanglement'. At its core is the root *plicare,* meaning 'to fold', or 'to plait'.[54] This expresses my intention here, which is to plait together this study's findings with broader issues of practice, theory, and research.

Implications for Practice

The study arose from context-specific questions of practice in a particular clinical field. While implications relate particularly to this field, they may also speak to wider fields of practice both within music therapy and across healthcare disciplines.

This study was prompted by problems of practice focusing largely on questions of parental involvement. I suggest that if therapy is considered as largely professional-led and dyadic in nature, then the inclusion of the parent as a third is indeed problematic. In de-centring music therapy, and considering it as part of the wider meshwork of child and family, the landscape changes. The primary dyad becomes that of child and parent, and it is the therapist who is, as it were, invited in. That the activity of sessions may then shift among the individuals, pairs, and the three can then be assumed, without any one configuration taking precedence over another.

Everyday practice takes place in context, in this case a healthcare organisation whose focus is on meeting the child's specific developmental needs. However, if music

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[54] https://www.etymonline.com/word/implication

therapy is also perceived as interacting contexts, then it can be understood as not only being done in the therapy room or in the presence of the therapist. If the borders between therapy and everyday life are seen as active, then musicing in its many forms travels freely. The family's musical life may find its way more fluidly into sessions, and events and things of sessions flow outwards. This is not to suggest the transfer of activity needs to be prescribed in what may be a 'downstream', static manner, but that parent, therapist, and child might be ready for the emergent potential of musicing as it appears.

The everyday practice of music therapists, at least initially, is also learned in context; namely, the educational institution offering training. That music therapy with a child and parent might be seen to occupy a fluid space between individual, group, and family work has presented some difficulties for trainees that the training institution expect to work with an individual child. I suggest this study's findings point towards the need for professional trainings to revise the ways in which they understand work with children and parents. This calls for a different approach which finds a middle ground between the conventional dyadic therapist-client model and a broader, ecological thinking. Such an approach would equip emerging therapists to understand parental involvement not as an extra to the therapeutic process between child and therapist, but rather as co-shapers of music therapy.

Trace-Making in Music Therapy Practice

While the trails of activity in music therapy are often ephemeral, I have argued in this thesis that music therapy is also enacted through a more substantial trace-making. This carries further implications for practice which I first address by considering the use of video in music therapy.

Video is used regularly in everyday practice, and particular aspects of that use can be considered in the light of this enquiry. In recording sessions, a digital trace is created which, in the healthcare context of this study, remains the property of the organisation rather than the family. In certain circumstances, particularly concerning children with life-limiting conditions, therapists and parents may agree that a family keep a copy. The ubiquitous smartphone has also, in recent years, enabled parents to film their child themselves in sessions, creating their own digital trace. This has previously been felt to be problematic, in part because of the consent and privacy issues it raises for therapists (Trondalen, 2016). More significantly, the conventional view within the

service has been that in recording sessions, parents are deemed to be distracted, unable to fully experience unfolding activity in the room.

I suggest that the positions taken both on ownership of such traces and assumptions around their creation carry with them an implicit paternalism. The perspective of the therapist, and wider organisation, in terms of knowing what is best for child and parent is privileged. At a practice level, the risk is that, if unquestioned, therapists too easily become complicit in propagating an approach in which the parents' values, knowledge, and expertise are effectively overridden (Rolvsjord, 2004; Hadley, 2013).

While conventions concerning the use of video recording are to be questioned, innovative ideas also emerge to be considered. If parent and child are understood as conductors of music therapy, generating together trails that flow through sessions and home life, the potential trace-making work of video is significant. Indeed, a recent study demonstrates the reach and impact of such traces across geographically disparate families (O'Neill and Crookes, 2018). I would suggest that the phone can offer an innovative element in a child's therapy. If used as a trace-making tool to link the musicing of the home environment with the people and place of the weekly session, the two become more closely entwined. Greater weight can be given to the work of child and parent at home, and the trace-making of video and its uses becomes a symbolic outworking of the ecological attitude in practice.

I have also argued in this thesis that the trace-making of music therapy, in terms of documentation, is largely achieved by professionals. The study's findings bring implications in this area, first at the level of everyday practice. As the work of child and parent away from the therapy room becomes visible in practice, it suggests that their voices may also become audible in terms of authoring the written notes, reports, and documentation of music therapy. This may not only mean contributing to existing documents, originating as they do from professional or organisational convention. Rather they are part of a radical rethinking of the functions, formats and production of written material.

Second, broader issues of authorship follow from this point. It currently remains the case that music therapy literature, both within the specific clinical field of this study and more widely, is predominantly authored by professionals, with few exceptions of which I am aware (Jones and Oldfield, 1999; Hooper and Procter, 2013; Dunbar, 2016). This is not to say that the voices of those who participate in music therapy are not included

in literature. On the contrary, their inclusion is the norm, but the difficulty lies precisely in the notion of inclusion. The written and verbal presentation of music therapy appears to be generally written by, and intended for, a professional audience. The words, opinions, and experiences of those who participate in music therapy are filtered through the lens of the professional gaze. I fully agree that it is not within the professional's gift to 'give people a voice', but I am convinced that there are other voices to be heard in print or speech that are currently inaudible within and beyond the professional community (Stige and Aarø, 2012, p. 5).

Contextualising Music Therapy

In considering practice implications, it is necessary to place music therapy within its organisational context and address wider structural issues. The study suggests that music therapy affords distinctive elements in the interaction between child, parent, and the wider organisation. It is valued for its emergent, improvisatory qualities, offering a 'golden thread' along which families and those who seek to work with them intertwine. The perception of music therapy as being less goal-oriented and constrained than other disciplines emerges as being of value within the organisation.

Paradoxically, the study has also revealed the apparent professional drive to align music therapy more closely with the conventions, discourse, and structures of an NHS organisation. This drive, I would suggest, has historic roots in the processes of achieving the professional legitimacy that some would suggest was achieved in gaining state registration (Barrington, 2005; Procter, 2014). Positioned as what Procter (p. 13) terms a 'modern paramedical profession', music therapy services are inevitably interlinked with organisational, commissioning bodies and professional structures, bringing expectations and constraints.

In aligning closely to the professional conventions and discourses of host organisations, the nature of music therapy is potentially compromised. The musical-social work of music therapy risks being formalised to such a degree that it loses its connection to the emergent, collaboratively crafted musicing through which this study shows it to appear. This is a tension that carries implications for practitioners, balancing the jointly crafted mobile meshwork of practice with organisational constraints in such a way that the distinctive nature of music therapy with child and parent is not lost.

Implications for Theory-Building

A challenge in theorising music therapy also lies in ensuring that the distinctive practices through which it appears are not lost. Indeed, my concern in this thesis has been to work towards theoretical frames that give accounts of, rather than prescribe, practice (Aigen, 2014). This echoes the practice turn in music therapy theory, in which processes and events are foregrounded (Ansdell, 2014; Rolvsjord 2015; Ansdell and DeNora, 2016; Stige, 2015). The term 'practice', Stige (p. 4) suggests, then broadens away from a focus on what particular people do, attending instead to 'bundles of activity', as people do things together with others across time and place. In the practice turn, such 'bundles of activity' become rich sources of knowledge, from which theoretical insights can emerge.

These ideas form their own interlinking trails with those of Ingold, who also writes of bundles. As he puts it:

> […] every thing is itself an entanglement, a tissue of knots whose constituent strands, as they become tied up with other strands, in other bundles, make up the meshwork. (Ingold, 2008a, p. 1806)

I have proposed the meshwork in this thesis as a way of conceptualising the interweaving practices through which music therapy with a child and parent appears. This is not to impose theoretical form on practices, but rather, through the methodological intention of following strands of people, place, things and events, to allow it to emerge as an apposite explanatory tool (Pink, 2010). Theory and practice are therefore reciprocally influencing. I might even propose that if music therapy is understood to work 'in the way music itself works' (Ansdell, 1995, p. 5), then perhaps music therapy theory needs to 'work' in the way that music therapy itself does.

This has been a context-specific study, coloured and shaped by its organisational context and the particular nature of the clinical work being explored. The theoretical frames emerging from it are not, however, limited to one particular clinical field in music therapy, but applicable more broadly (Aigen, 2014). The notion of the meshwork's active, border-crossing lines may, for instance, provide ways of understanding interacting practices that reach across individuals, groups, and contexts. Nor are the frames necessarily music-therapy specific. In healthcare with children and more broadly, there is ongoing concern with how best to build partnerships between patient, staff, and families (Swallow et al, 2013; Sabadosa and Batalden, 2014; O'Hara et al,

2018). The recent paper by O'Hara et al specifically addresses the work of patients and families in achieving the best care possible by creating links across healthcare borders. It is to such cross-disciplinary practice concerns and theory building that the ecological stance proposed in this thesis may also make productive linkages.

The concepts presented as arising out of this study are themselves entangled with the work of others previously, both in music therapy and elsewhere. My intention is not to present the ideas here as a final work, or even necessarily a good fit with comparable practices elsewhere. Rather, my hope is that in the spirit of entangling they allow space for discussions across further sites of professional and inter-disciplinary exchange.

Implications for Research

The practice turn also carries implications for approaches to research (Stige 2015). If practice is given equal weighting with theory and research, then research agendas and methodological approaches follow, seeking to explain practice as it shows itself (Edwards, 2012; Rolvsjord, 2015; Ansdell and DeNora, 2016). I would suggest that ruptures appear when the practices being researched and the research approach taken is misaligned.

Within the field of music therapy with children, such a rupture of the practice/research platform has been evidenced most recently in relation to the Time-A trial. Time-A was a multi-site, randomised controlled trial investigating the effects of music therapy on the social communication skills of children with ASD (Bieleninik et al, 2017). The study's primary findings did not 'support the use of improvisational music therapy for symptom reduction' (p. 534). The study's methodological basis has been subject to strong critique, notably on the choice of measure used and its potential insensitivity as a tool for measuring change (Broder-Fingert et al, 2017; Turry, 2017).

A further significant difficulty of the study that is of particular relevance here was that parent's experiences were considered as secondary. As Broder-Fingert et al report, parents may have wished to ask other questions of music therapy with their child than those posed by the researchers (2017, p. 524). My contention is that this example furthers the imperative for the music therapy community to pursue research approaches that adopt a practice turn, aligning themselves with the people, places, and events through which music therapy appears. One aspect of this may lie in working

with parents and children in co-designing research that speaks to the multiple interests of those participating in practice (Thompson and McFerran, 2013).

Future Research Areas

In looking forward, I propose four areas that may warrant further research in the future. All arise directly from this study's processes, but the second two can also be understood as addressing specific limitations of the enquiry.

The first research priority is to extend an ecological understanding of music therapy with children and parents as it appears in everyday life. This would expand the scope of this study, focusing more specifically on the people, places, and events of child and family within the home and beyond. Such a cross-contextual practice-led study could echo that of Rolvsjord (2015, p. 299), asking 'how do clients make music therapy work?'.

Second, video material has been used extensively in this study, as it is in everyday practice. Given that the study revealed the multiple perspectives brought to bear on ostensibly the same events, there is scope for pursuing an exploration of video practices. This would be timely, given the current developments in early years practice of using video review to support parents (Kennedy et al, 2011). Furthermore, I have proposed that innovative use could be made of video recording in the home. This could be explored further, but could also offer a creative method as part of a wider investigation of everyday life (Jewitt, 2012).

Incidentally, foregrounding practice as a 'site of knowing' (Stige, 2015) suggests that there is much to be learned from current uses of video material in terms of the public presentation of music therapy. Frequently, in making the case for music therapy services to those who hold financial or strategic influence, I and others would choose to show, rather than talk about, music therapy. We 'know' that seeing it in action carries weight. In terms of the challenge of presenting the complexities of music therapy convincingly, there is much to be gained, I would suggest, from bringing the practice turn to bear on investigations of video use.

A further research priority may concern gender issues within music therapy practice (Hadley, 2013; Scrine, 2016). While this study did not explicitly seek to address these issues, I have reflected on questions of gender throughout. The gender divide within the study was noticeable: of twenty-one participants, only two were male. This mirrors

to a large extent the numbers of men and women who work within the CDS or attend music therapy with their children. It certainly remains unusual for fathers to attend with their children, a situation echoed elsewhere (Thompson, 2017). While issues of gender in relation to working with fathers have been addressed in relation to NICU practice (Ettenberger, 2017a; Mondanaro et al, 2016), they have not been explored in children's clinical work more broadly. Investigating a father's experiences of the CDS and music therapy would allow a preliminary study in this area. Tilting the investigative lens towards the everyday life of child and family may also throw light on the activities of the father and other family members.

Finally, I have acknowledged throughout this thesis the difficulty of including the child's voice directly in the research. This itself has been an ethical dilemma for me. The inherent difficulties of including children in research are certainly not peculiar to this study, and are a focus of attention across various disciplines at present (Carroll and Sixsmith, 2016; Jacobsen and Thompson, 2017; Lees et al, 2017; O'Dempsey, forthcoming). Children with little or no spoken language, as was the case in this study, may present particular challenges for researchers in terms of inclusion. However, the experiences of children who can communicate verbally also remain unexplored in music therapy literature at present (Jacobsen and Thompson, 2017). I have worked within this study to include the child's voice particularly through attention to their activity. Musical transcription and microanalysis enabled me to foreground such activity. The child was also kept central through the meanings others made of their experience, action, and interactions. Inevitably, there is a distance in such interpretative work which I accept. I believe, however, that future researchers and practitioners share a responsibility to understand the areas that children themselves feel are significant to investigate. In part, this will mean rising to the challenge of developing creative research approaches through which children's greater participation can be enabled.

Considering Limitations

In outlining future research areas, I have touched on several associated limitations revealed in the research. A number of other, broader points should be made concerning the study's limitations, stemming largely though not exclusively from methodological decisions.

The study was underpinned by the research approach of 'gentle empiricism' characterised by careful observation and 'dwelling with' a phenomenon (Ansdell and DeNora, 2016). This, together with Bortoft's 'upstream' turn, implies a measured research attitude that retains an openness to what appears in the research process. The decision to employ specific methods such as modified Grounded Theory, Interpretative Phenomenological Analysis, and formats such as focus groups could be said to run counter to this stated overall approach. They brought structure and form to the gathering and analysis of material in ways that could be seen to be reductionist, or, in Pink's phrase, to ''arrest' the flow' of the research process (2012, p. 33). It could be argued that employing an ethnographic approach may have offered a greater congruence between practice and research.

While acknowledging the potential fault line here, the study's position in the context of an institutional epistemological framework should also be recognised. While it can be seen to be changing, currently the research culture of the NHS, as exemplified by the ethics approval documentation, continues to privilege the experimental, interventionist study. The difficulty of gaining approval for ethnographic research within such a framework has been previously noted (Procter, 2014). In this instance then, there was a pragmatic reality about designing a study that could both successfully gain approval while remaining sufficiently anchored in my own research values.

The specific research methods used were not, however, chosen as a compromise. Rather, they offered a broad range of methods and strategies intended to be used flexibly. The task was to use them in such a way that they did not obscure the underpinning approach, while welcoming the methodological rigour they offered to the study as a whole. While the methods used may have been less fluid than a more clearly ethnographic frame, I would argue that they have served the study well, enabling a significant step to be taken in broadening the understanding of the complex enactment of music therapy with a child and parent. From that base, and with a preliminary argument for an ecological attitude in this clinical area made, there could now be a stronger mandate for a broader method base for further research.

Finally on this point, the epistemological and methodological tensions here can be seen to reflect something of the tensions in practice revealed through the study. The formal, professionalised traces of documentation and the informal threads of a family's musicing (cf. p. 219) bear witness to a parallel tension between an institutional epistemology that grants ways of knowing either greater or lesser status. In these

terms, it is perhaps inevitable that questions of methodological congruence emerge in considering the potential limitations of the study, and fitting that they, in turn, might point again to a key argument of this thesis.

I have argued, in this thesis, for an ecological attitude in music therapy practice with a child and parent. I have distinguished between an ecological attitude and the more commonly used term ecological approach. The attitude, I have argued, suggests a positioning, a stance through which to be expectant of wider events of musicing. In what ways, however, might the attitude proposed here have limitations, particularly in regard to everyday practice?

I have argued that such an attitude is primarily concerned with a way of thinking, rather than specific action (cf. p. 242). As such, in terms of practice it should not demand additional activity for the therapist. Rather, a readiness to consider the musicing world of child and family, and their shared crafting away from the therapy room, shifts the locus of activity away from that of the therapist. Even so, keeping the complexity and expansiveness of a child's world in mind presents its own challenges. As Rolvsjord and Stige suggest (2015) the conventional medical model of healthcare brings advantages in terms of reducing complexity in both practice and research. By its nature, thinking ecologically may bring challenges in terms of finding the 'edges' in both research and practice.

Perhaps, however, the argument is not that the ecological attitude as such brings limitations but rather that it potentially highlights existing limitations. If the music therapy session, or therapist, is 'decentred', as I have argued, then the ecological attitude limits the ways in which change in a child can be easily assumed to be a result of the work of therapy. Parent, child, and the wider meshwork of a child's life are all entangled in such change. Following this trail of thought, at higher organisational levels, the efficacy and authority of music therapy could then be brought into question. The ecological attitude therefore potentially challenges conventional understandings of practice in this area, in what may be a timely way.

7.4 Questions of Quality

The extent to which the study's implications presented above carry weight will be, to a significant degree, a function of the quality of the study itself (Abrams, 2005).

Considering questions of quality brings its own complexities. In line with the proliferation of qualitative methodologies, epistemologies, and methods in recent years, ways of evaluating quality have themselves multiplied correspondingly (Yardley, 2000; Wheeler and Kenny, 2005; Stige et al, 2009; Smith, 2011). Stige et al identify and critique three primary means, ranging from the particular to the overarching, through which quality has been assessed in qualitative research: the generalised checklist, local, and meta-criteria. The checklist, while demonstrating a particular type of rigour, becomes a potentially inflexible tool, incongruent with diverse epistemologies and methodologies (Carter and Little, 2007). The proposal of criteria, rather than lists, deals to some extent with issues of congruence. Such criteria may be deemed local, suited to specific projects or research orientations (Smith, 2011), or meta-, used to evaluate studies across a range of qualitative approaches (Edwards, 2012; Charmaz, 2014).

In the critique offered by Stige et al (2009, p. 1506), neither resolve dilemmas of assessing quality, the former threatening 'isolationism', the latter tending towards 'vagueness'. In their place the authors propose an alternative approach, that of the evaluation agenda. Intended as a flexible framework, the agenda uses the acronym EPICURE to signal seven quality areas: Engagement, Processing, Interpretation, Critique, Usefulness, Relevance, and Ethics (p. 1507). The areas are themselves grouped into two particular fields, that of the production of the research itself and the resulting capacity of the study to effect change. I use these two aspects to ground my own reflections on questions of quality within this enquiry.

Producing Research

Stige et al (2009, p. 1508) describe engagement as 'the researcher's continuous interaction with and relationship to the phenomenon or situation being studied'. My intention has been to adopt an investigative attitude through which I might remain as close as possible to the phenomenon at the heart of the study, while acknowledging the dynamic, unfolding nature of such a process. In part, such unfolding could be attributed to my own evolving position during this time.

My roles, in terms of both research and practice, have been multiple and mutable through the course of the study. The move into a position of managerial responsibility generated a shift in relationships with colleagues and parents. I became responsible for the provision of music therapy by others, rather than only myself. This altered my

perceptions of music therapy practice itself, heightening further my engagement with the area of study.

The quality of my engagement was also influenced by the insider nature of my research position (Greene, 2014). I have needed to challenge ways of seeing that have become familiar to me through the years of identifying primarily as a practitioner (Alvesson and Sköldberg, 2009). The insider position has also brought with it the need to acknowledge the possibility of the 'unsympathetic critique' (Taylor, 2011, p. 11). An inability on my part to engage with a sufficiently critical attitude, given my closeness to the study's people, places, and events, posed a potential risk to the integrity of the enquiry itself. Conversely, critically examining the phenomenon of music therapy in context brought with it the possibility of damaging my relationships with those involved. On reflection I wonder if I was particularly sensitive to this given my recent move into management. Ultimately, the process of research seems to me to have strengthened my organisational ties, but in a robust way in which critique and challenge are possible and enriching.

Underpinning this research has been the orienting approach of 'gentle empiricism' (Ansdell and Pavlicevic, 2010; Ansdell and DeNora, 2016). This has impelled me to keep the phenomenon itself central, urging me to consider the familiar as unfamiliar. As an approach it informed further methodological decisions, the approaches of Interpretative Phenomenological Analysis and a modified Grounded Theory offering suitably aligned methods (Smith et al, 2009; Charmaz, 2014). Both approaches suggested methods that brought procedural stability within suitably flexible frameworks.

The study also utilised various research methods, including the Video Elicitation Interview (VEI) and focus groups. These methods offered what I considered to be creative and appropriate matches in relation to the study's demands. On reflection, I consider the VEI to have offered two particular benefits to the project. First, they brought a methodological congruence to the practice-led study, reflecting the everyday usage of video between therapists and parents. Second, they were instrumental in signalling moments of divergence in accounts given by participants that would not have become apparent without reviewing video. This implies the VEI could be utilised more broadly in music therapy research concerned with understanding multiple perspectives and experiences.

The use of focus groups enabled the study's scope to widen. Not only did it multiply the numbers of voices heard, but it brought those voices together in order to share narratives (Bradbury-Jones et al, 2009; Jayasekara, 2012). The groups were largely homogenous, although this is itself a crude descriptor. The commonality in the parents' group, for instance, was that each was attending music therapy with their child. I suspect that differences between parents, including those of ethnicity, age, language, and socio-economic status, were significantly greater than what connected them. Given the loose but inevitable homogeneity across groups, there were limits to the extent to which group members could share or feel able to discuss experiences.

Creating distinct cohorts of groups generated a further methodological limitation, effectively separating out the voices of those who populate music therapy. This was a limitation that I made efforts to mitigate in two ways: first, by using the same short video extract as a prompt for discussion in each group; and second, by cross-fertilising discussion in one group with material from another. These steps enabled me to maintain a sense of the research material as a whole, rather than partial units.

Finally, in considering the processes and production of the research itself, I want to comment on the study's scale, which, if if understood in numbers of participants, is an outcome of the research design of a single case (Smith, 2004; Smeijsters and Aasgaard, 2005). If, as Smith suggests (p. 30), case studies 'simply show us that (or how) something *is*', then this is what I sought to do in this study. The enquiry reveals music therapy within the frame of a single, overarching case. The numbers, both of participants involved and research events, were a natural outcome of the situated, practice-led nature of the study. As such, it is a study that focuses on the particular, on events unfolding between people at moments in time. It is in the pursuit of the particular – the detail – that I would argue one of the study's strengths is to be found.

Effecting Change

The EPICURE agenda also calls on researchers to address the 'preconditions and consequences' of studies (Stige et al, 2009, p. 1507). Having considered implications previously in the chapter, I want to focus here on preconditions, and more specifically on issues of ethics. These have been a significant part of the research journey for me, and in exploring them here, I return again to Bortoft's up- and downstream images (2012).

I suggest that, at its most functional, a concern with research ethics could become a matter of looking predominantly downstream at the work to complete. The main activity becomes the completion of research ethics approval applications, and the primary ethical focus is the avoidance of harm (Greenhalgh, 2004; Smith et al, 2009). This is not to minimise the importance of such processes, nor the harm that may be caused through participation in qualitative research (Stige et al, 2009). This became evident for me in sitting with a parent, for whom watching a video evoked a deeply personal response. This was a timely lesson for me as researcher. I became aware that ethical issues not only permeated the whole research process; they also shaped it. A different, 'upstream' perspective was called for, in which questions of ethics could be seen as appearing through the continuing flow of research. As such, this also signals an approach that goes beyond not doing harm, to an active consideration of how research might support and be of use to those involved in it (Stige et al, 2009; Trondalen, 2016). Research then becomes a way of enacting an ethical stance.

My intention in this study was to balance a research design that served the practices I sought to investigate, together with hearing, and representing as faithfully as possible, the voices of those between whom those practices appear (Stige and Aarø, 2012; Ansdell and DeNora, 2016). Hearing those voices occurred not within a vacuum, but rather within the ongoing warp and weft of relationships, concerns, perceptions of status, and roles. Design decisions needed to take account of these complexities. For example, the decision not to run heterogeneous focus groups that mixed parents, therapists, and staff arose from weighing up the potential ethical implications. I was concerned that mixing voices in this way, while possibly enriching the conversations and material, might compromise the freedom with which participants felt able to speak. At worst, I felt that mixed groups might create significant imbalances in perceptions of power and highlight potential feelings of vulnerability and unease. That is not to assume that such experiences may not occur in homogenous groups, but rather to demonstrate the need for reflexivity in managing the relationships between research design, practice, and the people through whom both come into being. The extent to which I have accomplished that becomes, for me, a further marker in assessing the study's quality.

Ways of understanding ethics within research, together with the particular ethical issues raised in this study, should not only remain contained within this thesis. I would argue that they themselves are consequences of this study, becoming, perhaps unintentionally, a further feature of the study's usefulness. Intertwined with the

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empirically grounded insight into the intricate joint crafting of musicing with child and parent, these consequences are already being expressed at a local, practice level. These shifts are manifested in changes in report writing, and in the instigation of a feedback form to use with children (Renault, 2018).   A research approach that aligns practice with an investigative attitude centred on the voices and questions of those participating in music therapy becomes a further outcome of the study with consequences for the future. Co-producing research, as I have previously noted, involves working to find out what matters to those with whom research takes place. As such, models such as action research, for example, may become frameworks of choice in working towards collaborative research endeavours (Stige, 2005; Warner, 2005; Elefant, 2010).

Looking ahead to developing such research approaches within the NHS is not, however, without its obstacles (Procter, 2014). While the research system is purported to be changing to better accommodate approaches other than the experimental, positivistic study, such change is not happening quickly. The privileging of quantitative over qualitative research, manifested in the design of the NHS ethics approval form, is perhaps also symbolic of the hierarchical power structures that underpin the wider institution. It is to be hoped that the pressure being brought to bear by leading healthcare academics in the UK, together with the emerging imperative for NHS Trusts to demonstrate patient and public involvement, will do much for the health research agenda in the future (Greenhalgh, 2017). Music therapy, as part of the wider grouping of Allied Health Professionals, has much to contribute to, and gain from, actively joining these debates.

Final Reflections on the Research Process

This study took as its focus everyday music therapy practice within my own working world. This focus brought specific challenges for me in the research process as the study unfolded. I have, of necessity, occupied various roles over time: practitioner, researcher, colleague, team manager. These have all offered differently angled ways of looking. They have also brought complexity to roles and relationships with those both actively participating in, and more loosely associated with, the research. I am aware that this has, at times, required others to make fine adjustments themselves to my changing and overlapping roles. While I cannot speak for all those involved in the study, from my perspective the entangling of roles has enriched the process, bringing research and practice into close contact with each other.

The proximity of practice and research brought with it, however, distinctive responsibilities. As researcher, a key concern was to understand and represent as honestly as possible the stories of those who participated in the study. As practitioner, and latterly manager, I needed to maintain an overarching responsibility for a group of staff, and the children and parents coming through the service. A third field of responsibility then emerged, in the 'in-between' area in which my researcher and practitioner selves met. This meeting ground enabled me to keep in mind the real-world context of the study, and the demanding work done within it day-by-day by children, families, and staff.

A vivid trail of human experience runs through this research arising directly from the nature of the setting. The CDS itself is inhabited by those who come in and out of it: children living with various challenges, parents and families for whom coming to music therapy is often a reminder of other, at times painful appointments, and those who work with families, seeking to offer the best possible support with often limited resources. There is an ebb and flow of emotional work for all. This was present through the research process itself, most clearly in the ways in which people spoke of their experiences, and the meanings such experiences held. I was frequently moved by the honesty with which people spoke of what were strongly felt moments in their lives. While I was able to make use of supervision, both within a research and clinical context, to reflect on these experiences, I also carried a responsibility to those who told their stories. Offering a response, if needed, was made possible through the ongoing relationships and encounters of the CDS, within which connections with me as both researcher and practitioner formed a part.

Being intimately connected with the people and place of the research brings a question as to the extent to which I was able to 'step back' from the practices I investigated. Returning to the 'trio' gives a way of reflecting on this. I began the formal research process with the notion of the music therapy trio already in mind. Born out of practice, it had offered me a way of understanding clinical dilemmas to that point. It then provided me with a conceptual springboard into research. In a way, I could be said to have stepped more fully into it at that point. The systematic activities of research, however, enabled me to consider the trio from the perspectives of others, repositioning my own understandings.

Ultimately, I have suggested that the trio is most useful as a way of thinking about this area of practice. As such it might be seen as more, or less than a trio, taking shape at times as a duo, quartet, or any other ensemble. As researcher, I have 'dropped in', as it were, to numerous trios through the research process, becoming part of the action if only for a time. But, in keeping with the trio as metaphor, so too have any number of other people, whether family, friends, CDS staff or any others who make up the broader meshwork of the child's world. The trio, as a heuristic then, gave me a particular way of continuing to consider and shift my own ways of looking at the practices being researched. Such reflective processes were further stimulated by processes of writing and supervision, together with the structures of the research methods used.

In part, my reflections lead me to suggest that the idea of 'stepping back' from the research phenomenon should also be treated with some caution. I have concluded that the contextualised nature of this study has meant an acceptance that the two lines of research and practice unfold alongside each other, touching, interweaving, each influencing the other. This has been a reality, and, I would argue, a strength of this particular study. My stance then has not necessarily been to step back unthinkingly. Indeed, to do so would, I believe, have compromised the everyday work needed for both. Instead, I have needed to step along each trail, alert as far as possible to my position at any one time. In doing so, I have tried to be as transparent as possible about this process at each stage. In part, that means acknowledging the limits of my own understanding. This thesis is of its people, place, and events, made possible by the extent and edges both of my knowledge, and that of all those involved at the time. In coming to an end, this work needs to stand as it is, with its flaws, limitations, and necessary incompleteness. Perhaps research and practice find themselves interweaving yet again in both striving towards a greater understanding of people relating one to another in, and beyond, music therapy.

7.5 On Endings and Beginnings

At the conclusion of this thesis, and as I reflect on its writing, I find I have three distinct hopes. First, that in the writing I have represented the voices and experiences of all those who have taken part as honestly as possible. Second, that in representing those voices I have done so in such a way as to give a persuasive and coherent account of the research into this particular area of music therapy.

My final hope for the thesis lies beyond the written page. As a practice-led study, its quality and usefulness is ultimately to be judged in whether 'people pick it up accordingly' (Dreier, 2008, p. 311). How, where, and by whom it might be picked up is, of course, impossible to know, and therefore relatively unimportant. What is important, however, is the hope that this thesis might contribute to changing practice, and provide the impulse for further research in the future. As Ingold, in a last word on threads, comments:

> Drawn threads invariably leave trailing ends that will, in their turn, be drawn into other knots with other threads. (Ingold, 2007, p. 169)

In drawing together the threads of this study, my hope is that this thesis adds further strands to the growing weave of knowledge and practice. If this is the case, then the trailing ends created by this study may themselves be woven into fresh meshworks, as children, parents, and therapists continue to work together in music therapy.

Postlude

For myself, the weave of this study has unfolded in and through time. While officially having a start date, marked by registration on the doctoral programme, unofficially it began long before. Its first threads can be found in my first experiences of working with children and their parents, strands that interwove over time as my working life changed. As I found myself working more closely with children and parents, and as I both wrote and talked about that work with parents and others, the need to ask more questions became more pressing. These questions led me directly to doctoral study.

The doctoral process and the specific demands of this study have both presented specific challenges for me. My roots in music therapy have been laid over many years in practice. Putting new roots into the research and academic worlds presented particular difficulties. At times, I was unsure which world I inhabited, and struggled to translate ideas and language from one to the other. Being a practitioner within the clinical environment in which I was also researcher brought these difficulties sharply into focus. The study's situatedness also meant that those complications were not mine alone: work colleagues and some parents also had to navigate their way around this with me. While occasionally longing for a 'cleaner' research environment, I now consider the proximity of practitioner and researcher, with all that comes with it, as a valuable part of the process, contributing both to my learning and to the richness of this thesis.

While having published work previously, the work of writing this thesis has made huge demands on me. It has required grappling with ideas, often new and complex, and working to get to the heart of what I want to express on the page. Bortoft (2012) again brought a fresh perspective to the act of writing. As though cognisant of my very real struggles to form thoughts which I was then unable to 'catch' once at my desk, he turns once again upstream, saying that 'sooner or later the words come, and as they do we see clearly *what* it is we want to say' (p. 128, italics author's own). With this guidance I began to trust rather more that in the act of writing itself, the thinking could be done, and as the words came, so too did previously elusive meanings appear. It is a lesson I continue to revisit.

That said, it is time now to turn away from writing and research, back to music therapy practice itself. In circling back, I recognise the extent to which the ways I approach my work have been touched by the research process. This is not overly surprising. As I said, the study has unfolded in time; many different factors have influenced my practice during the years of study. Nevertheless, there are some aspects which have been particularly affected. I am aware that I approach my contact with parents differently, that my curiosity about family life has changed, and my appreciation of the phenomenal knowledge, skill, and love that the vast majority of parents demonstrate day by day has grown hugely. With that has come a more humble questioning of what we, as practitioners, think we offer families in music therapy. This is not to devalue music therapy, but rather to understand it in more balanced proportion to the everyday lives of children and families.

It is not only the approach to my work that has been affected through the research, but also the type of work I now find myself doing. Recent charitable funding has enabled the music therapy service to work in partnership with maternity services within the hospital. The aims of this exploratory pilot project have been to consider in what ways music therapy might be helpful, and for whom, within maternity care, and what music therapy might 'look like' in such environments. This is an innovative area of practice, demanding new and creative ways of thinking. I find myself working with mothers hospitalised during pregnancy, or with fathers as they introduce me to their new babies in the days after birth. And as midwives talk of the impact of hearing live music on the ward, I begin to think differently about what musicing means, and for whom in a setting that is not bound by the walls of a therapy room. Innovative, it may be, but I also see it as directly emerging from the practices explored in this study, and the fresh ways of understanding them the enquiry has offered. Were it not for this study, I strongly suspect I may not have become involved in maternity- based work, and most certainly would not be approaching it in the way I am.

As I end with reflections on my own practice, I return to the shorthand image of the child, parent, and music therapist trio with which I began. In the Introduction I suggested the Mendelssohn Piano Trio No. 1 in D Minor as a potential musical template through which to understand the music therapy trio. I was interested in the ways in which musical lines interwove, and how that might illuminate the workings of the trio in music therapy. As the study progressed, it became clear that the apparently self-contained nature of the piano trio belied the more complex lines along which the music therapy trio was woven. Setting it aside until this point, I have now found myself

listening again for musical templates which better express a sense of the trio as I have come to know it, with the foregrounding and receding of multiple voices as they meld and separate from those around them.

As I have been writing I have also been listening. It is in Bach's Brandenburg Concerto No. 5 in D Major that I have found the music that brings this thesis to a close. Written for string orchestra and three solo instruments – flute, violin, and harpsichord – it has moments when those instruments are heard with clarity, or when they appear as individuals or pairs. Beyond that, though, soloists merge into the orchestra, becoming part of a different collective, or are supported in their 'trio-ing' by finely placed orchestral accompanying lines. It seems to me, even in the way it is presented in the score (Figure 8:1), with the soloists parts surrounding those of the orchestra, that it speaks of the trio as part of a wider ensemble.

Of the work that children, parents, and music therapists do together even Bach offers a poor or incomplete reflection.   It is as near as I can come, however, to a suitable musical metaphor at this point, and it is certainly one of great beauty. It is this sound world with which I am left as I finish this thesis, and which marks the completion of this research into music therapy with the child and parent.

Figure 0:1 Opening Bars of J. S. Bach Brandenburg Concerto No. 5 in D Major, BWV 1050

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Appendices

Appendix 1. CDS Leaflet.

Cheyne Child Development Service

Our service provides specialist assessment and healthcare therapy for children with significant developmental needs, including those who are likely to have difficulty accessing learning.

The service is committed to a child and family centred approach, and is organised into three geographically based teams:

St Dunstan's Clinic
St Dunstan's Road
Hammersmith
London
W6 8RB

Doughty House
Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH

South Westminster Centre for Health
82 Vincent Square
London
SW1P 2PF

Social Worker
The social worker for the Child Development service may visit you at home before the MDA to discuss it with you, answer any questions you may have, and talk about local services and resources that may be helpful.

The social worker may also act as a link person with the local social services office and can assist in claiming Disability Allowance.

Specialist Health Visitor (020 8846 6470)
The specialist health visitor is a health visitor with experience of working with families who have children with special needs.

He/she will work together with your family health visitor or school nurse to help you access community services that will offer you and your child the relevant support.

He/she can offer advice on the telephone or may do home visits to assess your family's needs. A visit can be offered before your child's MDA so that you can access the relevant services before your hospital appointment.

More Information

If you would like more information about our service or wish to discuss your child's needs, please contact the co-ordinator on 020 8846 1606 or 020 8846 6488.

Cheyne Child Development Service
Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH

T: 020 8746 8000
W: www.chelwest.nhs.uk

May 2010

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[Bengali] • [Tigrinian] • Lietuviškai
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Cheyne Child Development Service

Information for parents

Choose Chelsea and Westminster

Chelsea and Westminster Hospital **NHS**
NHS Foundation Trust

Multi-disciplinary assessment

Younger children who are referred to the service may be offered a Multi-Disciplinary Assessment (MDA) if there are significant concerns about one or more areas of development including large motor and fine motor movements, speech, language and behaviour.

The MDA involves appropriate professionals from the relevant team. The main aim of the MDA is to establish your child's developmental needs and to agree a plan to help ensure your child achieves his/her potential.

Children aged over 5 who are attending school may need detailed individual assessments and may already be involved with community school services such as speech and language therapy. In this case a review meeting may be arranged following individual professional assessments.

MDAs have 2 hours allotted for the appointment. In the first part the aim is to:

• find out about the family's concerns
• obtain necessary medical history, observe and assess the child's play and development
• complete a medical examination including weighing and measuring

This helps us to understand more clearly the nature of your child's needs and plan ways to help. We may need to arrange further assessments or tests which we will discuss with you.

In order to decide on these things we have a short break so the team can discuss together what we have seen and heard while you and your child also have a break.

We then meet with you to discuss our findings and to agree with you about the best ways to help. You will be given a brief handwritten summary to take away and a more detailed typed report will follow.

A review meeting, lasting up to 1 hour, may be arranged at this point for a future date and all the professionals working with your child will be invited to attend. This gives you a chance to review your child's progress with all those involved.

Who's who

Paediatrician
Paediatricians are doctors who have specialised in children's medicine.

Within each team there are doctors who have specialised further in the care, assessment and diagnosis of children with developmental problems and/or disability—this includes finding out whether there is a medical association, cause or consequence.

The doctor will want to spend some time carrying out play-based activities with your child to assess skills, including movement and usually follow with an ordinary medical examination.

Quite a lot of time will also be spent talking to you.

Speech and Language Therapist
The speech and language therapist looks at your child's communication including:

• understanding
• play and social development
• all aspects of communication including looking, pointing, gesture, as well as speech

The speech and language therapist will do this by asking how your child communicates with you and by observing play. They may ask your child to carry out some specific activities using familiar toys and pictures.

Following assessment, appropriate therapy input, if needed, will be discussed and planned with you.

Clinical Psychologist
A clinical psychologist is able to offer a psychological assessment and therapy to you and your child. This can involve:

• assessment of your child's development/learning abilities
• discussion and advice regarding your child's behaviour and emotional development
• discussion and advice regarding family relationships

The clinical psychologist will do this by talking with you and your child and, if appropriate, other family members about feelings and actions, by observing play and by asking your child to carry out specific tasks and exercises.

If following the assessment, therapy is needed, this will be discussed and planned with you.

Physiotherapist
Physiotherapy is a way of enabling your child to develop his or her physical independence, and of helping you and your child.

The paediatric physiotherapist has detailed knowledge and experience of normal and abnormal physical development in children.

If indicated, the physiotherapist will be present at the assessment and will want to look at your child to assess his or her physical skills and talk to you about your concerns.

The physiotherapist works in partnership with families and other professionals. It is vital for all children that their parents, carers and physiotherapist work together as a team.

Occupational Therapist
Occupational therapists assess and treat children who have delay or difficulties that affect their ability to independently achieve everyday occupational activities. Occupational therapists have expertise in:

• sensory development
• motor (movement) skills
• cognitive (learning) skills
• psychological and emotional areas
• social skills
• play development

The occupational therapist will assess your child by:

• discussing your concerns
• observing play and activity
• using standard assessments

(continued on back page)

Appendix 2. Music Therapy Referral Form.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Referral Form – Children & Young People's Music Therapy Services

Music therapy promotes a child's development across a range of areas and can provide support for the relationship between a child and his or her parents or carers. Music therapy is based on the understanding that children are able to respond to and participate in shared musical play irrespective of their developmental stage.

Please use additional sheets if required and attach any relevant reports e.g. MDA or MDR
Please print in CAPITALS

Child's Name:	**Name of Referrer:**
Hospital Number:	Profession/role:
Date of Birth:	Phone no:
Sex: Male/Female	Email address:
Parent(s) Carers(s) Name(s):	Have you discussed this referral with the child's parents/carers? Yes / No
Address:	What are the parents/carers main concerns?
Home Phone:	
Mobile Phone:	**Playgroup/ Nursery/ School:** Address:
Work Phone:	Phone:
Email:	Keyworker/ Teacher:

CDC Service/Borough/Pathway (please tick):

Cheyne Child Dev. Service		
Hammersmith & Fulham		
South K&C		
South Westminster		
Woodfield Road	SCD	Nurturing
North K&C		
North Westminster		

SENCo:

Phone no:

Name and address of GP:

Is the Child Development Service involved?
Yes / No

Recent or forthcoming MDA Date:

Recent or forthcoming MDR Date:

Other professionals involved:

Name:	Profession & Team:

Are there any current Child Protection/Safeguarding issues?
Yes / No

If yes, please provide details:

Child's Diagnosis (if known):

Does the child wear spectacles, hearing aids or use other equipment?

How does the child communicate?

English Language Spoken:- Yes/No

Would parents require support with form filling or interpretation? Yes ☐   No ☐

If YES, please specify the language required or additional support required:

Is there anything we need to know about this family which can assist us to support them?

Is there anything in/within the culture of the parents and child that we need to consider?

Does the child have a Statement of Special Educational Needs?   Yes /No

What kind of support does the child receive and what strategies are in place - e.g. School Action goals, or other therapy programmes?

Does the child have challenging behaviour?

Are they currently receiving any medication?

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Please send completed referral forms to the relevant team:

Cheyne Child Development Service -
(South Kensington & Chelsea, Hammersmith and Fulham and South Westminster)

The Music Therapy Service
Cheyne Child Development Service,
Doughty House,
369 Fulham Road,
London, SW10 9NH

Tel: 020 3315 6472

Woodfield Road Child Development Service -
(North Kensington and Chelsea and North Westminster Boroughs)

The Music Therapy Service
The Child Development Centre
Woodfield Road Medical Centre
7E Woodfield Road
London
W9 3XZ

Tel: 020 7266 8863

For any questions regarding music therapy please contact:

Stephen Sandford
Clinical Lead Music therapist
Chelsea and Westminster Hospital NHS Foundation Trust
Tel: 020 8846 6472 (Thursday & Friday)
Email: stephen.sandford@chelwest.nhs.uk

Find out more about music therapy at - www.chelwest.nhs.uk/musictherapy

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General description of child and their current needs –

What areas of development do you think a course of music therapy may help with?
(please choose up to three areas in which you feel that music therapy could support the child)

Communication	☑	Social	☑	Emotional	☑	Physical/Sensory needs -	☑
a) Intentional communication		a) Requesting interaction/initiating play		a) Expression of feelings e.g. frustration in relation to disability or communication skills		a) Purposeful use of hands	
b) Eye contact		b) Opportunities to be in control and direct play for themselves		b) Ability to regulate feelings and behaviour		b) Motivation to move/supporting impulse to move	
c) Shared attention		c) Accepting direction		c) Sharing feelings with others		c) Balance and co-ordination skills	
d) Communicative vocalisation		d) Positive experiences of flexibility, negotiation and change		d) Spontaneous enjoyment and fun		d) Hand eye co-ordination	
e) Gesture and signs		e) Building tolerance to sounds		e) Self-esteem and confidence		e) Body awareness	
f) Choosing		f) Concentration and attention		f) Support for parent/carer in understanding their child's difficulties and potential			
g) Turn-taking skills		g) Development of memory		g) separation from parent/carer			
h) Greater use of words through songs		h) Imaginative play					
		i) Using music to support child/parent play					
Other:		Other:		Other:		Other:	

Referrer's signature: _____   Date:_____

Appendix 3. Preliminary Study: Inclusion Criteria, Samples of Information and Consent Forms.

Inclusions and Exclusion Criteria – Preliminary Study

Inclusion criteria –

- Any family who are attending, or will soon be attending, music therapy sessions within the Child Development Service at the time of the recruitment process, and in which the parent will accompany the child in to the sessions.

- Any therapist from the Child Development Music Therapy Service

Exclusion criteria

- Any family who are attending, or will soon be attending, music therapy sessions within the Child Development Service at the time of the recruitment process, for whom the child will attend sessions accompanied by an adult other than the parent, or with no adult present.

- Any family who have not previously given consent for video recordings to be made of their child's therapy.

Sample of Information Form: Parents

CHEYNE CHILD DEVELOPMENT SERVICE

For children and young people

Music Therapy Department

Tel: 020 8846 6472 Fax: 020 8846 6480

Date/Version

Information Sheet for Parents/Carers

Dear ……………..

Your child has recently been having music therapy with ………… and you have been coming with him/her. I am writing to let you know about a small music therapy study which is being run here, and to invite you to take part in it.

What the study is about
When children come here for music therapy they often have one of their parents in the session with them. This project is interested in finding out more about music therapy with children and their parents through talking with a parent of one child who has had music therapy, and their therapist.
As part of the project I would like to find out more about your experiences of music therapy with your child.

What am I asking you to do

If you agree to be part of this study then I will arrange a meeting with you at a time that suits you. The meeting won't be any longer than an hour.

I am interested in finding out about your experiences of music therapy with your child. To help to do this, we will watch a video from one of your child's music therapy sessions. As we watch, you will be able to pause the video whenever you wish to make any comments you want. You will be able to pause the video as many times as you would like, speak as freely and fully as you wish. This process will be the same in the meeting with the therapist.

I will make an audio recording of the meeting which will then be typed up and used as a way of understanding the experiences of children, parents and therapists in music therapy trios. I will also select short sections of video so that I can write out the music and study it in that way.

If you agree to take part in this study but change your mind, then you are completely free to withdraw at any point. This will not affect your child's music therapy.

What I will do to help

If you agree to take part then I will take care to make sure that any information you give remains confidential, and will only be available to myself. Your name, the name of your child, or any other information about either of you will not be revealed as part of this study or in any subsequent publications. You will also be able to decide yourself how much you want to say as part of the discussion.

I will also ensure that all of the material from the discussion (for example, audio recording and written notes), is stored securely in a locked cupboard. These will all be destroyed once the project is completed. The original video recording will also be stored securely, just as it usually is in the music therapy service.

Helping you feel safe.

If as part of this process I became aware of any events or situations which might be harmful to your child or yourself, I would discuss these with you. I would also make sure that these concerns were passed on to appropriate people within Chelsea and Westminster Hospital to make sure that everyone is kept safe.

What will happen at the end of the project?

I hope that this pilot project will help the music therapists here at Chelsea and Westminster learn more about to working with children and their parents. I also hope that it will help us plan for a larger research project.

This project will be written up and made public in some form. I will make sure that you and your child remain anonymous in any publication, but will be happy to give you a copy of any publication produced.

Attached consent forms.

If you are happy to be part of the project then please sign and date the consent form attached.

Further info and contact details.

If you have any questions about the project, please contact Claire Flower. Once the project starts, and there is anything you are unhappy about then please contact ……………… who is the Independent Advisor for the project.

Thank you for your time and your interest in the project!

Claire Flower
Clinical Specialist Music Therapist

…………………
Independent Advisor

Sample of Informed Consent Form: Music Therapist.

Chelsea and Westminster Hospital **NHS**
NHS Foundation Trust

CHEYNE CHILD DEVELOPMENT SERVICE
For children and young people
Music Therapy Department
Tel: 020 8846 6472 Fax: 020 8846 6480

Date/Version

Music Therapy Project
Informed Consent Form for Parents/Carers

Thank you for agreeing to be part of the music therapy project about music therapy with children and parents/carers.

Please read the following list and circle your answer:

I have read the Information Sheet about taking part in this project.	YES / NO
I agree to take part and understand what I will be asked to do.	YES / NO
I agree that an existing video recording of a session of my child's music therapy can be used in this project.	YES / NO
I am happy for the discussion with the researcher to be audio recorded.	YES / NO
I understand that I can withdraw from this study at any time without having to give any reason.	YES / NO
I understand that the researcher will change my name so that I can not be identified.	YES / NO
I understand that any material to do with my participation (for example, audio recording, written notes), will be kept in locked storage within the Child Development Service, and that this material will be destroyed at the end of the project.	YES / NO
I agree to the findings from this study being published.	YES / NO

Name ....

Signature ....

Date ....

Sample of Assent Form: Child.

Date/Version

Music Therapy Sessions

You have been coming to music therapy with your Mum/Dad and ……………(therapist's name).

I would like to talk to your Mum/Dad and ……………….. (therapist's name) about your sessions and watch a DVD of one of your sessions with them.

I want to check if that's ok with you. Your Mum/Dad can help to let me know what you think.

☐   Yes, it's ok

☐   No, it's not ok.

Name of child ……………………..   Date ……………………..

Appendix 4. Descriptive Account of Whole Session

Narrative Description of Whole Session

Throughout, initials refer to the following –
B – child
Th – therapist
P – parent

RH – right hand
LH – left hand

In diagrams –
B – circle
Th – rectangle
P - triangle

2.14 start. B sitting on floor, leaning over a guitar to play. P and th talk, th sitting in front of B on the floor, p still standing sorting out buggy. As they talk th reaches intermittently over to B at his guitar, plucking strings (as though keeping him in mind, or part of the conversation).
Th – talking to B 'I think you're ready to start'
P – 'shall we put your glasses on?'
Th – picking up second guitar 'Make sure we leave time for piano today 'as though forwarding to end of session, signalling intent for closing activity).

Th introduces hello song (How?) As she does this, B is looking down at his guitar, particular plucking from th leads B to look up, at which point she says 'Shall we say hello?'
Hello song has musical direction to it, (familiar within this session?), and th makes it responsive to B (pauses with him, echoes his vocal sounds within the body of the song (his vocal sounds are short, single sounds here)).
? – th uses her voice (different various means) to stay in contact with B. She follows rise and fall of his sound. 'Ooh (with up and down), what a lovely start.'
5. These vocal shapes and continued guitar interest lead into a period of freer play. Th pauses for B – then raises her hand above the guitar, lowering it to strum as he looks towards her, catching her movement with his look. Th again pauses for child. Th then seems to end this game, signing and speaking 'finished'. (Does she feel as though L isn't picking up on what she offers?)

At this point, and from the start, the three are sitting like this…. (I notice p sitting just behind child, and the closeness of the contact between th and B)
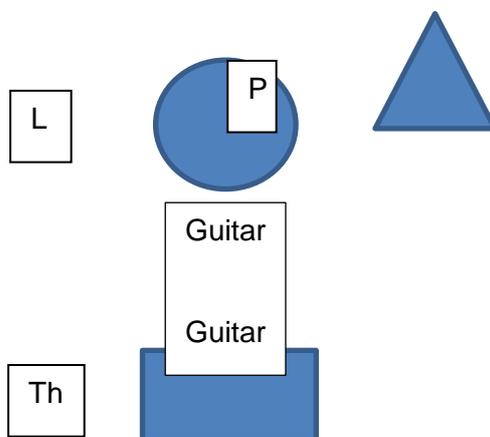
5.40 Th moves her own guitar away, B still resting on his, sitting, lying. Th offers tambourine, shaking it in front of him and singing formed melody line 'Oh, shall we play on this one?', putting tambourine down on floor in front of him.
Th plays it again on floor 'Are you ready for the tambourine?', and then plucks B's guitar (Is she trying to gain his attention here?)
Th moves B's guitar away, 'Bye guitar', B vocalises in up down swoop, P leans in to B and waves (as though emphasizing the bye).

6.30 Tambourine, shared play with th and B. Has p moved in a little more now (perhaps having used the waving action as opportunity?)
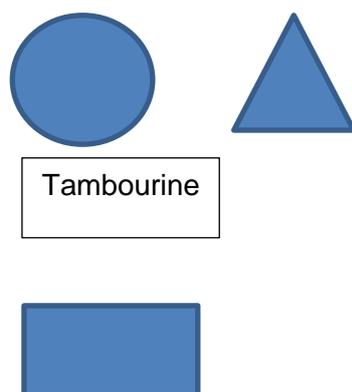
Tambourine

7.18 As part of song, th offers tambourine to parent, then on to B, then takes it to herself (as though involving parent directly, but also keeping the three of them together within frame of song).

7.56 Again, th offers tambourine to parent, then B. Quick to and fro excitement, backwards and forwards with some speed. Excitement as the musical phrase ends, laughing and movement from p and th. Pause, and then th asks 'Shall we do some more?' Slightly less clear patch of play then, B in and out, no clear musical thread here.

8.40 Back into formed song, from B to P again.

9.20 End of song. Pause. B puts his RH fingers in his mouth)
Th rests the tambourine on her lap, pulls over the big low floor drum. B starts to bang with his hands.

9.27 Th stands up to move to shelf. As she moves away, p leans in towards B. (First time we've clearly seen her head and face). Leans right in to B, and then, as th asks her something, leans back out again.

9.45 Th brings back three beaters. (Complex passage of play here involving exchanges of beaters, use of hands, etc).
Th offers 1 to child
P puts her hand on the drum
Chil drops beater, puts both hands on drum
P picks up beater, plays with it, B takes it from p.
P asks th if that was ok (th – 'Of course, of course' th to this point has sat back as though watching the two of them negotiating the new opportunities of the beater)
B drops beater, again 2 hands on drum.
P takes beater, offers it again to B.
Th also now uses 1 beater on drum.
B LH steadies himself on drum, beats with beater in RH. Pause 'Good boy' from p, and other sounds of approval.
Th offers beater to P
Th picks up guitar – L is watching her, while beating on drum with P.

B pauses, then begins again to beat, misses drum looking all the time at guitar.
Th begins to strum (picking up tempo of B's beating?)
B drops beater, leans over towards guitar – Words and laughing from th and P. Th says 'Oh dear, have I distracted you?' P still has beater in her hand, beats once.
Th beats drum with her hand (as though to redirect B's attention?)
B uses beater in RH on drum (P also beats?)
Th strums guitar, B leans in again to guitar. Again, th beats drum with hand. Echoed by P who beats drum too.

Now in to what feels like a fragile passage of play. B beats with beater in RH, using LH on drum. B also pausing to look at the beater.

11.22 P beats moving her beater towards B (as though to call for his attention?)

11.40 Again, P beats drum. B looks at guitar. Passage of play continues with various features –
- Th seems to try to pick up on B's beating, introduces a dotted melodic line, energetic. Is she wanting to sustain his beating and interaction?
Th takes up her own beater, and also expands beating to include tambourine, which is on floor next to large floor drum. (Furthest away from P)
B – multiple attempts to beat. He often generates the movement but misses the skin of drum and no sound is generated.
B is turned more to the therapist here. Doesn't appear to look at P.
P leans in and out, Sporadic beating. (Does her play follow the th?)
B touches, holds, looks at the beater
B occasionally vocalises, a high pitched up and down swoop.

14.05 Th offers what sounds like a final cadence. B resumes play briefly, and th and P join in to play again. Th then offers final cadence as B drops beater and looks up. Th – 'What a lot of banging!'
Th and P both talk (impression of great energy here, both talking and gesticulating at once, as though describing the prior play, summing up. B continues to beat drum and vocalises (a lower, longer sound?) as they talk.

All come in towards the floor drum. Th introduces two hand roll (B looks at her hands), then she raises hands, then back to drum. Repeats cycle. (Does Mum echo her movements here?)

14.49 Comes in to a song 'We'll bang together…' P looks at B, and her movements echoes those of th. Here the group are sitting like this –
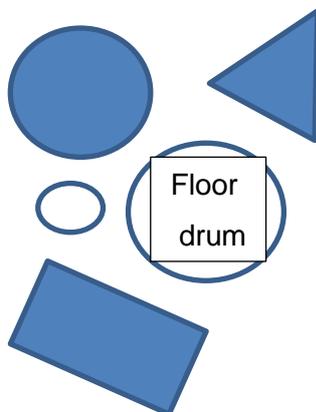
16 Th moves guitar out of way, and brings over (without getting up) a box of smaller instruments (such as hand bells, animal castanets etc.) B is still beating. The music has stopped (how?)
Th and P talk – B continues beating.

Th offers B box, B reaches in and takes green bell (nearest?)
Th moves floor drum away, and picks up her flute. Plays a short, low phrase, L looks up.
B fingers bell, looking at it. He laughs, seems to shudder and sit up further, Mum seems to echo his movement here, sitting up more upright herself.
B looks to therapist, puts bell to his mouth
Th keeps flute to her mouth, while taking two more bells out of box, moving them across in front of B. (I wonder why she is doing what she's doing here?) P picks one bell up

20.20 (I notice Mum sitting very still holding bell out in front of her. Still holding it…)

20.35 Th voices 'We've all got a bell', and begins a song 'We can ring together (Notice the dotted rhythm, or maybe triplets again here – seems to recur throughout?)
(Increasingly aware of lower pitched sounds from L)
More instruments from box – B seems to put them mainly to his mouth, or hold them close to his face, while vocalising, low, grunt/groan sound.
Th looks to clock –'How are we doing for time'
B busy with box and contents. The activity here seems to be between th and B. P seems to be sat v still looking at L.
Th often plays other instruments, or introduce vocal lines. Picks up cabasa, and plays with dotted rhythm. P sits with her left hand on the side of her head.

23.15 Th introduces putting things away in the box. P smiles at this (is this something shared between them – does this allude to what's happened in previous weeks?) Th also signals to Mum next activities, the ocean drum then piano.
P now becomes much more active. Moves in towards L more, and talks in clear loud voice 'B, in' repeated a number of times. The sound level and pitch of his vocalising seems to rise as she persists. Th joins in now, both speaking the clear 'In' word, but then moving it in to a song. 'In, in, in', with rising intervals, then changing words to 'Ti-dy up', again with rising shape.
As B puts bell in box someone says (P?) 'That was good tidying up'.
Th says 'Hard isn't it when you want to do a bit more'.
(Putting things in the box, then B taking them out goes on for a few minutes here)

25.15. Th brings in ocean drum. Game is between th and B (P does not hold on to instrument, though sitting close). Game is up and down.

29 Game brought to an end (by th?) P rubs her eye, B watches th roll drum away.
Th indicates it's time for the piano, signing piano play with her hands. P also enacts playing in front of L. Both adults move, th managing shifting chairs etc,P picks up B, comes to sit at piano with B on her lap.

30 B immediately places hands on keys and plays.
Th and B both play, P has arms wrapped round B's waist. (Is th working to 'catch' bits of B's play here?) Sudden loud exclamation from B, P smiles and looks at th. Th echoes sound of B's voice.

31.15 Th offers simple song line 'We can play together'. Now B looks v clearly and with stillness at her.

31.40 When th repeats same line, again B seems to still, although doesn't look clearly at her this time.
Again, sudden high pitched voice from B. P smiles at th. Th says 'Wow!'.

I realize in watching this section at piano, that it is the first time I can see parent's face fully.
The three are now sitting like this.
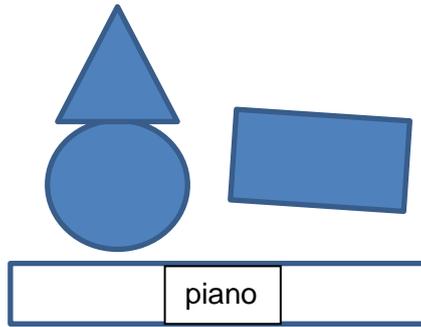
33.30 Cadence initiated by th. Th then talks to P. Pause then th begins goodbye song. Here the energy and pace of song (as in hello) is changed by the th in response to B's own sounds and movements.
Th finishes song, leans towards L.
B carries on playing. Th and P talk, as th leans over to turn off video camera.

Appendix 5. Samples of Interview Transcripts.

Parent Interview Transcript

KEY
R – researcher
P - parent
L – therapist

VIDEO STARTS and time – denotes when on the audio recording timings the video of session began to run. This is followed in next line by time on the audio recording when the video was paused.

1 R - Perhaps, just as we start, I mean one thing that would be good to know is how you came to
2 be in music therapy, how L came to be in music therapy, anyway, from what you remember.
3 P – I guess thinking back quite a long way now actually, um. Because B's got global
4 developmental delay we've been, we were seeing early on when he was just over a year old we
5 started seeing speech therapy and physio, and one of the things we noticed when we were, um,
6 working with him, trying to motivate him, was that music is a major motivator, and ever since B's
7 been teeny, when he was crying if I started singing to him he'd go silent. If there was music on
8 television he turns around you know music just really really engages him so his, I think it was
9 his speech therapist, K, who said 'Ah! I think he'd really love music therapy.' And then, quite
10 separately, I've got a friend who works in the music industry who'd done this little course with
11 music therapy and he said to me 'Oh, it's amazing, you must go and do this', so that kind of
12 gave me the confidence to kind of push for it and, and check how the referrals were going,
13 having heard separately about it as well. And, er, I think we were told we'd have to wait quite a
14 while and I think, you know, it wasn't too long a wait, and er, yeah, then B, B started from there.
15 And we were kind of, I was going to little groups in the children's centres where they do nursery
16 rhymes and things, but the problem I was having with that was B would cry quite a lot through
17 the sessions because there were so many other children, it was very noisy, um, so it didn't work
18 as well, as obviously music therapy's quite, quite a different experience from that,.um, but yeah,
19 that, that's kind of how I got involved, how I've, you know, was quite in, in, into the idea of it to
20 be honest.
21 R - And you've come for two lots now?
22 P – I've had two loads of one to one, the first was ten sessions the second was six, and then
23 we've also been to music, a music therapy group which is actually quite a different experience
24 with, with other children which is brilliant as well for different reasons but that, that was another
25 thing we've done. We did that twice but we couldn't attend quite a few of the second ones but
26 on and off quite a lot of music therapy, yeah
27 R – Yeah, OK. So if it's alright with you then we'll just have a look, have a look at the session
28 and as I said just pause it or shout whenever you want to, whenever you want to stop it to say
29 anything at all, ok, and I'm just going to write down the times. OK
30 VIDEO STARTS 2:34
31 3:04 p – Stop there a minute. When we first started, um, music therapy, B would never have
32 done any of this. I think that's important to say, um, the first thing you can notice he's
33 vocalising, that's very new, him vocalising in music therapy sessions. B's always been, at
34 home, when he was very small he'd kind of make noises and things, and then when he was out
35 and about be totally silent. And he's, he's, he's, I think his confidence has definitely grown, you
36 know, partly through what we're doing in music therapy, getting used to L and that environment,
37 and also his other little things he does as well, but it was this last load of music therapy where B
38 has started actually vocalising in sessions, so not just communicating by responding to what L
39 was doing but also with his voice. So I think that, that's really nice, that he's already making,
40 singing, almost, while he's playing, which he does a lot at home now.
41 R – Right, and you, and you really notice that?
42 P – Yes, and I remember that session I noticed it, yeah, and then, the only other thing I was
43 going to say as well is the way he's playing the guitar that again he's learned from music
44 therapy, which again it, because we're trying to encourage his fine motor skills it's brilliant (R
45 and P speak together – unclear) strings where he used to, like, just flick stuff, he'll actually
46 single them out and he's worked out that he's kind of playing a tune and that he can sing along

47 to it. And, he, he does this at home, he does it with the piano, and we've got a little mini ukulele
48 guitar thing and he'll sit there doing that at home now as well, it's really lovely.
49 R – Mm, ok. Is there anything else you want to say, or shall we go on (Mum laughs – unclear
50 comment)
51 VIDEO STARTS 4:44
52 5:40 P – Again, what was really lovely there, first of all eye contact, that's really great and that
53 again has really developed over the, the whole process of music therapy, the fact that B's
54 looking up and looking, looking at L as she's doing it, and looking at what she's doing, and then
55 also he kind of said 'hello,' so he, again communicating with his voice which, again the first
56 session he wasn't doing that at all, and in the group I'd say he probably wasn't doing that, and
57 that's come out recently, it's really lovely. He's doing it more at home as well now as well.
58 R – Mm. And are they things that you noticed at the time do you think or are you
59 P – That day I did, I remember I think saying it to L and I think maybe we saw, I saw you soon
60 after that, I think I remember saying something about it, so yeah, yeah, I noticed that at the time.
61 Sometimes you, I don't notice things, um, because you're so involved in it, or you're so used to
62 it that you don't see, but vocalising's quite a big thing, so I did,……..

Therapist Interview Transcript

KEY
R – researcher
Th – therapist participant.

VIDEO STARTS and time – denotes when on the audio recording timings the video of session began to run. This is followed in next line by time on the audio recording when the video was paused.

1   R – So, what I'm wanting to do, or what we're going to do today is, is just to find out a little bit
2   about your experiences.
3   Th – Mmm
4   R – Really, it's about what it's like for you being in music therapy with B and his Mum. And
5   what, what we're going to do is just watch some of the video and I'm just going to ask you to
6   pause it, stop it, and whatever the easiest thing to do is, it's probably just to hit the pause.
7   Th – Yeah
8   R – At any point that you want so just to say anything that comes to your mind
9   Th – OK
10 R – About what you're seeing right now, or what it reminds you of, or, or anything at all
11 Th – Mmm. OK
12 R – OK? Um, and when you pause it, the only writing I'm going to do is just to write down the
13 time
14 Th – Oh, OK
15 R – OK? So that I've got a note of that and it means that I can go back to it later and look at
16 some of those points a bit more and I'm not writing anything otherwise, apart from that. So, is
17 that OK?
18 Th – That's fine, yeah.
19 R – Yeah, ok.
20 Th – I don't know, do I need to give you any kind of details about, kind of background or
21 anything, or is that just if it comes up?
22 R – Well I was just going to ask you, perhaps as a way of starting, whether you can just say,
23 um, a bit about how you came to, to be in, in this session I suppose, how you came to be in
24 music therapy with B and his Mum anyway? And you can give me as much or as little detail on
25 that as possible, but maybe that's a good place to start?

26   Th – Mmm yeah, yeah, just to give some background. Um, so B's a little boy who I've seen
27   quite a lot of over the past year or so, so I was involved in his initial assessment when he was
28   referred here to the kind of core service, and then picked him up off the waiting list for a block of
29   individual sessions, mmm, and following that we, parents were really keen for more and there
30   wasn't anything immediately happening here so, um, he, he is in the kind of area where we
31   were doing some of the H and F community work so he ended up coming to a group, umm, that
32   we did that was a new group for children with additional needs and their carers, very kind of
33   broad range of children and families, umm, and that was great because I think Mum, it was
34   around a similar time that Mum stopped working to just kind of be with B and care for him and
35   things, and it was something that she could come and meet other parents and also interesting
36   to see B in that different situation which I think was hard for him at times because it was, could
37   be quite a big group some weeks and it, you could just tell that it was a bit overwhelming at
38   times but good that he kind, he got very used to it and he got familiar with things and I think
39   quite nice for Mum to see that, um, but I think we both had that sense of this is just big and a lot
40   for him and there was, something wasn't quite happening that was happening when he came for
41   the one-to-one
42   R – Right, and you think you both (unclear)
43   Th – Yeah, I think so and we kind of talked as we went along and then had a chat with her over
44   the phone, and the group came to an end, um, and he was, he was still on our list here anyway
45   so um, so yeah, when a space came up I offered him another, shorter block of sessions, so he
46   had six in this recent block whereas he's come for ten before, um, and that was really
47   interesting then, to kind of pick him up having seen him very recently but in a very different way,
48   because I guess I found it easier to, to compare kind of how he was responding and how we
49   were playing together to the previous one-to-one sessions we'd had, and I hadn't had the
50   space or the ability to do that in the group because there was so much else going on. Um, so
51   there's been quite a positive feel I think to this block because he, having him in here, and being
52   able to focus on him, being able to see what he's doing that he wasn't doing, I think it's almost
53   exactly a year ago that we finished the last block, so
54   yeah, this is kind of quite a long way in to the picture with B.
55   R – Mm, mm, and you've had the experience of being with him here and then it expanding out
56   to include, to include a group and a different setting and other children, and then, and then
57   coming back to something quite, well more focused here.
58   Th – Yes, yeah, umm, and I think that, I don't know, perhaps, there's something very rewarding
59   in working with him in this setting that I kind of knew that I wasn't,um, wasn't kind of getting from
60   him, or he wasn't getting from me or the group or whatever it was in that, in the kind of wider
61   community setting
62   R – Mmm
63   Th – Um, but that perhaps that was something more for Mum than him to come to and who they
64   could meet and things, cos there were some other children who really took, you know, (unclear?
65   Liked having?) B there and became quite familiar with him so he was getting something but it
66   was just coming back in here that felt more, felt just more focused
67   R – Mmm
68   Th – and positive in a different way.
69   R – Mmm, so shall we have a look
70   Th – Yeah, so this is the, the last session I think
71   VIDEO STARTS 5.50 (on audio recording)
72   6.14 Th – So this is a, I'll just pause it, this is a kind of set-up that we have had every week at
73   the start, and I think I use the guitars because he was so, um, familiar with them from the group,
74   so I felt that maybe it made it (unclear - a bit easier?) for me but also Mum has talked quite a lot
75   about how they have
76   one at home and I think Dad plays the guitar, err, and it's, it's just felt like a nice marker for him
77   to have them down there. Umm, but..
78   R – something familiar from the group but from home as well
79   Th – Yeah, I think so, because Dad was actually able to come to I think one of the last sessions
80   last year but he, because of work obviously couldn't get here, um, so yeah, I think most weeks
81   there's a comment about how he's been using it at home so perhaps it's something about
82   bringing in, you know, dad a bit
83   R – Mmm
84   Th – and what's happening at home. Um, I'll play it again
85   R – Mmm

86   VIDEO STARTS 7.23
87   8.42 Th – That moment there when he, um, when he looked up has been kind of one of the key
88   differences I think in this block which I think, there's a kind of smile on Mum's face when he
89   does that, um, because previously it's been very hard to tell, um, what his awareness is of other
90   people playing with him or
91
92   being around him, um, yeah, his awareness and you know whether that's a positive thing or it's
93   too much so there's been very little kind of eye contact at all or acknowledgement really of, but
94   over this block, especially at the start you get this real sense of (outbreath) 'Ahh, You're here
95   too' and, um, that's something that Mum and I have talked a bit about, um and I was just going
96   to mention that previously he's not been as physically strong, um, so her role has, was, in the
97   last block a lot about kind of supporting him from behind, um, and so it was a lot of kind of me
98   and him playing and her kind of being physically supportive rather than being involved, so when
99   we've looked at video before, um, it's been very interesting for her, I think, to see it from the
100   other way round
101   R – Because she wouldn't have seen it before from that, seen him so clearly?
102   Th – Yeah, so literally kind of holding him up at the drum, or with him and then the guitar like
103   this, um, so there's been a bit of a sense of opening out a bit I think so it's a bit of more of a trio
104   at times rather than a kind of straight line or something, don't know.
105   R – (And she's/actually? Unclear) sitting, sitting a bit more beside him
106   Th – Yeah, yeah, although I, at times I'm not sure about that this week because I haven't
107   watched the video since we did the session but I think there were sessions where I think we
108   almost tended to revert to that position a bit and I had to, perhaps, just initiate her coming in to it
109   a bit more, um,
110   R – And how would you do that?
111   Th- Um, I, probably, not necessarily in this opening part but by, just by introducing something
112   that we could share, um, kind of practically be around together, um, and I think it would be me
113   as much as her that would allow that to happen (to go? Unclear) actually we can, we can do it
114   together, um, so I'd be interested to see what happens this week
115   R – Right
116   Th – yeah, being the last session, whether that kind of happens more or less. There's also a bit
117   of a sense this week I think of wanting to get everything in that we've done cos, because his
118   focus had got better, um, a few sessions previously we'd got to the point at the end of the
119   session where, say, we hadn't made it to the piano or done something he particularly liked, and
120   I think we talked about 'Oh, it'll be the last one' and wanting to have a bit of everything
121   R – Mm, mm. So that, that is why you, you say something about
122   Th – Yeah,
123   R – about wanting to get to the piano this week
124   Th – Yeah. Shall I play it?
125   R – Mm………

Appendix 6. Emerging Statements.

Therapist Transcript - Emerging Statements	Illustrative Quotation – Line in Transcript Indicated
Making sense of the child in music therapy in the present in relation to the past.	Line 58-60 'So there's been quite a positive feel I think to this block…and being able to focus on him, being able to see what he's doing that he wasn't doing. I think it's almost exactly a year ago that we finished the last block, so this is kind of quite a long way in to the picture with Barney.' Line 350-353 'Thinking about this part of the session and some of the smaller instruments, and the way he uses them, I think is quite different to how he plays in what we've seen so far and reminds me of some of the less, less interactive Barney that we saw in the group and previous block.'
The child emerging as a relating individual	Line 330-333 'There's quite a lot of what he's doing at the moment that feels quite new, in terms of all that vocalising which just wasn't there really at all until quite recently, and his kind of gaze up and you know, at us.' Line 103-105 '(Previously) there's been very little kind of eye contact at all or acknowledgement really of, but over this block, especially at the start you get this real sense of (audible outbreath, as though imitating child) 'Ahh, you're here too'.'
The emerging possibility of a trio	Line 107-110 'Previously he's not been as physically strong, so it was a lot of me and him playing and her kind of being physically supportive rather than being involved….literally holding him up at the drum. There's been a bit of a sense of opening out a bit I think so it's a bit more of a trio at times rather than a kind of straight line or something.' Line 264-267 Commenting on the child's recently acquired capacity to hold and manipulate the drum beaters, 'Bringing the beaters in as a thing in the session has been quite a marker I think, or a little bit of achievement that we do in the middle that's a physical thing that he's doing that he wasn't and it allows us to do something a bit different.'
Making sense of the child's sensory activity	Line 353-357 Commenting on the child's use of a hand held bell, 'He becomes quite fascinated with things that are near his face and his mouth and especially that I think he has the bell on his mouth and he flicks it along, feeling the sense of it and the feel of it as well as hearing the sound.' Line 374-381 'His vocalising is a bit different as well, it's got more a self-stimulating quality or something to it, it's less spontaneous or, no it's still spontaneous but less of an expression of his enjoyment of something than it was before. It's more just 'Ooh I'm quite enjoying this'. It's about his sensory stimulation'
Making sense of the child's	Line 145-154 'He can find putting things away, finishing with things quite difficult…At the end of

experiences of transitions and endings	something big and focused, like if we'd been at the piano together, and if he got a sense of the end of the session coming, he did really show distress and things. And, I guess awareness on some level of something coming to an end. So I introduced this idea of trying to give him a bit of a sense of there's something else, this will go but there will be something else.'

Line 208-210
'There was a moment there (on video) of him wavering a bit I think, or just showing a tiny bit of the distress that I've seen before when something's gone, or finished or, in the group if it got too loud…it just always feels a bit of a tightrope with him as well about when is it going to be too much.' |
| Attuning to the close attunement of mother to child | Line 97-100
'That moment there when he when he looked up has been one of the key differences I think in this block. There's a kind of smile on Mum's face when he does that because previously it's been very hard to tell what his awareness is of other people playing with him.'

Line 222-228
'When he (child) has become a bit upset I think Mum manages it very well in that she can comfort him. But she sees it as a kind of, 'well he'll be OK, he does kind of get distressed at times and things'. But I maybe feel this 'Oh no, is that going to happen again?', and she's the one that can be quite calm about it or let it happen if it needs to, or calm him down when he needs it.' |
| Speculating on the mother finding a role | Line 246-254
Pauses the video to comment on the parent asking the therapist if she can help the child to hold a drum beater,
'That's interesting 'cos I think Mum says 'is it alright if I help him to hold it', perhaps suggesting she's anxious about not wanting to do too much. And I think I did a, 'Oh, of course, you know.' I found it interesting at that moment that I then thought about why does she not feel like she can. Because it's the last session and actually I've felt that she's been quite sensitive about how much she is involved or not, but I think she just literally wants to show him how we hold it and then he can do it.'

Line 320-326
'I think I noticed there that Mum stopped playing a lot or she started a bit and then paused again and I think at the time I was thinking 'oh', 'cos she's always very attentive to kind of what his expression is or how he's playing but watching it I was wondering if she was wondering how to play or how to be part of it a bit. Maybe just showing her that's quite a new thing for him to be actively involved in the music, it's hard to know what her experience is of it.' |
| Following the mother's initiatives | Line 152-160
'Practical things that we've been thinking about in sessions and perhaps that Mum's brought in, is that he can find putting things away, finishing with things quite difficult… So I introduced this kind of idea of trying to give him a bit of a sense of there's something else… I think Mum's working on that at home as being a strategy for helping him to manage a transition….'Cos she'd brought it up a few times it felt quite important to try and bring it in to what we were doing here.' |
| Accompanying mother and child | Line 289-292
Commenting on her use of the guitar to accompany the parent and child playing together,
'As I watched myself do that just now I think I had the same impulse again which was 'Oh look, something's happening that they're doing together that I can support', play more of a supportive role, wanting to come underneath it.'

Line 302-306
Commenting on the way in which she might support the reciprocal play of parent and child, |

	'Giving them a bit of a framework to play as part of. Maybe because I imagine that Mum playing with Barney in that way might be quite difficult for her to know how to keep it going or how to sustain it. And so that my role might then be to give them something to play within.' Line 459-466 Speculating on future music therapy, 'You know what I was talking about before of Mum and Barney doing things together and me trying to withdraw a bit or, play a bit more of an accompanying role or something. It feels like there's the possibility for that now that he's showing more active kind of awareness.'
Balancing relationships within the trio	Line 278-282 Pausing the video to comment on how, in picking up the guitar to accompany the parent and child playing together on the drum, the attention of the child is drawn to the guitar, 'I remember feeling quite guilty at that point, that there was potentially something quite nice that had been possible with Mum. And then I went for the guitar without really thinking about it and actually that's probably the worst thing I could have chosen because of his association with it and how much he is motivated by it. And it's immediate isn't it, that he turns to me. So, just reflecting back on that, probably the timing of that not being great.' Line 305-309 Commenting on her impulse to encourage the parent/child play, 'My role might then be to give them something to play within. But actually retrospectively I could have probably just let them play. But what happens is Barney comes back to it being me and him, and him wanting something that I've got, and Mum, well she's stuck there with the beater.' Line 452-458 Commenting on playing at the piano, 'It feels a bit more companionable at the piano, we can be side by side and maybe that's just easier for him and he can see my hands rather than all of me. But I think the effect is or how it ends up, is that it's me, very definitely me and him. And Mum's physically holding him, and not playing, so it feels like just the two of us rather than the three of us.'
Contextualising the trio in terms of other people and places	Line 85-92 On the decision to start each session with the guitar, 'Mum has talked quite a lot about how they have one at home and I think Dad plays the guitar…Dad was able to come to one of the last sessions last year but because of work obviously couldn't get here. So I think most weeks there's a comment about how he's been using it at home so perhaps it's something about bringing in Dad a bit.' Line 272-275 Commenting on his recent physical developments, 'In the last block his physiotherapist came in to a few sessions so I guess we had a bit of a practical, physical element to what was happening in here.'

Parent Transcript – Emerging Statements	Illustrative Quotation – Line in Transcript Indicated
Making sense of the child in music therapy in the present in relation to the past.	Line 50-54 'The only other thing I was going to say as well is the way he's playing the guitar. That again he's learned from music therapy, which, because we're trying to encourage his fine motor skills, it's brilliant. He used to just flick stuff, he'll actually single them (the strings) out.'

	Line 62-68 'What was really lovely there, first of all eye contact. That's really great and that again has really developed over the whole process of music therapy. The fact that Barney's looking up and looking at Laura as she's doing it, and looking at what she's doing. And then also he kind of said 'hello'. So he's communicating with his voice which, again in the first session he wasn't doing that at all.' Line 178-181 'Again, it's all new things that Barney's learned, Barney's just started holding a beater, and hitting objects with it. It's really nice in these sessions for him to have a go at doing it. He's actually quite proud of himself as well that he can do it.'
The child emerging as a relating individual	Line 82-89 'I can see that he actually looked at Laura and was engaging with her, which is really lovely, and he is vocalising to her. I keep talking about vocalising but it is such a big thing. He's actually having almost a conversation with her there.' Line 44-48 'It was this last load of music therapy where Barney has started actually vocalising in sessions, so not just communicating by responding to what Laura was doing but also with his voice.'
Experiencing music therapy as a positive event	Line 111-115 'One thing I'd say generally about the music therapy sessions is that it's something very positive. You come away feeling really positive from the sessions. Well I guess it's because Barney enjoys music so he's not resistant, whereas with all the other things we've done, at least initially, Barney found it very hard and would cry.' Line 121-124 'Generally just coming to this has always been really positive, and he just loves it, he never wants it to finish, so from my point of view that's great, 'cos I can see he's happy, he's not crying. He's enjoying himself. It's really nice.'
Making sense of the child's sensorial activity	Line 289-295 'Sometimes Barney will get very drawn in by particular things, like toys and instruments. So here I was thinking he's not engaging so much in what's around him because he's worked out that there's a vibration coming off the bell which he can put to his mouth.' Line 299-308 'Maybe he is listening but he's choosing not to listen to us because he wants to just have that oral stimulation at the moment. That, and his whole thing about vibrations, anything in his mouth, he must be getting tons of input from that because it does tend to make him zone out a little bit sometimes.'
Making sense of the child's experiences of transitions and endings	Line 122-123 Commenting on music therapy sessions, 'This has always been really positive, and he just loves it, he never wants it to finish.' Line 295-299 'One of the things we're trying to teach him is to put things back in the box which is a bit of a challenge 'cos he never wants to give things back. And so he might drop one in and then you'll, we'll see in a minute he'll pull another one out.' Line 348-363 'From the beginning (of music therapy) he just loved the piano. And we always try and make sure at the end of each session that's what we finish on as well. And so it's like the real treat at the end to get the piano time. He wouldn't ever finish if he had the choice with the piano I'm afraid!'
Finding a role	Line 140-147 'I know that when I, when I first started music therapy I was really conscious, I don't know why, not to get involved and to let Barney be the one to initiate. I was quite nervous about that at the beginning, so I wasn't sure what I was supposed to do.' I guess it must just depend on the parent and the situation.'

	Line 164-172 'At the beginning in particular I had to consciously sit back and just not do things 'cos I think it was important that he bond with Laura. And I'd just wait to be told when I needed to be involved rather than, you know, try and make him do things, 'cos it would change his experience of it as well. I remember at the beginning thinking like that, I don't know, because Laura has these little games she makes us do and I'm used to it but at the beginning I remember being a little bit 'I'd better make sure, I, you know, don't get involved (laughs), try to just sit back and just watch'.' Line 209-220 Commenting on her use of beaters on the drum alongside her child, 'Early on in the sessions I never would have done that. But as we've come along we've kind of built and got much more…I've, as a parent got more comfortable in the sessions and knowing what to expect as well. And getting to know Laura as well. I just remember before that I wouldn't have been confident to do that maybe at the beginning'
Valuing the witnessing of the child as an interactive individual	Line 269-276 'It's just nice to watch how he responds, and see what he's doing, 'cos, you know, then I'm the third party, I'm not the one doing the therapy. You know often a lot of the things that we're doing we're being taught so we can do it at home. But it's nice sitting there and watching, seeing how he responds, 'cos you can really see that in here which is nice.' Line 252-259 Commenting on the therapist playing flute, 'That sound he does on the bell, and she kind of repeats it almost exactly. It's like 'Ooh (inbreath)' and then smiles 'cos he's realised there's a game there, which is lovely. Which again is what Laura does most of. At the piano it's very obvious as well. He kind of will look at her and realise she's kind of copying the loudness, the quietness, or the number of bars if she plays, and so he plays with her.'
Linking music therapy activity fluidly with other people and places	Line 261-269 'We try and copy some of it at home as well because some of it is very similar to speech therapy too. This idea that if Barney makes vocalisations, copy them, or if you can't, interpret them in to a word…And so we'll sit at the dinner table, if he's banging the table my husband would bang the table too and we'll do responses, you know, respond and communicate. We've kind of learned that from speech therapy and watching music therapy.' Line 325-329 'At home now we play a game with up and down with a cloth, and we do a similar song to the one Laura made up. But I got the idea from Laura, and he'll reach up and he'll shout, and with this now, this game, he's got quite confident and will demand 'I want it down here'.'
Observing the child is contingent on pragmatics	Line 76-84 'You can't always see, like where I'm sitting there you can't see the eye contact side of things so that's interesting, because I can see he's looking right at the guitar. (It) is obviously where I'd chosen to sit. Barney will often look around, and he'll look out a window, you can't always tell where he's looking if you're sitting behind him. From here I can see that he actually looked at Laura and was engaging with her.'

Appendix 7. Graphic Representation of Key Themes.

Graphic Representation of Key Statements

Chronological Time

The child in time emerging as a relating individual

The child in time emerging as a relating individual

Understanding the child's ongoing developmental needs through the lens of music therapy activity

Understanding the child's ongoing developmental needs through the lens of music therapy activity

Experiencing as positive the witnessing of the child as an engaged, interactive partner

Attuning to, and accompanying the mother and child as a pair

Speculating on and responding to the mother's finding of a role

Child

Therapist

Parent

The trio appears as a set of dynamic relationships, manifested in relation to people and places

Finding a role as parent happens within evolving relationships and pragmatic factors

Music therapy as part of everyday life

Key to colours

Themes from parent interview

Themes from therapist interview

Appendix 8. Graphic Score: Handwritten and Computer Generated Versions.

Therapist Comment - 10:37
"I remember feeling quite guilty at that point, that there was potentially something quite nice that had been possible with Mum and then... I went for the guitar without really thinking about it and actually that's probably the worst thing I could have chosen because of his kind of association with it and how much he is motivated by it.
As I watched myself do that just now I think I had the same impulse again which was 'Oh look, something's happening that they're doing together that I can support', play a more of a supportive role, sort of wanting to come underneath it...
But actually retrospectively I could have probably just let them play. But what happens is then Barney comes back to it being me and him... and Mum kind of, well she's stuck there with the beater."

Appendix 9. Patternings in Microanalysis: 9:57 – 10:47.

Clarification of Terms.

- Child often makes beating motion while not actually striking drum to create sound. I have included these moments as 'musical' when the intention (signalled in posture, gaze etc) appears to be to create sound, and labelled them 'air beats'.
- Some moments when a pair play fall within a larger segment in which all three play at different times. For example, parent and therapist playing drum and guitar at 10:41 At such points, I have chosen to subsume the playing of the pair into the larger pattern of the trio.
- An exemplar of each identifier is marked within the large scale graphic representation.

Identifier in score (one example of each)	Patterns	Activity	Timing	Comments
	In pairs			
A	Therapist and child	Drum Tambourine/drum Guitar/drum Voice/guitar	9:57-9:58 10:01-10.02 10:25-10:28 10:42-10:47	Episodes of playing concurrently.
B	Therapist and child	Drum Guitar/drum	9:57-9:57 10:24-10:25 10:35-10:36	All examples of child playing two drum beats or guitar strums before therapist joins.
C	Parent and child	Drum	9:58-10:00 10:14-10:16 10:17-10:18	All examples of playing at the same time Child plays air beats Child plays air beats
D	Parent and child	Voice/drum	10:03-10:04 10:21-10:22	Parent vocalises (M) full 6/8 bar before child begins to beat drum
E	Therapist+child/ parent+child	Drum and voice	9:57-10:05 10:14-10:19	Music alternates between each pair
	The trio			
F		All singing/playing	10:07-10:10	Actual timing of all thee 'sounding' is extremely brief and framed either side by activity of pairs or individuals. Arc of play?
G		All silent	10:09-10:11 10:28-10:30	Little resonance from previous sound, and little physical movement. Held guitar chord continues sounding through this period, and child is

				beginning to move towards the guitar.
H		Episodes of shifting pairs within a trio interplay	10:03-10:10	Could draw arc here – parent/ parent+child/ trio/ therapist
			10:30-10:36	More fragmented arc – Therapist/ therapist+parent/ child - so never trio, although as above there is movement towards sound.
			10:36-10:47	Therapist/ therapist+child/ trio/ therapist+child – although trio is never in sound, includes child's movement towards guitar, towards making sound.
I	**Moments of Handovers Between Pairs**	Therapist+child – parent+child Parent+child – therapist+child Therapist+child – parent+child Parent+child – therapist+child	9.58-9:58 10:00-10:01 10:02-10:03 10:15-10:16	Swift exchanges.
J	**Rhythmic Patterns**	In 6/8 quaver, quaver rest, quaver	9:57-9:58 10:01-10:02 10:36-10:36	Suggested by child, picked up by therapist Therapist and child together Therapist. **All drummed**
K		In 6/8 crotchet, quaver, quaver, crotchet.	10:03-10:04 10:16-10:17 10:21-10:22	Parent voice, repeats once Therapist voice Parent voice **All used melodically**
L		6/8 pulse dotted crotchets	10:04-10:08 10:07-10:10 10:09-10:10 10:11-10:28 10:14-10:15 10:17-10:19 10:41-10:42	Child drumming Therapist drumming Therapist voices pulse Child drumming Parent drumming Parent drumming Parent drumming
M	**Melodic Patterns**	'Barney do it'	10:03-10:04 10:04-10:05 10:21-10:22	Parent voice Parent voice – slight alteration in interval Parent sings. **All use same rhythm pattern as K**

N	**Emergence of Tonal Centre.** The guitar chords, beginning at 10:25 move between E and A major. A tonal centre of E major can be seen to have its roots in a number of previous musical events as follows – **10:03-10:05** Melodic unit (M) spoken/sung by parent. E above middle C, down to B below. Modified on repeat to E down to C sharp. **10:16 – 10:28** Two melodic fragments of therapist, followed by (M) from parent. As a whole these could suggest a harmonic progression within E major of IV – V – I (A major (sub-dominant), B major (dominant), E major (tonic)), which is confirmed by subsequent guitar chords of E major and A major.			

Appendix 10. Main Study: Inclusion Criteria, Information and Consent Forms.

Inclusion and Exclusion Criteria – Main Study

Inclusion criteria –

- Any parents who have attended or are attending music therapy sessions with their child within the Child Development Service at the time of the recruitment process.

- Any therapist from the Child Development music therapy service.

- Any staff member from the Child Development Service, across all disciplines.

Exclusion criteria

- Any parents whose child has attended or is attending music therapy sessions within the Child Development Service at the time of the recruitment process, but who does not accompany them into sessions. This might include parents who remain in the waiting room while their child has music therapy, or where another adult attends sessions with the child.

Sample Information Form: Parent.

CHEYNE CHILD DEVELOPMENT SERVICE

For children and young people

Music Therapy Department

Tel: 020 3315 6472

Date/Version

Information Sheet for Parents

Dear ……………..

Your child has recently been for a music therapy assessment, and has either started, or is going to start, a course of sessions soon. You will be coming with him/her to the sessions. I am writing to let you know about a music therapy study which is being run here, and to invite you to take part in it.

What the study is about
When children come here for music therapy they often have one of their parents in the session with them. This project is interested in finding out more about music therapy with children and their parents. We are interested in finding out parents' views on their child's music therapy, and the ways in which you have been involved in it. We are doing that by inviting parents to come to two discussion groups with other parents over the next few months. Discussion groups will also be run with music therapists, and with other Child Development Service staff.

What am I asking you to do

If you agree to be part of this study then you will be invited to a discussion group in the next few weeks with roughly 6 other parents. We will arrange a time for that meeting which suits everyone. The discussion will last for no more than an hour and a half.

Before the meeting I will ask you to fill in a short question sheet, which I will collect from you before the group. This will give you a chance to think about some of the areas we are going to cover in the discussion, and give me an opportunity to find out beforehand what things are most important to you. We will also watch some clips of music therapy together in the group as part of the discussion.

I will make an audio recording of the discussion which will then be typed up and used as a way of understanding how children, parents and therapists work together in music therapy.

If you agree to take part in this study but change your mind, then you are completely free to withdraw at any point. This will not affect your child's music therapy.

What I will do to help

If you agree to take part then I will take care to make sure that any information you give remains confidential, and will only be available to myself. Your name, the name of your child, or any other information about either of you will not be revealed as part of this study or in any subsequent publications. You will also be able to decide yourself how much you want to say as part of the discussion.

I will also ensure that all of the material from the discussion (for example, audio recording and written notes), is stored securely in a locked cupboard. These will all be destroyed once the project is completed.

Helping you feel safe.

If as part of this process I became aware of any events or situations which might be harmful to your child or yourself, I would discuss these with you. I would also make sure that these concerns were passed on to appropriate people within Chelsea and Westminster Hospital to make sure that everyone is kept safe.

What will happen at the end of the project?

We hope that this project will help the music therapists here at Chelsea and Westminster learn more about working with children and their parents.

This project forms part of a research training, and will be written up in a thesis. Parts of it may also be published elsewhere. I will make sure that you remain anonymous in any publication, but will be happy to give you a copy of any publications produced.

Attached consent forms.

If you are happy to be part of the project then please sign and date the consent form attached.

Further info and contact details.

If you have any questions about the project, please contact Claire Flower. Her email address is Claire.flower@chelwest.nhs.uk and phone number is 0208 846 6472. Once the project starts, and there is anything you are unhappy about then please contact Stephen Sandford, Music Therapy Clinical Lead who is the Independent Advisor for the project. His email address is Stephen.sandford@chelwest.nhs.uk and phone number is 0208 846 6472. Alternatively, you can contact the Membership and Patient Advice Liaison Service (M-PALS) at Chelsea and Westminster Hospital. Their email address is m-pals@chelwest.nhs.uk and phone number is 0203 315 6727.

You can also write to any of these people at -
Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH
Thank you for your time and your interest in the project!

Claire Flower

Sample of Informed Consent Form: Parents.

Chelsea and Westminster Hospital **NHS**
NHS Foundation Trust

NORDOFF ROBBINS
music transforming lives

CHEYNE CHILD DEVELOPMENT SERVICE
For children and young people
Music Therapy Department
Tel: 020 3315 6472

Date/Version

Music Therapy Project
Informed Consent Form for Parents

Thank you for agreeing to be part of the music therapy project about music therapy with children and parents in the Child Development Service.

Please read the following list and circle your answer:

I have read the Information Sheet about taking part in this project.	YES / NO
I agree to take part and understand what I will be asked to do.	YES / NO
I am happy for the group discussion to be audio recorded.	YES / NO
I understand that I cannot share outside the group any information shared by other participants about themselves, or their identity.	YES / NO
I understand that I can withdraw from this study at any time without having to give any reason.	YES / NO
I understand that the researcher will change my name, and the name of my child, so that we cannot be identified.	YES / NO
I understand that any material to do with my participation (for example, audio recording, written notes), will be kept in locked storage within the Child Development Service, and that this material will be destroyed at the end of the project.	YES / NO
I agree to the findings from this study being published.	YES / NO

Name ....

Signature ....

Date ....

The samples above were adapted for use with music therapists and CDS staff.

Appendix 11. Handout for Participants: Parent Group Template Sample.

Thank you for agreeing to take part in a discussion group with other parents who also come to music therapy with their child.

In the group we will be talking about your experiences of music therapy as a parent, from the time your child was referred to this point.

This question sheet lets you know about the main areas we'll be discussing in the group. It would be helpful if you could write short answers to these questions on the sheet. Writing down your thoughts might help you to prepare for the group. Claire will contact you to collect it before the group, and will read it to help her plan for the group discussion.

Thank you for your time in doing this, and please don't spend too long on it!

I'm interested in finding out about your child being referred to music therapy.
Who suggested music therapy to you, and what did you think about your child being referred?

And what about the assessment session?
What did you expect before you came, and what do you remember most strongly about the assessment session?

If your child has already started a course of therapy, how did you expect to be involved?

How has your involvement changed since your child started therapy?

Is there anything else about music therapy that you would particularly like to talk about in the group?

Thank you.
Claire Flower

Template for Handout, adapted for use with music therapists and CDS staff.

Appendix 12. Focus Group Discussion Guide: Music Therapists' Group Sample.

Focus group for Music Therapists 1.
Topic and question guide.

There are two main aims for this group.
- To talk with music therapists in the Child Development Service about their experiences of working with children and parents through the whole music therapy pathway, referral, assessment and therapy processes as anchors for discussion.
- To elicit perspectives on therapists' expectations, roles, and practice in working with parents in music therapy.

Comments from question sheets, previously completed by participants and collected by the researcher prior to the group, may be used during the group to prompt discussion.
Brief extracts of video material will also be used as a further aid to enrich discussion.

<u>Outline of Topic and Question Plan</u>

Introduction
- Welcome and introducing myself.
- Introducing the topic – we are interested in finding out more about therapists' experiences of working with children and their parents, and how they work together.
- Intention of study – to develop the understanding of working with parents, and to develop practice and theory based on existing practice here.
- You were invited – because your work in this service means you work closely with children and their parents.
- Guidelines for today –
  o Acknowledge the existing relationships in this group, and the need to feel you can speak freely about your experiences and views. Important to respect the views of everyone, even in differing.
  o If possible phones should be turned off. If you need to keep it on, and respond to a call, then pop out and join us again as quickly as possible.
  o Discussion is being recorded. That's so I can write it up afterwards.
  o My role today will be to help the discussion move along, and to guide us.
  o Any other questions?

Referrals to Music Therapy
- I'm interested in finding out how children are referred to music therapy in the first place, and how the process of referral happens.
  o When you receive a referral, what do you do?
    ▪ Who might you talk to? What might you talk about? Where do those discussions happen? What activities do you need to do in response to the referral?

Assessment Sessions
- I'd like to know about the assessment process and session itself.
  o What do you do to prepare for an assessment session?
    ▪ Who do you talk to? What might you read? What about musical resources and preparation?
  o What are the tasks you need to do in an assessment session?
  o How are parents involved in assessment sessions?
    ▪ In discussion (before, during, after the session), active observation, direct musical involvement with their child, little or no direct involvement?

Courses of Music Therapy

- I'm interested in your experiences of music therapy with a parent present.
  - When you pick up a child for therapy, what are the tasks you do before therapy begins?
  - How do you prepare with parents for therapy – what happens in the pre-therapy meeting?
  - Parents don't always come into music therapy sessions? How do you negotiate parental attendance?
  - How do the three of you (child, parent, therapist) work together in sessions when a parent is present?
    - Do you have particular ways you might involve parents?
    - Are there particular ways of working you might have developed with a particular child?
  - What might be difficult about parents attending sessions with their child?
    - What do you do when things are difficult?
    - How do you talk about it with parent/child?

Using Video in Music Therapy
- Music therapy sessions are often recorded.
  - How do you discuss the use of video in sessions?
  - What are the uses you might make of video? How are they negotiated with parents?

Watching Music Therapy
- I want to show you a bit of music therapy video, where I am the therapist. This was filmed some time ago here, and the parent is happy for us to watch it as part of our discussion. It lasts a minute or so. I'm interested to hear what you notice when you watch it, about any aspect of it at all. Again, there's no right or wrong answers here, I'm interested in your views on what you see and hear.
  - Possible prompts –
    - What did you notice the therapist,/parent/child doing?
    - What surprised you when you watched that?
    - Maybe watching it brought your own experiences in music therapy to mind again? Would you like to say any more about that?

Any Closing Comments?
- Is there anything else you would like to say before we end today?

Conclusion
- Thank group for making time to come, and participating.
- Next group – will be in touch in the next two or three months to make a further date. At that group we will talk about some of the areas which have come up today, and will introduce new things to discuss.
- Ask group about completing a question sheet prior to group? Did it help them participate in the group, feel prepared and informed prior to coming, was it a burden, would they be willing to do that again next time?
- Thank you!

Template for Focus Group Discussion Guides, adapted for use with CDS staff and parents.

Appendix 13. Notated Transcription of Video Extract.

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Appendix 14. Samples of interview Transcripts.

CDS Focus Group Sample.

2016.03.17 CDS FG Transcription v1

Focus group attendees.
CF   Researcher
Frances (OT), Tina (Physio), Gina (Clinical psychologist), Rosie (social worker), Wanda (administrator/receptionist).
Absent – Sara (administrator), Rachel (speech and language therapist), Natalie (MT administrator), paediatrican (actual individual undetermined prior to group).

Sample starts when group are preparing to watch video extract.

72   C – So, while I'm getting there … um, I'll just tell you… a little bit about what what I'm going to
73   look at. So this is a sort of two minute little bit of video. I always try and do this, I try and talk
74   while ferreting around on the laptop, and I never can quite manage it… So, it's a little tiny bit of
75   video, and it's a child who will be familiar to some, if not all of you. So if I put that there, then
76   you can work out how close you're going to have to get. Snuggle up, snuggle up! Can you see
77   that?
78   So, this is a little boy, I'm going to use his name because   and some of you will know him, Milo,
79   and Mum has watched this video with me, and she knows how we're using it in this study, and
80   she's happy for us to be doing this. Now in every other group I've given a little bit of
81   background to Milo, and it's funny because the moment I think about doing that in *this* room
82   then I'm, then I;m thinking 'oh, there are people here who know Milo' and, and I suddenly get a
83   bit 'Oh, I might not give the right background to him, in technical terms' (*quiet laughter*), which is
84   quite interesting actually… What could we say, helpfully, about Milo, just those people who do
85   know him, just a nutshell that you might need if you were going to watch video.
86   T - I think a nutshell would be that he doesn't really fit into a very clear presentation. Do you
87   agree? (*referring to Frances*) so, he's got lots of, he's quite complex in lots of different aspects,
88   which perhaps are fairly unique I would say in, as a sort of whole picture.
89   F – I would say that a lot of his difficulties can be masked by what he says, and by what I would
90   say, his interaction, but, um, in a different way maybe that you might mean it (*referring to C*), but
91   just that he, becaue he's quite engaging in many ways, not so, has difficulties in other ways, but
92   in some ways I think he masks some of his difficulties.
93   C – Yeah. And his development really across all areas is delayed, isn't it? (*referring to F and T*)
94   So he came for a block of music therapy sessions and I saw him for ten weeks, and this is in
95   the, either the ninth or the tenth session, so it's right at the end of this block. And we were
96   working in music therapy really to support his development across all areas, so both his
97   movement, his comunication, his speech and language, his interactions, and his attention. So,
98   this little bit is just at the beginning of one of our sessions, and we're going to start singing hello
99   together. Um, so we'll just have a little look at it, and, and all I'm sort of asking really is 'what do
100 you notice?' You know, what stands out to you when you see it. I'll just tell you one other thing
101 which will help you in watching it. He gets really interested in this little thing here at the end of
102 the piano. There's a little rubber stopper thing,
103 R – Right
104 C – He gets really interested in it, and he uses it to play 'bee-beep-bepp'. So, there's quite a bit
105 of him going 'beep-bepp-beep'
106 R – Right
107 C – Ok. Just so you know.
108
109 VIDEO STARTS
110
111 (*when video reaches point when C and Mum are whispering and gesturing about Milo using*
112 *single fingers to play, C looks towards F, who looks back at her, nods and smiles*)
113

114   VIDEO ENDS
115
116   C – Ok. There we are, (*pauses video on opening frame)* we'll leave him there. We might just
117   talk a bit and then we might look at it again, ok, jut becuae you see things a bit differently.
118   What, what do you notice? It might be that that's the first time that you've seen sort of music
119   therapy, or that kind of music therapy so what do you notice.
120   G – I think just for me, it's just overall how, what a lovely gentle approach it is to developing
121   interaction because it's indirect and I think, thinking about in psychology, we're often trying to
122   think about depersonalising, sometimes the one to one, like face to face is too much, and you're
123   kind of using the instrument as a sort of third person almost, and so it's kind of triangulating it,
124   so think it's a really lovely gentle, non-confrontational way to interact, which allows him to join in
125   without feeling too pressured, just like you're there looking at the piano together. So yes, for
126   me, that's what stood out.
127   C – mm. It's gentle. And that the piano kind of plays a [role]
128   G- [a role]
129   C - being a bit outside somehow
130   W – For me I think being (*the opportunity for)* being able to express themselves, because
131   without music, does he sing at home, or.. I wonder if he has any instruments at home,
132   because here, you could see he's really interacting with you, it's like you know like having a
133   computer with a child, and 'Oh, don't touch that, don't touch that', then you actually then give
134   them the chance to go on the computer or the laptop and they're like so excited. And he
135   seemed very um involved like you said, involved, 'cos without.. you waited for him to then 'Is it
136   Mummy? His interaction, it's really lovely, very nice.
137   C – But it makes you wonder whether he's got music happening somewhere else, or whether he
138   does that at home, yeah.
139   F – I think as well, I think, in the two, it's interesting how in a two minute clip, because that's all it
140   was wasn't it, that you can see, um, um, work on physical development, work on
141   communication, fine motor development, gross motor development, all within that two minute
142   clip, which is quite interesting actually.
143   G or T? - Bridges all the disciplines in fact we don't need any of us (*loud prolonged general*
144   *laughter)*
145   F – But I have to say what struck me, which I'm surprised which struck me
146   C – yeah?
147   F – And I don't know if it's just the angle of the video, is just the proximity of everyone together,
148   and him being in the middle, and I'm, I guess I;m comparing it to my where a lot of the time we
149   try to get parents involved but they, but it's almost like everyone gathered here, and I'd just be
150   interested to see what would have happened next, was it almost following him, or just you know
151   he came and then mum came, and I just I don't know what struck me about it but just the
152   proximity of him in t
153   he middle of two people supporting him I think. I don't, it just struck me but I don't know if it's
154   the way we're looking down at it.
155   G – Like it's quite intimate.
156   F – And the level of support he's getting?
157   C – Yes..and what sort of support do you think?
158   F – Um…
159   R – Well, there's the physical support, isn't there? Mum helps to lift him up, as well as the sort
160   of emotional [support]
161   T – [Yeah], I think linking to like the emotional support how, how you're actually responding
162   through the music, so making it quieter, making it louder, how you, you know when he was
163   saying something, you were building that into what you were doing, so you're kind of waiting for
164   him to, and responding, so it becomes a sort of two way thing as opposed to you just playing
165   something and him just joining in, you can see how it then, like evolves and how he gets
166   involved, so it's probably then he knows that he's got some control (*sounds of assent)*………
     .

2016.03.03 MT FG2 Transcription v3

Focus group attendees.
Claire Flower (C)   **Researcher**
Laura, Hannah, Ellie, Felicity, Debra   **Music Therapists**

Sample starts at line 211 of original when we are talking about negotiating space in the therapy room with parents. Hannah is giving an example of a child and father.

211   H – [Sometimes, sometimes] I, if I've been close by and I can see she's moving, and Dad's on
212   the *other* side of her and it's close to me then I'll just move, but again, we've never, we've never
213   had that discussion. It's a bit of her that needs to happen, so it just, it just gets moved as, you
214   know, as needed. But again I think that comes from the sense of familiarity with the service,
215   and what's being offered. I *don't* think that might be the same in another family who would
216   come in for their first block of music therapy. I think you might be having all sorts of other types
217   of conversations about, 'Oh, is it alright to touch that, and how does it work, and how far, and,
218   you know, what happens if', we've never needed to have those conversations, we've got a very
219   different physical presence in that room. I haven't worked with others who've had quite the
220   same use of the room in the way that they have. There was a known issue that they've got, and
221   I think that's about their history of music therapy.
222   C – Yeah, yeah. Which means you put yourself even physically somewhere different in, in the
223   space, as well
224   H – Yeah, and then, and then that, and then you find that that starts translating into other parts
225   of the session, so *musically* then you might do things differently
226   C – What might you do differently?
227   H – Just the way you might do 'hello', you might not, it might not be so formalised, it might be, it
228   might not even *happen* some days, it just, you know, we, ok, we're here, we're ready, we know
229   what we're doing, let's just get going, and the Hello might be only a snippet of the session. Or
230   you may not, you may not, *initiate* in the same way, because there's not the same need for you
231   to do that because there's so much familiarity with the instruments or what you might do with
232   the space.
233   C – Mm. Are there other thoughts about sort of the physicalness, or the kind of real, *bodies* in
234   the room and that sort of involvement.
235   F – I do keep thinking there are some parents who, or perhaps combinations of parents and me
236   as a therapist, who just come into the space and just join in, and some who need a bit more,
237   perhaps, *guidance* or support to join in, because they might not be used to being active, being
238   involved in sessions elsewhere.
239   C – And what sort of support or guidance might that mean for [you?]
240   F – [Might] just be as simple as saying, 'come on mummy, come, come and sit on the floor with
241   us', or, or, or, just allowing them to be in the room for a minute, and saying 'ok, where, where
242   would you feel comfortable *being*?'
243   C – So you might just ask
244   F – Yeah. And it would depend a lot on if the child is able to sit independently, or stand, or
245   move around, or how little or big they were, that, and that makes a difference to whether they're
246   even – oh no, this is about being in the room, isn't it, so, yeah.
247   C – Mm
248   F – Yeah, the, this, this, I find that I'm extremely adaptable to cues from the parent about how
249   awkward or comfortable they feel, and that makes a big difference as to how I talk to them, and
250   the kinds of suggestions that I make. There was a mum today with a little boy who, he has
251   extremely low muscle tone and he's very little and we had, and she also finds it difficult to sit on
252   the floor, so there's been a difficulty about how to have them *together*, and the physiotherapist
253   is there as well, but it's been difficult to, so far, to get Mum and child, in the same moment, 'cos I

254   can turn to her and say something to her, and I can work with the little one, and I can work with
255   the physio and the little one, but because Mum finds it difficult to support him because of her
256   physicality.
257   C – Ok. So she's not sitting, they're not connected in their sitting together, they're not, they're
258   not physically sitting together?
259   F – Not on the floor no, that's been tricky
260   C – Mm….
261   L – I was thinking, been thinking, about what you said about who makes the decision as to how
262   involved and how involved parents are, with a lot of families I actually don't know, it changes.
263   So I'm working at the moment with two families where Mum and Dad both come, and they are
264   very very different, so one, actually Dad just came for the last session, and he happened to
265   have a day off, so Mum said, 'well this is your last session to come and see this', and he was
266   very much there as an observer, to look what his daughter was doing in music therapy and it's,
267   it felt very much that Mum and Dad were watching the work that was happening with myself and
268   their daughter, and they *did* comment and, and, the, but actually being part of the play wasn't,
269   didn't *feel* their agenda for the, for the session. And the other family just come in and sit down
270   and it's, it feels a lot more like working with co-therapists, that sometimes I do things, sometimes
271   the child does things, and the parents do – and it feels a lot more like a group, that there's more
272   bodies to, turn-taking games are much, feel much easier choice-making, and more people to
273   go to. But I'm not sure, I don't think *I* made that decision, I think *they* made that decision, it's
274   just how they, how the *family* came in and presented. Some families, some *children* will make
275   the decision that, I worked with a little girl who, she just went and got her mum and just dragged
276   her to the floor.
277   C – MM. So it might be the child's [decision]
278   L – [It might be] the child's decision and sometime it might be my decision. And sort of similarly
279   to what you were saying about sort of inviting the parent to make a choice (*unclear*) an
280   instrument that they might like to play or a song, that if we're singing a nursery rhyme maybe it's
281   Mummy's turn to choose, and I might make that decision to, to invite them to join in.
282   C – Mm. So there are decisions being made but we might not be sure quite whose decisions
283   they are, and how they're, how they're being made. But they're being felt somehow?
284   L – And then there are times when I feel as though I want parents to be *less* involved
285   that they, so times when the parents might sort of, like you were saying Ellie earlier
286   about if you leave a gap for the child, and the parent fills it, how, how to encourage the
287   parent, to model the parent to leave space for the child to fill the gap And I think I
288   would make *more* decisions *that* way round, than inviting them to join in…..

Parent Focus Group Sample.

2016.04.12 Parent FG2 Transcription v2

Focus group attendees.
Claire Flower (C)   Researcher
Orla, Nia, Patsi Parents

Sample starts at line 127 of original as the parents talk about their children's recent developments.

127   P – Sam was a lot like that as well actually. He doesn't like strangers, doctors, dentists, it was
128   an absolute nightmare, I couldn't even take him to get his hair cut. I have to cut his hair myself.
129   Strangely enough he actually went in and sat in the chair with me, and opened his mouth and
130   let the dentist look in his mouth
131   C – [Really?]
132   O – [Seriously?]
133   P – Honestly, he's developed *so* much, and even in hospital they were like, I said 'I really don't
134   know how you're going to look in his eyes, he's got', and she was like 'yes, I've seen the notes',

135 like literally the nurses, doctors were outside the room, they weren't coming near him, he just,
136 strangers like that, just no, no, he just wouldn't have them in the room, just wouldn't have them,
137 and he actually let her, you know, examine, put the drops in, and he's just so much more, I get
138 [what you mean, the]
139 O – [I can relate] to that. Joshi had a dentist's appointment last week, and he was so ok with
140 having his mouth checked, like all his teeth, he was like (mimes opening mouth wide), like that
141 for like two minutes, which
142 C – Great, that's great (general sounds of agreement and unclear comments
143 O - The dentist was like 'wow', you know, we went through the notes, and we were kind of like
144 prepared for, you know, Joshi, and she said, 'wow, we can just, we'll have him in for a filling,',
145 'oh, ok'. That's gonna be hard, but, you know, she said 'this was so easy'
146 C – That's great
147 O – So he's calm now
148 C – That;s really good.
149 O – You know, like he's just ok with a lot of things now. I think he's self-regulating in a lot of
150 ways.
151 C – Managing it himself
152 O – He is, yeah.
153 C – And how about Eddy, cos' he's still having his music therapy. How's it, how's it going.
154 N – He likes to come here
155 C – Yeah?
156 N - The first thing I do like about music therapy is he is always thinking about the music
157 therapy, and he's asking me about it, which is good for me, because he never asks for things,
158 but now he knows even the days, he know that every Tuesday he say, 'music therapy?'. You
159 know, he has PE at school in the morning, and then after that I pick him from school, so he
160 knows, so every Tuesday he's always waiting for me to come to the music therapy. This is a
161 good thing for me to be honest [(*unclear*)]
162 C – [It's good for you] yeah that he remembers, that he recognises, and that he really wants to
163 come [yeah and he lets you know]
164 N – [Yeah, he really wants to come] yes, when we come here, yes the first two, three session,
165 he doesn't sit, he wants to go around, he's not only one thing, but I think last week and the week
166 before he was a bit calm, and he likes to bang on this, especially this (points to windchimes)
167 C – Ok, the chimes, [and this one]
168 N - [and this one], he like, he likes a, a, loud, loud noises, and loud things. He wasn't like this
169 before, he would always do this (gestures putting her hands over her ears)
170 C – Oh, [so this is different]
171 N – [At the moment], he makes it, but still is happy, and sits with Laura to do the piano, so he is
172 changed, and he is asking to have things as well.
173 C – Like what, what does he?
174 N – He wants her to sleep, because when she's singing about sleeping, he wants her more,
175 pulling her to say 'more, more'.
176 C – That's great.
177 N – This is a new thing for us. Yeah, [which is really good]
178 C – [That's really] good. (Door opens, and child appears in doorway, quickly taken away by a
179 parent). We just had a little visitor there (general laughter). That's good, because when we
180 spoke last time in the group one of the things you talked about was how um he was enjoying, he
181 was rolling this drum, [wasn't he (points to large floor drum) and getting inside and rolling it].
182 N – [yeah, and still, still enjoying it].
183 C – And you were having to help, because Laura, the therapist he sees is quite pregnant, and
184 so you were having to get involved.
185 N – I always involved because I know Eddy, he's very hyper, and I don't want him to hurt her,
186 because he doesn't know what he's doing. Sometimes he's very, he does things very fast, so I
187 always with her here around, but at least he listen to her, he's, especially when she does the
188 piano, he listen, and he bang here, and he wait for what she's going to do next, so, this is
189 different thing, yeah, the last two session, so we have two more, so hopefully there is more
190 change.
191 C – So when you all, when you all talk about being here with your children, um, it sounds like
192 there's quite a mixture of, of how you are, as Mums, in the room, like because you've talked
193 about having to help (referring to Nia), being on the floor, and then you've talked (referring to
194 Orla) about sitting over there, you know kind of wanting the action to happen here. How do you,

195 I know, I think I asked this last time, but I'm kind of really interested in how did, how did you
196 know how to do that, or what, what to do, how? Did you talk about that with your therapists,
197 about 'oh I'm going to sit here', or 'I'm going to get on the floor'. Or, how, [how does that
198 happen?]
199 N – [(*unclear*) we talk together] with Laura
200 C – With Laura, yeah
201 N – Yeah. If I want to involve or not. But I never talk to him or say something, but I'm just
202 looking at him. I need, I'm helping her because I know she's pregnant, and I know him very
203 well, what he's going to do. That's why I'm helping her but most of the time I just sitting her and
204 looking at them but I don't involve…

Appendix 15. Emerging Statements and Sources.

	being a parent in music therapy involves questioning	Par indiv - 469-471 Par FG2 - 651-652, 777, 789, 791, 796
	discussing future options is reassuring	Par FG2 - 678-691, 681
4 Expectations of multiple parties generate activity and shape the experiencing of music therapy	The assessment process involves considering expectations	MT FG1 - 228, 239, 242, 245-246, 261, 272, 279-280, 324-325, 328-329, 332, 606
	Parental attendance in sessions is the norm	MT FG1 - 480-483, 493-494
	music as an expectation raiser	MT FG1 - 253-254, 363-366
	Therapists may make assumptions about a parents intention of involvement	MT FG2 - 292-295, 299-300
	Parents may shatter therapist's assumptions	MT FG2 - 296-298
	perceiving parents as more or less concerned about roles	MT FG2 - 314-316
	The post-therapy meeting involves acknowledging parental expectations of therapy	MT FG2 - 669-671
	The post-therapy meeting focuses thinking on goals	MT FG2 - 632-633
	matching of referral reasons and parental concerns	MT FG2 - 672-674
	Parental expectations arise before therapy begins and may change over time	MT FG2 - 701-705
	Referral to music therapy raises expectations for parents	Mt FG1 - 62
	Parents have expectations when their child starts therapy	Par FG1 - 445-447, 539-545 Par indiv - 217-218 Par FG2 - (of therapy for future) 192
	Parents have expectations of the parent/therapist relationship	Par indiv - 268-270
	parents have expectations when their child ends therapy	Par FG2 - 828
5 Music therapy is enacted through a fluid interplay of relationships between child, parent, and therapist	The therapist puts own feelings to one side	MT FG1 - 286-290, 293-294, 319-322, 330
	Music therapy enables a fresh picture of parents to emerge	MT FG1 - 305
	Assessment involves considering and assuming responsibility for a child	MT FG1 - 176, 190
	The assessment session involves considering the experiences of child, parent, and therapist	MT FG1 - Therapist. 282-285, 291, 306-313, 316, 324-325, 328-329 Parent - 238-241, 244, 255, 261, 272, 275-278, 332