

ANGLIA RUSKIN UNIVERSITY

**THE INCLUSION OF THE FAMILY MEMBERS AS PRIMARY
CARERS IN MUSIC THERAPY SESSIONS WITH CHILDREN
IN A SPECIAL EDUCATION CENTRE;
HOW DOES THIS HELP THE CHILD AND THE CARER?**

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ABSTRACT

This qualitative study aims to explore the parents' or other family members' experiences in participating in music therapy sessions with their children with special needs. This aim leads to three research questions which were; 1) Can music therapy help to achieve aims set out for individual children with special needs and their parents or other family members 2) What are the functions of music therapy in nurturing communication between the parents or other family members and their children? and 3) How can the music therapist develop ways in which parents or other family members can use music to help their children?

Six children who are attending the Special Education Centre, region 9 in Thailand, aged four to twelve years old with their family members who are their primary carers, participated in 24 music therapy sessions. Each session was videoed and the video recordings were discussed every two weeks with the carers. The carers were interviewed three times by the research assistants. Interpretative Phenomenological Analysis was employed to evaluate data collected from interviews. Furthermore, there were two home visits, one after a month when the 24th session was finished and another visit was two months after the 24th session was finished.

From the interview analysis, there are 28 themes under five categories namely: 1) The carers' expectations of the music therapy 2) The carers' experience of seeing their children in the music therapy sessions 3) The carers' experiences of seeing themselves in the sessions 4) The carers' experiences of reviewing the video recordings from the music therapy sessions and 5) The carers' experiences of using music at home.

It can be summarised that music therapy made a positive impact on the children and their carers. The finding highlighted how the music therapy enhanced the social and communication skills of the children. Moreover, involving the carers in the sessions enabled the carers to have positive experiences with their children and these experiences led the carers to see and interact with their children differently. The findings suggest the ways to work with the carers in a therapeutic process and how to encourage the carers to use music at home with their children.

Keywords: music therapy, family, carer and children with special needs

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Chapter 1 Introduction

1.1 Background of the study

Music therapy has been widely used with children with special needs. One reason is that music-making is very appealing, accessible and interesting to almost everyone. Music therapy can enhance many skills of children with special needs, such as social skills, motor skills, and cognitive skills. Also the children with special needs require special care and understanding from their family, in order to nurture their wellbeing and develop their life skills. Many studies have shown that music therapy not only has a positive impact for the children, but also for their parents. Having children with special needs in the family has an effect on everyone in the family. They encounter grief, loss and challenges. Therefore, it is difficult for them to have a good time together. In music therapy sessions with their child, the family can experience a positive time with their child and also experience new ways of looking at their child (Nicholson et al., 2008; Oldfield et al., 2003; Williams, 2009). In addition, some families find techniques of employing music that are beneficial for them to use at home (Abad & Edwards, 2002; Nicholson et al., 2008; Shoemark, 1996), thus improving their home life with their child. These experiences can help form a good relationship between the children and their parents. This good relationship is a crucial factor in bringing up healthy children.

Moreover, from my experience of being a piano teacher to children, I found that parents had a big influence on their children's learning effectiveness. The parents spent much of the day with their children and often know the most about their child. Having the parents involved in the learning process helped both the parents and me, as the piano teacher, to have the same expectations of the child so that we could appreciate every progression the child makes. The parents helped me to understand more about their child and they motivated the child to practise. The parents were the most important source of support. Therefore, in this study I aimed to include the parents in the music therapy sessions, in order to have a positive impact on both the children and their parents and I also aimed to

explore the effects of music therapy on the children when their families were presented. I was interested in exploring the different ways in which the families could be involved in the music therapy process, and how this involvement influenced the children, the families members and the therapeutic process.

In addition, parents' perception about the music therapy sessions could help me to establish collaborative work with parents in order to support each other in the process of developing the wellbeing of their children with special needs. Good understanding of the clients' needs could lead to a successful service. In contrast, without a good understanding between the music therapist and the parents, confusion and mistrust could occur, making it difficult to establish a relationship which is the base of the therapeutic process. In turn, effective support of these parents and children will increase the use of music therapy with the family in this context. Moreover, there are not many music therapists in Thailand, limiting the number of children with special needs who can receive a music therapy service. Working together with the families and encouraging them to use music with their children at home, may mean that they would be able to overcome some of the challenges.

In Thailand, the music therapy discipline is at an infant stage of development. This study is the first research not only in Thailand but also in Asia to examine children receiving music therapy treatment with their extended families. Understanding the experiences of the parents who are included in the music therapy sessions with their children, will better my understanding of ways to provide music therapy to children with special needs and their families both in Thailand and other similar context. Also this investigation enabled me to adjust the western-influenced music therapy approach to be more suitable to a Thai environment. The experience of providing music therapy sessions in Thailand allowed me to do the necessary groundwork in order to provide evidence and an infrastructure, for future music therapy in Thailand

From a western perspective, this study is unique because it involves relatives of children rather than the parents themselves. It is also original because the relatives of the children

take part in the daily school curriculum with the children, something which is not usual in western schools.

I hope that the results from this study will contribute to the existing knowledge and provide some information not only to music therapists but also to parents, teachers, or anyone else who works with children with special needs. In addition, the parents' perception about the music therapy sessions can build a platform for my approach and can help me to understand and develop my music therapy approach with children and families.

1.2 Objective and questions of the study

The focus of this study is on exploring the parents or other family members' experiences in participating in music therapy sessions with their children with special needs. This aim leads to three research questions which are;

1. Can music therapy help to achieve aims set out for individual children with special needs and their parents or other family members?
2. What are the functions of music therapy in nurturing communication between the parents or other family members and their children?
3. How can the music therapist develop ways in which parents or other family members can use music to help their children?

1.3 Overview of the thesis structure

The Introduction chapter presents an introduction to this study. The chapter introduces how I became interested in this topic, and the rationale for focusing on the families' involvement in the music therapy sessions with their children with special needs. Also I explain the purpose of this study. Then the research's objectives and questions are identified.

The Literature Review chapter is divided into four main sections. Firstly, literature related to parents' experiences of having children with special needs is reviewed. Secondly, I focused on music therapy intervention for children with special needs. Thirdly, I explored the music therapy work which involved families in different settings.

Lastly, I explored the specific benefits from involving the families in the music therapy sessions with their children.

The Context of the study chapter provides an overall picture of the environment where this study was conducted. It firstly presents an overview of Special Education in Thailand. Then families' general views regarding children with special needs, is explained. I then explain the setting up phase which covers the process of making contact with the Special Education Centre, region 9, a description of the room I worked in, providing initial music therapy sessions, the arranging timetable, providing music therapy assessments, conducting pilot interviews and communicating with parents. Later, I explain how I conducted music therapy sessions at the Special Education Centre. This section includes characteristics of my approach, how I worked with the parents, the process of video reviewing and home visits.

The Methodology chapter is presented as an overview of research methodology, which I employed in the study. I clarified my roles in the research process. Both the research participants and the recruitment process are explained. Later, I present the research design including the overall timeline of this study. The data collecting process is also discussed. I also explain the rational of employing semi-structure interviews and how the set of possibly used questions emerged. Afterwards, the data analysis process is explained. Finally, I raise the ethical issues in this research.

The Findings chapter is divided into two sections. The first section is presented and explained in a case study form. The data in these case studies are based on data from video reviewing, home visits, and my reflection from the research diary and clinical notes. The second section presents a set of key themes from data analysis in semi-structured interviews which is related to the research questions.

The Discussion and Conclusion chapter summarises the main findings from the study and connects them with the research questions and existing literatures. The limitations of the study are explained and also the recommendations for future research.

Chapter 2 Literature Review

Introduction

This literature is important for the investigation in many ways. First this chapter provides a theoretical background which is relevant to the research objectives and questions. The background knowledge can guide this study to develop further. Secondly, this literature helps to acquire more understanding of parents' experience of having children with special needs and how music therapy could support both the parents and their children; therefore this study is able to develop further from existing knowledge. Lastly, doing a literature review and learning from previous work not only develops my understanding in the areas but also can point out gaps and help me to fill some of these gaps in existing knowledge.

Many different sources from books, searches of music therapy journals including The British Journal of Music Therapy, The Nordic Journal of Music Therapy and Music Therapy Perspectives are explored. Moreover, online databases, which were accessed via Anglia Ruskin Library and Google Scholar, including EBSCOhost, PsycINFO, Journals@Ovid, Academic Search Elite, ERIC, JSTOR and OneFile (GALE). These sources are used not only in this chapter but also throughout the research process. This chapter is divided into four main sections: parents' experience of having children with special needs; music therapy intervention for children with special needs; music therapy and children with their families in different settings; and the benefits of involving families in the music therapy sessions. In each section, I have chosen specific topics which are particularly relevant to my study in order to make sure that my literature review did not become too wide and general.

The first section (2.1) begins by exploring the experiences of parents who have children with special needs. Because of the word limitation and in order to address the areas most relevant to this study, the literature in this section will be divided into three topics relating to their experience, which are: how the family members respond to the birth of a

child with special needs; how they cope and manage with the children's difficulties; and what they expect for their children with special needs in the future.

The second section (2.2) aims to explore different music therapy interventions, which were employed with children with special needs. This section mainly focuses on interactive music therapy interventions including using the voice, playing instruments and using movement.

The third section (2.3) reviews the different settings where music therapists work with children and their families. I will explore the work in community centres, hospitals, psychiatric unit, educational settings, and families' homes

The last section (2.4) explores the specific benefits from involving the families in the music therapy sessions with their children. The benefits, which will be covered, are having fun and positive experiences together, improving communication and nurturing relationships between children and their family members, and improving parenting skills.

2.1 The parents' experience of having children with special needs

Most parents who have children with special needs experience more stress than parents with healthy children. Moreover, they usually suffer from ongoing loss and sorrow, not only for the parents (Marshak, Seligman, & Prezant, 1999) but also for the rest of the family. The sickness or pain of anyone in the family can affect all the family members in some ways (Satir, 1967). The parents have a grieving process for their loss of expectation of having a healthy baby, which is similar to a mourning period of the death of a family member (Marshak et al., 1999; McCubbin, Cauble, & Patterson, 1982).

When parents first receive their children's diagnosis, they may find this event is the most difficult and shocking experience. They may experience emotional stress, anxiety, fear and guilt (Heiman, 2002). Some parents blame themselves, wondering what they did wrong, while others will reject the diagnosis. However, some parents are able to cope with their sadness and adapt to the new roles they need to take (Falik, 1995).

There are many factors which influence the reactions of parents of children with special needs and their own need for support. Hornby (1995) suggested that the type and severity of the child's illness, disability or psychological problems and also different development stages very much affected the parents. Not only do the children affect the parents but also parents' personalities, coping strategies and state of health will all affect the child.

Both physical and psychological needs of the children are difficult to predict and understand for the parents. Children with special needs cannot reach the usual milestones that normal and healthy children can. Special care is needed which can cause the parents to feel helpless and disempowered because of the overwhelming work that they did not previously expect. The parents may feel isolated from their extended families and community because of the children's limited mobility or behavioural problems (Woolfson, 2004). Moreover the time needed for any medical or therapeutic intervention that the children require takes away from the parents' personal life. Therefore the parents cannot have enough rest or look to their own needs. Usually, children with special needs show challenging behaviours which cause confusion for the parents because they cannot understand why their children behave in these ways (Midence & O'Neill, 1999). Consequently, parents find it difficult to provide appropriate care and understanding to meet the needs of the children. This problem can lead to an unhealthy relationship between the parents and their children with special needs. Moreover, if the children show a lot of difficulties and the parents are struggling to respond to their need, this will lead to the parents feeling less confident in their own parenting skills and parental stress will be increased. If this problem does not get enough attention and care, misunderstanding between the parents and their children will be increased. Also the emotional bonding may not be able to consistent and strong. The parents of children with special needs need as much support as their children (Alvin & Warwick, 1991).

Spouses, friends and family members are very important sources of support for the family to get through the crisis and help the family to have a successful adaptation process (Barnett, Clements, Kaplan-Estrin, & Fialka, 2003; Heiman, 2002; Yau & Li-

Tsang, 1999). Besides family support, the parents of children with special needs also employ a combination of various types of supports, such as psychological services and psychiatric consultation, support groups, social workers, educational advisors, or support provided by voluntary organisations or special education systems (Heiman, 2002). The parents needed knowledge about child development, sensitive parenting, and coping strategies. This knowledge could help them to get through the parental adaptation period (Barnett et al., 2003). Furthermore, it is very important to explore what has influenced the parent toward the particular parenting style they adopt. There are two most influential factors in parenting styles are: the amount of emotional support parents have at that time, and the mothering style that the mother received when she was young (Bowlby, 2005). In addition, the social environment in which they are living, including the extended family, the services available and community attitudes will directly influence how the parents take care of their children with special needs (Hornby, 1995). Therefore, when planning interventions for parents who have children with special needs one should consider including these factors in the interventions.

The literature shows that not only the children's parents are affected by the children's difficulties but also the wider family. The support from the wider family members is crucial to help the children and their parents to cope with the difficulties. In this current study, I did not directly work with the children's parents in the sessions because they had to work. Instead I worked with aunts and grandparents who were supporting the children in many aspects including wellbeing, education and health while the parents support them financially.

2.2 Music therapy intervention for children with special needs

The positive effects of music therapy on children with special needs are evident in a number of research reports (e.g. Aldridge, Gustroff, & Neugebauer, 1995; Edgerton, 1994; Geretsegger, Holck, & Gold, 2012; Gooding, 2010; Holck, 2002; Kim, Wigram, & Gold, 2008). They are also extensively described in case reports (e.g. McTier, 2012; Oldfield, 1995; Tomlinson, 2010). Music can provide structure, steadiness, flexibility and variability, therefore these qualities enable the music therapists to achieve different therapeutic goals. There is evidence that supported the effectiveness of using music

interventions with children with special needs to facilitate social skills (e.g. de Mers, 2007; Duffy & Fuller, 2000), communicative skills (e.g. Gattino, Riesgo, Longo, Leite, & Faccini, 2011; Groß, Linden, & Ostermann, 2010; Holck, 2004) and behavioural skills (e.g. Bean, 1995; Kern & Aldridge, 2006; Krakouer, Houghton, Douglas, & West, 2001). Music is fun and motivating for every child, even for children who have severe and multiple disabilities (Elefant, 2002; Stephenson, 2006 and Kern, 2008); music therapy has the potential to reach them and help them to communicate, assert themselves and experience being in an interactive relationship (Van Colle, 2003). In addition, music can sustain participation in turn-taking, and can maintain attention and engagement in the interaction (Rainey Perry, 2003).

Music therapists initially aim to establish a relationship with another person through music. From musical interactions, the music therapists can observe and learn about the children's strengths and weaknesses (Oldfield, 2006b). In order to successfully establish the relationship with the children, music therapists employ different approaches and ways of using music including singing, moving, playing instruments, and listening. They choose suitable music interventions according to the context they are working in, the needs of the children and, importantly, the children's preferences.

This literature in this section presents some music interventions that were widely used in the music therapy sessions for children with special needs. The interventions in this study aim to encourage the children to interactively engage with the music therapist, therefore the literature here does not include passive music listening interventions, although passive music listening has been used in children with ASD to help with behavioural problems (Ellis, 2004; Lundqvist, Andersson, & Viding, 2009). In addition, listening to soothing music can enable children to relax in situations of tension (Longhi & Pickett, 2008). Shoemark (1996) suggested to families to listen to pre-recorded music at home for quiet time or relaxation, especially with small infants who are too young to actively engage in the sessions.

2.2.1 The use of the voice

The human voice is the first instrument for everyone and is highly portable, so using the voice is the easiest instrument to find for anyone (Hamlett & Mackenzie, 2005). Oldfield (1995) suggested that when a mother sings to her baby in order to soothe when he/she is crying, this singing also gives her a calming influences as well as enables her to feel closer to her baby. Also, singing lullabies may help to provide a sense of trust, security and safety (Loewy, 1999).

Many case reports illustrated the wide uses of Hello songs and Good-bye songs especially with young children (de Mers, 2007; Oldfield, 1995). The Hello song gives the sense of beginning to the children (de Mers, 2007) and serves as a transitional function from previous activities (Kern, Wolery, & Aldridge, 2007; Pellitteri, 2000). In group settings where each child has a chance to strum the guitar and sing their names during the Hello song, this can create the awareness of peers (de Mers, 2007; Nicholson et al., 2008). Oldfield (2004) suggested that while singing the Hello song, the music therapist can observe the child's emotional responses toward an adult's warmth and affection and how the child manages to focus or listen to others. Also it can send the message to the child that the music therapist is going to actively take part in this interaction. While the Good bye song delivers a sense of closure to the musical experience (Pellitteri, 2000) and the music therapist can use this chance to observe how the children cope with ending (Oldfield, 2004).

Occasionally, music therapists compose songs to match the unique needs of each child. The pre-composed songs were used to convey structures that help the child to reach their objectives (Kern & Aldridge, 2006; Kern et al., 2007). The patterns and structure of the song can encourage the children to remember their tasks and encourage the children to follow each step along with the song. Although it was a pre-composed song with some structures, it sometimes combined flexibility, which allowed the child to alternate their choices of peers to join in the activities (Kern et al., 2007). Unlike in this current study, I did not pre-compose the songs but I improvised with repetitive chord progression and lyrics to give the children simple structures such as whose turn it was to play or when to start and stop. Also, I found that some of the children in this study quickly moved from

one thing to another. So I had to be more flexible than Kern et al. (2007) suggested. By singing simple and repetitive lyrics of what the children were doing, I was enabled me to match and reflect their actions at the right moment. This also encouraged the children to be aware of themselves and others. Sometimes pre-composed songs were used in this study but not in order to give structures to the children, instead the songs were used to provide the children with something they were familiar with and something the children and their carers could sing together.

When working with children who have limited communication skills, the music therapist can interact with the children through singing. Music therapists are able to match the way they sing in order to respond to or reflect the children's responses, which they present through their body and limb movements, facial expressions, hand gestures and vocalisation (Elefant, 2010; Van Colle, 2003; Wigram & Elefant, 2009). Similarly, mothers employ "infant direct singing" to respond to the infant's cues (O'Gorman, 2006). Sometimes music therapists use their voice to imitate the children's noises; this enables the children to be aware of what they are doing. Usually, this becomes the basis of turn-taking. Also imitation can provide that sense of self and the other person, which allows shared focus and later can lead to mutuality (Oldfield, 1995, 2004). In addition, Shoemark (1996) suggested that parents who attend music therapy sessions with their children could learn how music therapists sing playfully and use their voice creatively so that the parents could encourage their infant to have pre-speech vocalisation outside the music therapy sessions. Moreover, music therapists employ songs and leave strategic gaps at the end of phrases, which provide chances for the children and the carers to participate by filling the missing sound.

There are similarities between this literature and the way I used the voice to work with the children with special needs. For example, the flexibility in the vocalisation, which is similar to the way mothers sing to their infant to respond to the infants' cue, is also beneficial in engaging with the children who have pre-speech communication. The vocalising allowed me to imitate the children's musical signals and then extend these signals to make the children's sounds more meaningful. Moreover, in this current study

vocalising could help the children like Nina and Aden to develop their verbal communication, which will be shown in 5.1.1 and 5.1.2

2.2.2 Using musical instruments

Music therapy sessions always involve the children playing musical instruments and this playing can serve different purposes. For example, it allows the children with non-verbal communication to express themselves and the music therapist can learn about the child from their music. Instruments provide a wide possibility of sound exploration and experimentation. The children are invited to differentiate, associate and compare, using simple basic techniques. Often, the process of the initial experimenting and tactile handling will eventually lead to creative music-making and improvisation, again a process of negotiation and teamwork between the adult and the child. Also it helps to engage the child, focus and lengthen the attention span and invite active music-making (Burrell, 2005).

Improvisation is one of various ways by which music therapists invite children to engage in playing the instrument. Music therapy improvisation is widely used in music therapy (e.g. Aldridge et al., 1995; Edgerton, 1994; Kim et al., 2008; Rainey Perry, 2003; Sorel, 2004). Nordoff and Robin's "Creative Music Therapy" mainly establishes the musical relationship, by which the music therapist encourages a client to engage in the musical interactions while the music therapist accompanies on an instrument (Aldridge et al., 1995). Through the musical interactions, the therapist and the client can meet and know one another and create intimate interpersonal relationship (Pavlicevic, 2000). Nordoff and Robin (1977) believed that improvisational music can evoke responses, develop relationships and address emotional, cognitive, social and musical goal areas.

Music therapy improvisation also includes creating variation of songs by adapting the accompaniment style, tempo and dynamics (Rainey Perry, 2003). The music therapist improvises the music in order to invite the child to engage and then extend the interaction and make it purposeful (Nordoff & Robbins, 1977). In the musical interaction between the music therapist and the child, the music therapist is a leader and takes control, but the child also acts as an active creator. The music therapist improvises

the music to reflect the emotional state of the child, to stimulate and to enhance communications skills, and facilitates active music-making between the participants (Sorel, 2004).

Percussion instruments are commonly used as they do not require so much skill from the children and can give a very strong effect to the music interactions. It can bring a child and a music therapist to the same level (Oldfield, 2004). The music therapist usually accompanies the spontaneous playing from the piano, providing a structure for the children to participate in free improvisation on the percussion instruments (Oldfield & Bunce, 2001; Oldfield, 2008). The freedom and flexibility of the structure of this activity allows the music therapist to observe different aspects of the child such as how does the child communicate non-verbally, how does the child's playing makes the music therapist feel (excluded, excited, bored, sharing enjoyment?), and to see if the child is trying to be in control or if she/he seems desperate for a music therapist to lead the session (Oldfield, 2004).

Musical improvisations allow the children to express their feelings, emotions and needs naturally and sometimes highlight issues of who is in control (Oldfield & Bunce, 2001; Oldfield, 2011a; Williams & Abad, 2005) In addition, through musical improvisation children can develop attention and awareness of each other and also it can promote their confidence in being a leader through playing a musical instrument with another person. In Woodward's work (2004), she provided everyone with an instrument and they all played together until the leader (at first a parent or staff member, then the children, take turns to lead) hits the cymbal, while she facilitated this musical interaction on the piano. In the music therapy sessions, the music therapist encourages the child to take turns vocalising or playing the music instrument with him/her. Turn-taking is needed in order to have further development in communication skills. For children with severe difficulties who have very limited communication skills, this provides them with a positive opportunity to influence others, improve motivation to communicate, and an opportunity to experience a flow of interaction involving repeated turns in musical conversation. It also provides a framework for a communication partner to sustain interaction (Rainey Perry, 2003).

In a similar way, I found in my clinical sessions that a wide array of musical instruments could catch the children's interest and encourage them to explore and experiment. However, a totally nondirective form of music-making was not suitable for some children such as those with very short concentration span who would be unable to settle to any constructive playing. Simple structures and guidance allow the children to use the musical instruments in more meaningful ways. In my approach, the music therapist improvises a song along with the exploration to extend the musical exchanges which later became musical games. This was clear in the case of Paul (5.1.5) and Nathan (5.1.6).

2.2.3 Movement

Music is able to encourage the children to move, and including movement activities in music interventions can promote both body awareness and fine motor skills. Music and movement sessions may be run with the involvement of a physiotherapist and may be highly structured with specific movement goals, or improvised (Meadows, 2002). Unlike Meadows (ibid), the movements the children did in the sessions in the current study were not prescribed. However, there were important aspects of the work. Sometime, I followed the children's movement and improvised songs to match their movements. Many of the children were very active and liked to move, so combining movement such as running, jumping or hopping could encourage the children to engage in our musical interactions and enjoy the sessions more.

Action songs were widely used in music therapy sessions especially with young children (e.g. Nicholson et al., 2008; Shoemark, 1996; Wimpory & Nash, 1999; Woodward, 2004). Singing with movements or actions can increase the meaning of the songs (Rainey Perry, 2003; Wimpory & Nash, 1999) as the movement makes the songs more interactive for the children. Moreover, actions can encourage the child to learn about body parts or can help to practise spatial concepts (Thaut, 1984)

Music therapists create the songs to match the children's actions in order to gain the children's awareness of the others' communication and the music. Moreover, the children's movements provide a common rhythmic pulse for interplay (Holck, 2004).

Sometimes music therapy sessions use movement with the music to increase young children's vestibular strength, upper body control, and spatial awareness (Abad & Edwards, 2004).

For children with ASD who struggle to have a healthy relationship, some movements require the children to engage in physical closeness and this enables the children to develop bonding with adults and their peers (Abad & Edwards, 2004; de Mers, 2007). It is common in children with cerebral palsy to have stiffness, involuntary movements, lack of balance and lack of posture control. Therefore in the music therapy sessions children with cerebral palsy were encouraged to participate in head, leg and arm movement activities as well as relaxing at other times (Bean, 1995). The study of Galloway and Bean (1974) showed that when the children with hearing impairment responded to the directions in songs which encouraged actions such as shaking, pointing and waving to specific body parts, this could promote a better body image for the children. In this study body image refers to their awareness and knowledge of the physical and spatial characteristics of their bodies.

Thaut (1984) developed a general music therapy treatment model for autistic children which is focused on their specific areas of impairment, including perceptual motor disturbances. He suggested that movement to music could improve the integration of tactile/kinesthetic and audio perception and differentiation of self or non-self. Moreover, the music therapist can use rhythmical or musical accompaniment in order to develop fundamental motor patterns such as hopping, skipping, walking or general strengthening, similar to Saperston's case study (1973) in which he described the way he worked with a child with learning disability and ASD. He accompanied the child's movements with different accompaniments; the child was gradually aware of the therapist's music and this could develop into the child's awareness that he was able to control the music played.

According to the literature, movement with music could provide a more meaningful experience for children with special needs. In my clinical work, imitating or using music to accompany the children's movement could enable the children to engage with me in a

similar way to Sapaerston's study (1973). In addition, combining movement with a musical game with a child who struggled to sit still or focus in any way, enabled me to engage with Paul (5.1.5) for longer. Allowing the children to move around the room and explore their space could also bring out the children's liveliness and energy in a positive way.

2.3 Music therapy with children and their families in various settings

Recently music therapy works with families have become more widely acknowledged. Involving the parents or other family members in the therapeutic process brings positive results for both the children and the parents themselves. The literature shows that music therapy sessions with children and families were conducted in different settings, for example in community centres, hospitals, psychiatric unit, educational centres and children's homes. This section will explore music therapy work with children and their families, which is categorised by the settings where the work took place.

2.3.1 Community centres

Shoemark (1996) provided music therapy sessions in a playgroup programme, which aimed to enable the children with special needs and their families to have positive times together. The sessions employed familiar songs; singing activities and also action songs were included. Moreover, this programme provided cassettes and lyrics books for the families to use with their children at home in order to extend the support from the staff. The cassettes and lyric books received very positive comments about how they enabled a positive experience to engage the family relationship. Also, participants found the cassettes and lyric books helped the way the music was used at home.

As in Shoemark's work (ibid), Sing & Grow provided early intervention to the children at risk and their families nationally in Australia and later expanded to the UK. There are extensive articles (Abad & Edwards, 2002, 2004; Abad & Williams, 2006, 2007; Nicholson et al., 2008) regarding the Sing & Grow project. Both music therapy in a playgroup and Sing & Grow provided music resources such as CDs, cassettes and booklets of songs to the participating families. These resources helped the families to use music to engage with their children at home. The Music Together programme

(Hamlett & Mackenzie, 2005) is also early intervention but aims to strengthen early attachment, build social supports and increase the resilience of the family unit for “well” families with children aged 0-4 years. The music therapy sessions in this program have a similar structure to the early intervention in Shoemark’s (1996) project. The findings showed that Music Together enhanced interaction at home. Most families found themselves singing, dancing and laughing together more and also some families could integrate activities from Music Together into their everyday lives to develop new parenting strategies (Hamlett & Mackenzie, 2005). These music therapies with children and their families in community centres shared similar goals, which were to provide early intervention to the children and their families with and without risk and to strengthen the relationship between the children and their families. Moreover, these studies focused on encouraging the parents to seek support from each other and their community. In this present study creating a network among the carers was not a particular focus as the music therapy sessions did not occur in a group setting. In addition the carers appeared to already know each other well from attending the classes at the Special Education Centre, Region 9. They already had a good relationship and had been supporting each other. Additionally, the music therapy in playgroups and Sing & Grow project were able to encourage the families to explore different ways to engage with their children through music outside the sessions, and this finding is similar to one of the aims in this study.

2.3.2 Hospitals

There are a numbers of studies regarding music therapy for infants and their families in neonatal intensive care units (Loewy, Stewart, Dassler, Telsey, & Homel, 2013; Loewy, 2011; O’Gorman, 2006; Shoemark, 1996; Whipple, 2000). The families were encouraged to sing or use their voice creatively with their infants, and this enabled facilitation of the infants’ development (Loewy et al., 2013). This music therapy work for infants is quite a different way of working from the current study, however it provided the knowledge that even with a very small child, the parents-infant connection could be nurtured through music. This was especially important when they were in

hospital where they were surrounded by other professionals who took control over their children's life.

Ayson (2008) conducted her study in a children's ward in New Zealand, examining the role of short-term music therapy in supporting children and their parents facing the difficulties of hospitalisation. In her work, not all the parents were involved in the music therapy sessions with their children. The parents reported that it was not crucial to always be in the sessions but they felt it was beneficial to get involved in the sessions in some ways. Some parents also felt that the flexibility of sometime attending sessions but at other time not attending was important. The author suggested that while the children were in the sessions, their parents could sometimes have a break or take time on their own.

In my study the family members were asked to be involved in the music therapy sessions so they did not have as much flexibility to choose whether or not to attend as in the cases described in the literature. However, the families in this study could choose how much they wanted to take part in the sessions. This flexibility appeared to enable them to be relaxed and gradually engage in the musical interactions with the children at their own pace.

2.3.3 Psychiatric units

A variety of music therapy works with children and their families in a psychiatric unit, is described by Oldfield (e.g. 1993, 2004, 2006b, 2011a) and jointly by Oldfield and her colleagues (e.g. 2003, 2012; 2001). She called her approach "Interactive Music Therapy" in which she mostly employs musical improvisation to engage with the children (Oldfield, 2006a). In her early work in family music therapy at the family and child psychiatric unit, Oldfield (1993) explained different ways in which music therapy helps families with different needs. In the sessions both the parents and their children were invited to play music together. Varied kinds of activities were chosen according to the child's age and the problems presented. She ran the sessions in a predictable and non-threatening manner. Playing instruments together not only enabled the families to have a good time together, but also enabled her to address the conflict between the

children and their parents. This work of hers had much influence on later music therapy work with children and their families. She pointed out that difficult behaviour or any difficult issues which were not able to be explained verbally could be seen from playing music together, and then the issues could be discussed further.

Similar to Oldfield's work, Molyneux (2005) explained her short-term interventions in a child and adolescent mental health service. She explained her work by using three case studies, and two of them involved work with children and their parents. The children in these cases had unhealthy relationships with their mothers. The music therapy provided chances for the parents to develop positive ways of interacting with their children and the non-verbal nature of music-making was able to highlight different sides of the children to their mothers.

In her chapter, Davies (2008) aimed to illustrate how working with children and families in music therapy sessions can be beneficial, and also how it can address difficulties in the family context. She presented her work at the children's psychiatric unit through two case studies. Her case studies demonstrated her work with children with challenging behaviour and their fathers. There are not many case studies with a male carer. These case studies showed how music therapy helped to strengthen the relationships and reinforce existing bonds between the children and their fathers and also develop new ones. She finished her chapter by describing her approach, which emerged from her clinical practise. She concluded that her role as a music therapist is *"to provide the opportunity for families to express and process difficult issues within a contained and supportive environment, and enable them to find their own ways of interacting (p.137)"*

The children who participated in the music therapy sessions in the psychiatric settings had challenging behaviour and had unhealthy relationships with their parents, which is quite different from the children in this current study who did not present very challenging behaviour. However, these studies had a similar goal to the current study which was to provide a safe space for the children and their families to express both their negative and positive feelings appropriately.

2.3.4 Educational settings

There is limited literature regarding music therapy with families in educational settings. Woodward (2004) wrote about a variety of work with children who have ASD. She described two case studies regarding work at a nursery school with a four-year-old girl with her mother and a case of a mother with her two sons, one of whom had Asperger's syndrome. Both cases showed that music therapy helped them to communicate and interact. It helped mothers who were under stress to feel supported and helped the mothers to interact with their children positively.

Howden (2008) described her work at a mainstream primary school with children who had witnessed or had been victims of highly traumatic events involving violence. She used a case study of a six-year-old girl with her mother to explain the work. The work started with working solely with the girl who was referred because of her aggressive behaviour in the classroom. After several music therapy sessions, the mother was included because the author felt that the child's difficulties probably came from the relationship between the family members. The author employed music with the young and vulnerable children in this context as a therapeutic tool as she believed that it was able to help the children feel safe enough to communicate something of their traumatic experience. In addition, she suggested that the families felt more comfortable attending this therapeutic process in a school rather than in other settings because their child's mainstream school gave the feeling of a safe, non-threatening, child-friendly and child-centred environment. However, some parents were concerned that the children might be labelled as "having special needs" and they might verbally share the families' personal issues.

Davies and Rosscornes (2012) explained how they started music therapy work in an educational and day-care setting. This case of a father who was involved in music therapy sessions with his two-and-a-half year-old son with ASD was described. In the sessions they were encouraged to explore many ways of communication through improvisation. Like other cases mentioned in this literature review, this case highlighted the importance of the non-verbal nature of music for working with children who have difficulties in verbal communication and are still in the pre-verbal stage of life.

Although almost all the work above was presented in case report form and reflected the music therapists' points of view, the case reports were able to provide a full and rich description of how music therapy had positively changed the relationship between family members. There is one music therapy study with children with their families in an educational setting (Gilboa and Roginsky, 2010). They examined whether the dyadic music therapy treatment (DUET) was successful in developing the relationship and the communication patterns between a mother and her son with cerebral palsy. The focus was on the improvement of the mother-child communication and relationship. All eight sessions were video recorded and each session took place at a kindergarten for 30 minutes. Each session was followed by feedback sessions with the mother, which were audio recorded. The mother's feedback was used in order to explore the types of relationship and communication patterns that occurred in the sessions. It was also used to examine the trends and tendencies of the relationships and types of communication used across the sessions. There were interviews before the treatment started and another follow-up interview one month after the treatment was finished. This study will be mentioned again to illustrate other points later in the literature review. Similar to this literature, the current investigation aimed to develop the children's communication and to encourage the communication between the children and their families. The current study employed video recordings to review the children's progress with the families and to gain their feedback. However, the video recordings were not used for identifying communication patterns between the children and their carers in the same way as Gilboa and Roginsky (2010). Because of time limitations I decided not to analyse the video as previous studies such as Kim et al., (2008), Oldfield (2004), and Plahl (2007).

According to Howden (2008), the atmosphere of the settings where the music therapy sessions was conducted, influenced how the families' felt in the music therapy sessions. In my investigation the positive atmosphere and the educational setting of the centre I was working in affected both the families' expectations and the way I conducted the sessions.

2.3.5 Families' homes

There have not been many studies where music therapy sessions were conducted in the family home. Warwick (1995) described her work with Muller which carried out in the families' home and aimed to study the effect of music therapy on children with ASD, as well as their families' perception of the treatment. She described some of challenges while she was working with the children and their parents. One of the challenges was to encourage the parents to actively engage in the sessions as most parents found it was difficult to use music freely and spontaneously. They felt self-conscious about engaging in music-making. Also some parents were anxious that their children did not actively participate enough and were too involved in making their children play rather than allowing the children's space to be engaged at their own pace.

Wimpory, Chadwick and Nash (1995) employed musical interaction therapy (MIT) which aimed to encourage a child to have joint attention and actively participate. The music therapist played piano to reflect a child and her mother's actions in order to motivate them to engage. The child and her mother were provided with twice-weekly 20 minute sessions over seven months at the child's home. The sessions involved mother-child games such as swinging, patting, vocalising, action-rhymes and singing. The researchers observed the child's social and symbolic skills outside the MIT sessions by video recording the child in a semi-structured setting during home visits. There were six visits over a four-month baseline followed by seven visits over seven months of MIT sessions, followed by five months of unmonitored MIT. Moreover, there was a follow-up measure twenty months later. The findings following the treatment showed that the child showed more interest in engaging with others, and there was more eye contact. Also the follow-up measure indicated that the positive changes were sustained.

Chaing (2006) conducted her investigation during her clinical placement working with young children who have various disabilities. The study aimed to explore how carers and other professionals perceive the music therapy process. Three children aged from two to three years old attended individual music therapy sessions once a week over a period of three to nine months. The music therapy sessions were usually conducted in the children's home and sometimes were conducted at child development or childcare

centres. Each child's carer participated in an in-depth interview, which mainly focused on the carers' observation and perception of music therapy. Moreover, there was an in-depth interview with a speech-language therapist. A thematic analysis approach was employed in this study. The data from the interviews showed that the music therapy sessions were able to help the children to develop their motor, communication, cognitive, and social skills, and to regulate their emotions. Moreover, the carers expressed their interest in having more music in the family.

Pasiali (2010) conducted a study which aimed to investigate family-based music therapy as a prevention strategy, targeting parental self-efficacy and competence while promoting adaptive child outcomes. This family-based music therapy focused on interaction patterns within the family. Three families received semi-structured music therapy at their home and one family had music therapy sessions at a clinic over an eight week period, once a week. The family members who participated in this study encountered multiple adaptation difficulties and the most common challenge that the participants had was maternal depression. In the sessions, the family members could learn from the music therapist to use music expressively and creatively in order to interact with their children. Moreover, there was musical material and instructions for the families to help them maintain the use of music at home during the week.

Thompson (2012) conducted family-centred music therapy sessions for preschool children with severe ASD at the children's homes during period of sixteen weeks. Her mixed method study aimed to investigate whether family-centred music therapy positively influenced the social communication development of these children with ASD. The results from quantitative analysis were consistent with the results from the qualitative analysis, which were that the music therapy sessions in the home environment could strengthen the parent-child relationship.

Walworth (2012) recommended guidelines for parents to include music in the home environment in order to nurture children with ASD's communications skills, to regulate their emotions, to encourage joint attention between them and their families, and to facilitate transition times for their families. Walworth believed that, with some support

from a music therapist, parents could help their child with ASD to generalise skills they learnt in the music therapy sessions into the home environment. She suggested that music therapists who want to provide home-based music therapy for children with ASD, should familiarise themselves with natural teaching strategies (such as focus stimulation, incidental teaching, or embedded teaching) and integrate these strategies in the interventions. Moreover, it is useful for the parents to see how the music therapist uses music in a home environment before the parents engage in singing or playing a song to support their children's learning process.

The common reasons why the music therapy sessions were conducted in the home were that the children and their families were more comfortable and at ease in their home environment, that the family members could learn about music therapy and that they would have more chances to get involved (Chiang, 2008; Thompson, 2012). Also Warwick (1995) chose to conduct music therapy sessions at the children's home instead of a school because she believed that the home environment could provide a consistent environment to the children while there was more uncertainty in schools. In addition, Thompson (2012) suggested home-based music therapy enabled the music therapist to promote collaboration between the families and the therapist, to work directly with issues that affected the child and family on a daily basis and that the music therapist could model to the parents how to integrate the therapeutic interaction in the usual home situation. However, it was challenging to keep the children from being distracted by toys or to prevent being disturbed by the visitors.

All the home-based music therapy work shared similar aims which were to generalise the way music was used in the sessions into the home environment and to maintain the musical interactions between the children and their parents. These aims were similar to the music therapy work in community centres where the families received musical resources to use at home with their children. The current study provided home visits which included short musical interactions with the children and their families. These home visits aimed to explore how the families used music at home and also to show the families how they could engage their children through music, which was similar to what Walworth suggested (2012).

2.4 Particular benefits of music therapy and children with their families

The family is a basic unit of social organisation. It is responsible for nurturing, supporting socialising and educating its members (Minuchin & Minuchin, 1974). Children and their parents have a strong bond and they directly influence each other both physically and psychologically. Besides feeding and providing care and security for the baby, parents also create the sense of self for the baby (Stern, 1995). Winnicott stated, *“there is no such thing as a baby - meaning that if you set out to describe a baby you will find you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship* (1964, p. 88).”

A healthy relationship with their parents is a basic need for infants. The infants' development of self-confidence and security, emotional stability, readiness to learn, and social competence is established by having a relationship with their parents (Browne & Talmi, 2005). When the congruent interaction between the carer and the infants emerges, the infants' physiological, behavioural, social and emotional responses can be well adjusted (Hofer, 2008). Subsequently, the infants can develop their self-regulation capacities (Sameroff & Fiese, 2000). Moreover, to be there and respond appropriately to the child's needs, the mothers or carers have to have great dedication and devotion in order to be able to actively adapt to the needs of the child (Winnicott, 1966).

Involving the parents or other family members in their care plan can support the children in many ways. Starting from the planning process, parents are able to identify their child's strengths and weaknesses in many different situations (Chandler, 1992). The information, which the parents are provided with, can create a suitable care plan for their children (ibid). The parents' role in music therapy sessions with their children varies. It depends on the parents' personalities and also on the aims of each session. This section will explore particular benefits of involving the children's families in the music therapy sessions.

2.4.1 Having fun and positive experiences together

Normally, the first reason why parents agreed to participate in music therapy sessions with their children is that music therapy enables them to have fun and have positive

experiences with their children. As mentioned above, having children with special needs usually creates stress, on-going sorrow and feeling of loss. As a result parents often do not have very much quality time with their children. When the parents were involved in the music therapy sessions and were encouraged to engage in fun activities instead of being worried, they could witness their children's enjoyment (Howden, 2008).

As the music therapist is trained to engage with the children who have limited communication and social skills, they are able to follow a child's lead, and they know how to use music as a non-verbal communication tool to interact with the child. Therefore, children can engage with the music therapist in a different way from when they communicate with others. In the music therapy session, the parents are able to see the children's new way of interacting with others and see them differently (Alvin & Warwick, 1991; Woodward, 2004). Loth (2008) described a music therapy group for pre-school children who have a learning disability (most have little or no verbal language) with their parents. From participating in the group, the children were provided with the opportunity to succeed and to enjoy the experience of being "able". These experiences allowed the parents to see their children learning new skills and to be more aware of their children's abilities rather than their disabilities which is similar to Shoemark's early intervention music therapy work (1996).

In music therapy sessions in a paediatric ward the parents were sometimes included, and they reported having fun together even in a short period of time. This experience lessens the stress in both the parents and their children. (Ayson, 2008; O'Neill & Pavlicevic, 2003a). Also the hospitalisation experience can become less threatening and music therapy was able to alter this experience by adding some fun and normality to the situation (K. Lindenfelser, Grocke, & McFerran, 2008). The parents of a terminally ill child defined song-writing during music therapy with their child as "treasured memories". Their music therapy experiences and the song they wrote supported the parents in their grief by enabling them to hold on to significant memories as a way of continuing the bonds and their relationship with their child (ibid.)

Providing fun and positive experiences to the children and their families is the first aim in this current study. From experiences of working with the families, I found that many family members were anxious about their children's disabilities and worried that their children could not improve. Therefore it was necessary to provide the families with a chance to relax and have fun, and with an opportunity to recognise their children's abilities.

2.4.2 Improving communication and nurturing relationships between children and their families

Music therapists are trained to use music to engage with the children who appear to be remote from others (Oldfield, 1993; Woodward, 2004). For some families who are confronted with verbal conflict and who struggle to use verbal communication, music allows them to explore their feelings, often towards one another in a subtle and non-confrontational way (Ayson, 2008; Davies, 2008; Howden, 2008; Oldfield, 1993). Playing musical instruments can carry sensitive messages, which the family can feel more comfortable to express in this indirect way (Davies, 2008). Moreover, the instruments create both involvement and safe distance and they can be seen as a metaphor for family functioning, where closeness and distance, and balancing power within a family may be important themes (Hibben, 1992). With support and help from the music therapists, the parents can be motivated to engage with their children who are speech-delayed or who are at a pre-verbal stage of communication (Drake, 2008; K. Lindenfelser, 2005). The music therapist can provide an opportunity for the mother and child to re-experience, or experience for the first time, the early mother-baby types of interactions which are spontaneous and playful within a secure and contained space (Davies, 2008; Oldfield & Bunce, 2001).

Additionally, during non-verbal communication the issue of control between the parents and the children can be explored (Oldfield & Bunce, 2001; Oldfield, 1993). After the non-verbal communication through music has occurred, this can lead the families to explore or discuss how they feel. However, the musical communication between them can be enough to lead each member of the family to move forward with their relationship (Howden, 2008).

The children's growth is directly influenced by the carers (Bowlby, 2005). The mother's readiness, to care for her child both physically and psychologically is necessary for the baby's development (Winnicott, 1964). Shoemark's playgroup (1996), was influenced by the family system model of Dunst and Trivette (1987). This model views the family as a unit, where *"events and changes in one unit resonate and in turn directly and indirectly influence the behaviour of individuals in other social units (ibid, p.5)"*. The practitioners are encouraged to recognise the family as their intervention unit so that they can increase the chances of making a positive impact on all the family members. Recognition of the family, and not just the child, as their intervention unit, improves the chances of making a positive impact on all the family members. Not only can the progress in the individual child indicate the success of the work but the way the family develops is also very important in the family-centred playgroup (Shoemark, 1996). With this thought in mind, the music therapists can support the parents who struggle with their own depression and do not have enough time to take care of themselves. In music therapy sessions with the families, the children are the primary client but the parents' needs cannot be disregarded (Howden, 2008; Oldfield, 2006b).

When working with families who have negative interaction patterns or negative feelings toward each other, music therapists may focus on non-verbal communication enabling the parents to explore new ways of engaging with their child and increasing the interactions between the parents and their children (Davies, 2008; Hibben, 1992; Horvat & O'Neill, 2008; Howden, 2008; Oldfield & Bunce, 2001). Music therapy enables parents to begin to respond more sensitively to their children (Davies & Rosscornes, 2012; Molyneux, 2005; Oldfield & Bunce, 2001; Woodward, 2004). In the Gilboa and Roginsky study (2010) mentioned earlier, where the dyadic music therapy treatment (DUET) was established as being successful in developing the relationship and the communication pattern between the mother and her son with cerebral palsy, the focus was on the improvement of the mother-child communication and relationship. The results showed that there were three types of communication pattern between a child and a mother; non-verbal communication, musical communication and verbal communication. There was an increase in the use of communication, especially in the

second half of the treatment. Also the mother and her son used mostly non-verbal and musical types of communication rather than verbal types of communication (ibid).

This overview shows that the music-making by the children and their families could convey sensitive messages, which then could lead them to discuss how they felt. In the current study, the children and families were not encouraged to discuss how the music made them feel because most of the children who participated in the study had difficulty with verbal communication. I used music as a tool to interact with the children. The music could create a playful atmosphere, which could capture the children's interest and motivate them to engage with me. Similar to Davies (2008), Oldfield and Bunce (2001), I also employed music to create a contained space for the families to be playful and spontaneous so that they could try to use music to interact together.

2.4.3 Improving parenting skills and increasing parents' self esteem

In some studies, the parents and the music therapist discussed or reviewed the sessions by looking at video recordings of themselves and their children after each music therapy session (Loth, 2008; Oldfield et al., 2003; Oldfield & Bunce, 2001; Oldfield, 2004, 2008, 2011b). This helped the parents to recognise how they could enjoy being with and interact positively with their children. This enabled the parents' confidence of their parenting skills to increase. Moreover, the music therapists' comment to the parents about their good parenting skills helped the parents acknowledge their success (Oldfield et al., 2003). Also the parents were allowed to rediscover the fun and spontaneity of being a child again through playing a simple instrument and this reminded them of similar interactions they had had with their own mothers. Therefore the parents could recreate warm and simple interaction with their own child (Oldfield & Bunce, 2001).

For the parents who appeared to be lacking in confidence to engage with their children, they could first spend time observing how the music therapist engaged with the children in a different way. This could remind the parents how to be playful and childish with their children (Oldfield, 1993; Woodward, 2004)

In the hospital, especially in neonatal intensive care, the mother of a hospitalised child might feel that her mother's role is diminished because her child's health is depending

on the medical staff. Music therapy can assist parents to be involved in a supportive role during treatment (Edwards, 1999). With some support from the music therapist, infant-directed singing can be used to provide the infants with care and love from their mothers. This helps the mothers to maintain their own primary role in soothing their infants, and facilitates pathways for the infants' recovery and development (O'Gorman, 2006). Also the study showed that the infants showed preferences for the auditory stimulus of their own mother's voice (Standley & Madsen, 1990).

My clinical study employs video recordings from the sessions to review and to discuss the work with the family members after some sessions. I found that when viewing the videos the family members saw themselves as being more able to engage with their children than they thought (5.2.4). In addition, most of the family members who participated in this study initially appeared to be shy and quite quiet, however when they were in the sessions they could observe how the music therapist engaged with their children which is similar to what Oldfield (1993) and Woodward (2004) stated in the literature. This enabled them to be more playful and confident to try new ways to engage with their children.

2.4.4 Developing partnership between the carers and the music therapist

When the parents were involved in the music therapy sessions, they are not seen only as the child's carer but sometimes they are also seen as the co-therapists with the music therapist. Therefore, establishing a strong and a trusting relationship with, and supporting, the parents is very necessary either when they are in or outside the sessions (Horvat & O'Neill, 2008; Shoemark, 1996). Horvat and O'Neill (2008) and Oldfield (2008) showed that the parents and the music therapists worked together during the sessions and then discussed their roles, and thought carefully about the aims and approach at the end of each session. This meeting with the parents alone also provides them with their own space to discuss their needs, their concerns about their children, and other issues in their lives that are worrying them. When the parents feel that someone listens to their stories, this enables them to find the resources to help them change their responses and change the way they relate to their child (Bull, 2008). The partnerships between the parents and the music therapist are established through the experience of

working closely together both in and outside the sessions. A warm and respectful relationship is needed. A good balance between the input from both the parents and the music therapist enables them to work collaboratively and help each other to address the children's needs (Oldfield, 2008; Shoemark, 1996).

The music therapists working with the parents must carefully think of how to make the parents feel as comfortable as they can. However, it is still very difficult to prevent all conflict which can occur during the sessions. As the music therapist can often engage well with the children, the parents might feel excluded from the relationship between the therapist and the child. It is rewarding for some parents to see their child interacting in new ways with another person, while other parents can see this as discouraging and undermining of their own parenting skills (Woodward, 2004). The music therapists have to carefully decide when they should suggest new ways for the parents of engaging with their children (Loth, 2008). Additionally, some information is considered as a confidential but also useful for the parents. The music therapists should think carefully about what information is appropriate to share with the parents (Procter, 2005).

One of the aims in this study is to encourage the family members to experience using music with their children both inside and outside the music therapy sessions. In order to do that it is important to have the music therapist and the families to work together to provide suitable sessions and also to find ways for the family to feel comfortable to interact with their children through music. In my study, I found that the family members were more familiar with following the directions than initiating their ideas. (This is elaborated more in 3.3.) It was crucial for me to acknowledge the family members' suggestions so that the family members and I could work collaboratively in a similar way to Oldfield (2008) and Shoemark (1996).

Conclusion

Having children with special needs can affect the rest of the family members in many ways. The parents encounter loss and sorrow and these feelings can diminish the healthy relationship between the parents and the child. Much of the literature examined shared similar beliefs regarding the importance of parent-child's interactions and the influences

the parents and the children have on each other. The aims of these studies focused both on the children and their families separately and also on the relationship between them. In summary, the findings from the literature show that music therapy for children and their families was successful at nurturing the relationship between the child and their family, independent of the children's age, their particular difficulties or the setting where the music therapy sessions took place. All the music therapy work was recognised and valued by the family members and other professionals (Chiang, 2008).

Only a small amount of music therapy with families was conducted in educational settings. Similarly, there was only a small amount of literature exploring how music therapy was used in the home environment.

Most of these studies involved the children and their parents. There were very few studies working with the children and other extended family members in the music therapy sessions.

Many of the studies described how helpful it was to have the families to work together with the music therapist. However, only a few music therapists have suggested guidelines of how to work collaboratively with the families.

All of these studies were conducted in a western context such as the United Kingdom, the United States, Australia and New Zealand. There was no study regarding music therapy with children and their families conducted outside western culture and influence.

The literature suggested that more research is needed to understand the experiences of family members participating in music therapy sessions with their children with special needs, how the families can be involved in this therapeutic process and how their involvement affects the process, the children and themselves.

It is clear that my study which is looking at music therapy with children and extended family members in an educational setting in Thailand is filling an existing gap in the literature. The fact that I have also included work in the children's homes and have attempted to produce some guidelines regarding how to work with parents is also important as little work has been done on these two aspects.

Chapter 3 Context of the study

Introduction

This chapter aims to explain the context which influences this study in many ways, such as the way parents or family members responded to the music therapy or how I understood the parents or family members. It will cover related issues, namely, Special Education in Thailand; the Special Education centre, region 9; family and children with special needs in Thailand. It will also explain how the music therapy research investigation was set up in the Special Education Centre, region 9.

3.1 Special Education in Thailand

This study was conducted in the kingdom of Thailand. Thailand is located in Southeast Asia. It is the third largest country in terms of total area in the region. It covers an area of 513,115 square kilometres and it is divided into 77 provinces. The official language is Thai and the majority of the population are Buddhist. Bangkok is the capital city of the country and also is considered to be the most densely populated area in the country. 9.3 million people live in the city of Bangkok.

According to the Ministry of Social Development and Human security, from November 1994 to September 2012 there were 1,265,224 children with special needs in Thailand (Ministry of Social Development and Human Security, 2012). Children with special needs in Thailand are divided into nine categories. These are: visual impairment; hearing impairment; severe learning disabilities; physical disabilities; learning disabilities; speech disabilities; behaviour and emotional disorders; autism spectrum disorder (ASD) and multiple disabilities (Ministry of Education of Thailand, 2008)

During the past few decades, the special education policy in Thailand has been changed significantly. In 1938, the first special education programme in Thailand was conducted by Ms. Genevieve Caulfield, a blind American woman. Later, taking influences from the Western education system, the first education program for deaf people was established in 1952 (Yotanyamaneewong, 2012). Since then there has been an increase of services

sponsored by the Thai government for children with special needs. The children were allowed to go to school, however it was not an obligation for the parents or family members to bring their children to school. Also the schools were able to refuse to be responsible for children with special needs, if they were not ready for them. The major impact on changes for special education in Thailand was the education reform in 1999. The policy stated that every person with special needs could have access to free education from when they first receive a diagnosis. Moreover, they have a right to access any facilities which provide them with help and support. Later in 2004, the policy was changed to make it clearer. It stated that any Thai nationals, including people with special needs, are able to access free education for at least twelve years.

Three years later, the government launched the latest piece of legislation promoting and developing the lives of people with special needs. This policy aims to protect people with special needs and ensure they are treated equally (Ministry of Education of Thailand, 2008). The legislation identifies rights, benefits and services that people with special needs should receive. In the legislation, it first declares that it is the right of all people with special needs to have free education for the whole of their lives from when they are first diagnosed. Also they have rights to access technology, educational resources and any services related to their education. It also stated that it is against the law if any educational institute refuses to accept people with special needs into their institution. Moreover, it intends to encourage and develop the wellbeing of people with special needs, according to their individual desires and needs. The Ministry of Education divides the education system for children with special needs into three groups, namely, an education system specifically for children with special needs, mainstream schools and classroom education combined with rehabilitation in hospitals or rehabilitation centres (Yotanyamaneewong, 2012).

Over the past ten years, the government has shown more concern over special education. The government launched many social events and campaigns to encourage more understanding and acceptance of people with special needs. Extra funding is provided to the schools, which start inclusive programmes (Yotanyamaneewong, 2012). However, there are many children with special needs that cannot access some facilities and

services that exist in Thailand. The support systems are mostly situated in big cities, therefore many families in rural areas who have a child with profound disabilities cannot gain access to government health support services. The families' economic problems do not allow them to pay for transportation and the parents cannot stop working. The facilities in rural area seem to give insufficient support to the children. During my clinical work I saw many children and their families from rural areas travelling to special education centre region 9, as it has a good reputation and they have enough available resources to provide for people from a wide catchment area.

Moreover, there is still a lack of education for families, teachers or staff who are involved in the children's lives. The educational policy in Thailand seems to move rather quickly to a more inclusive practice toward individuals with disabilities. These policies have been implemented at rather a rapid pace, therefore they have caused some associated difficulties which relate to insufficient qualified education, lack of appropriate services and the persistence of out-dated practises (S. L. Carter, 2006; Srisuruk, 2012).

3.2 Special Education Centre, Region 9

The special education system in Thailand is continuing to develop. The number of resources and facilities are increasing. The Thai government sponsors all 76 special education centres. Each centre aims to provide free services to children with different needs for all their life from when they are first diagnosed. According to the latest national piece of legislation on special education, a special education centre refers to an educational institute, which has a responsibility to provide early intervention. It also conducts education for people with special needs and educates the families, carers, teachers, and also anyone who is involved in the life of a person with special needs (Ministry of Education of Thailand, 2008). Moreover, the centre provides help to children with special needs at home and also children with chronic illness in hospital (Special Education Centre Region 9, 2014).

Special Education Centre region 9 is situated in Khon Kaen province in the north east of Thailand. The northeast of Thailand (this region is also called Isaan) is the largest area

of Thailand and also contains most of the population. It is considered to be the poorest part of the country. Khon Kaen is the second largest town of the northeast region after Nakhon Ratchasima. The approximate population is 2 million. It is considered to be a big city in a region. A major hospital, a university and many factories are situated in the city. Between November 1994 and September 2012, there were 37,955 children with special needs in Khon Kaen (Ministry of Social Development and Human Security, 2012). Most of these children have physical difficulties.

The Special Education Centre Region 9 normally receives referrals mostly from hospitals, schools, or the parents or family members themselves bring their children as they learn from other parents about the centre. The centre is situated in a well-equipped building and there are adequate educational resources for children with different needs. The children receive both group activities and individual lessons. The centre provides physical therapy, speech training, and everyday life training. There are seven classrooms, two classrooms for children with ASD and two classrooms for children with intellectual difficulties. The rest of the classrooms are for early intervention, children with hearing impairment, and physical difficulties. Every new child with different needs will start from the early intervention classroom for both the parents or family members and their children to adjust to a new environment. While the children are attending this classroom, they also receive a preliminary assessment in order to set both short and long term goals, to design an individual education plan (IEP) and to provide suitable educational material. The assessment is conducted by a classroom teacher, a teacher who is specialised in speech therapy, an art teacher, and a physical therapist. The result from the assessment will be discussed among the teachers and also with the parents or family members before the children are referred to a suitable classroom. Each classroom has a big room for group activities and two small rooms for keeping education resources for the children to choose and play with and to provide individual interventions. The centre has obligations to provide many services such as a) to enable the children to access learning according to their needs, b) to provide learning support aids as appropriate, c) to provide early intervention in order to prepare some students to transfer to normal school in an inclusive classroom, d) to research and to develop the curriculum, lesson plans and

learning aids, e) to develop and train staff in the centre and also from other places outside the centre who are involved in the children's education plan, f) to follow up and evaluate the children's progress and to provide information about special needs education.

Each classroom has at least two teachers who are in charge and one assistant teacher. Most of the students come to the centre with their parents or family members. The parents or family members participate in all activities along with their children. In 2012, there were approximately 60 children with special needs who regularly attended the Centre (Table 1). The number of the children varies according to the children's health, their parents or family members' employment. As many children did not originally come from this city when the parents or the family members needed to manage their personal issues in their home town, they tended to miss the class for a while. Some of them had to move back to their home town and attend another institution to get support or to take care of their children themselves at home and to get support from time to time. In this centre, the parents or family members were encouraged to come to the centre with their children every day. There is accommodation provided for some families who come from other cities. Many fathers or mothers have to earn a living and cannot afford to come to the centre with their children every day. For those children who do not come to the centre with their parents, their grandparents or their aunts often accompany the children to the centre instead. In some families, the children live with their grandparents or aunts while their parents work in different cities. In this centre, the teachers, the parents and other family members work closely together to improve the children's wellbeing. They participate in every activity with their children. They take some activities to work with the children at home. In Thai society, each family member including in extended families tends to develop strong connections and support with each other, including helping parents and children with disabilities in the home environment (Vorapanya, 2008).

Table 1: Number of children in each classroom in 2012 at the Special Education Centre, Region 9

Room	Number
Early Intervention	7
Autism Spectrum Disorder 1	12
Autism Spectrum Disorder 2	12
Intellectual Difficulties 1	6
Intellectual Difficulties 2	5
Hearing Impairment	7
Physical Difficulties	9

After the children are ready to go to the next academic level, the centre normally refers them to attend the normal school which provides an inclusive classroom. Some schools have a connection with the Centre, therefore the teachers from the centre accompany and support them along the way. Moreover, some children were referred to schools which provide education specifically for children with hearing difficulty, physical difficulty and visual difficulty.

3.3 Families and children with special needs in Thailand

In the past, society had little understanding and had difficulties accepting people with special needs. Therefore, people with special needs could not receive appropriate help. This affected the country's economic development because if the children were left without special help, finally they became helpless and became a burden on the family and society. The families have not been satisfied with the service, as the service is still not fully developed yet. There are some issues that need to be addressed such as the shortage of trained teachers of children with special needs and the lack of funding (Ahtmitr, 2011; Ayawongse & Pungah, 1983; Carter, 2006). Thai families who are poor or live in rural areas are less likely to be aware of existing programmes or have the will

and means to access those services (Fulk, Swerdlik, & Kosuwan, 2002). Also, some parents or family members do not have a good education and they therefore lack understanding, which could lead to them being in denial.

Many studies recommended viewing special education in Thailand through a religious perspective (S. L. Carter, 2006; Fulk et al., 2002; Naemiratch & Manderson, 2009; Rukwong, 2008; Sethabouppha & Kane, 2005; Yotanyamaneewong, 2012). Ninety-five percent of the Thai population is Buddhist. Buddhism is a very important part of Thai people's life. Thai people's belief in Buddhist philosophy reflects on so many things, namely culture, arts, music or literature. Also its philosophy has a strong influence on everyday activity. One of the main philosophies that the Thai Buddhists strongly hold onto is 'doing good, will bring good' and 'doing bad, bring get bad' (Naemiratch & Manderson, 2009). In some parts of Thailand, people believe that if people do bad things, a ghost or supernatural being will punish them so that they have bad luck or an unhappy fate (Rukwong, 2008).

In Thailand, children with special needs were considered to be the punishment for their own or their parents' misbehaviour in their previous life. This belief came from Buddhism which said that a person's current life was based upon their actions or behaviour in their previous life (S. L. Carter, 2006; Fulk et al., 2002; Yotanyamaneewong, 2012). This belief leads the parents or the children themselves to think that in their previous life they did something bad and this could be a cause of the disability they have in this present life. Therefore, many parents or family members of children with special needs tend to blame themselves and feel guilty, consequently parents or other family members may over-protect their children in this lifetime. In an opposite way, some parents or family members choose to neglect the child because they think that the child him/herself did something bad in the previous life. However, both ways of thinking may cause the parents or family members to provide unsuitable care and inefficient support to children with special needs (Yotanyamaneewong, 2012). In the past, many children with special needs have been kept at home without any education because their parents believed that they cannot learn anything (ibid) and also, because the parents were ashamed of their children (Srisuruk, 2012). Additionally, some parents

refused to include their children with special needs in everyday activities because they wanted to protect them from becoming the objects of others' pity (Naemiratch & Manderson, 2009).

Nevertheless, there are also studies which were conducted in the western context and they suggested that having children with special needs can also have a positive impact on the families. Many families found that the children with special needs were a source of joy and happiness and this theme emerged in many studies (Greer, Grey, & McClean, 2006; Hastings, Beck, & Hill, 2005; Jones, 2011; Scallan, Senior, & Reilly, 2011; Stainton & Besser, 1998).

The studies also showed that the families saw themselves as having a greater sense of purpose and revised priorities, then beginning to be aware of what was really important in their lives. When they managed to cope with many challenges, they felt more empowered as parents and as people. They felt that they could do more than they used to be able to do. Being a parent of children with special needs developed their personal growth and strength (Greer et al., 2006; Jones, 2011; Scallan et al., 2011; Stainton & Besser, 1998). Also, families expanded their social network as they learnt to seek help from the community and support services (Scallan et al., 2011; Stainton & Besser, 1998). The family units became closer because all the family members had to support each other and shared challenging experiences and survive together. The family's positive perceptions toward their children with intellectual disabilities were related to the family's coping strategies and support from family members and friends (Hastings, Allen, McDermott, & Still, 2002).

According to Sethabouppha and Kane's study (2005) which explored the experiences of Thai Buddhist care-givers who took care of their relatives with seriously mentally illness suggested that Thai Buddhist care-givers also follow the path of Dharma (Buddhist teaching) to take care of their family members who have serious mentally illness. The care-givers believed that they could collect merit by helping others, meditating or giving care to their family members, and consequently they could achieve a better life in the next. Some care-givers believed that according to the law of Karma, in this life they

were repaying their relatives who suffered from mental illness, from doing harmful things to them in the past life.

Moreover, Dharma also influences the way Thai families cope with their stress which results from their family members having illness or special needs. When Thai Buddhist people face difficult situations, which they cannot change, they tend to accept, be patient, understand and oblige. They usually employ the Dharma principle of “ubekka” (equanimity) to help them be at ease when they have to take care of their ill family members (Naemiratch & Manderson, 2009; Rungreangkulkij & Chesla, 2001; Sethabouppha & Kane, 2005). There are different interpretations and translations of this word. In this context, the explanation from Thich Nhat Hanh (2008, p. 161) says *that the Sanskrit word “upekha” means “equanimity, nonattachment, non-discrimination, even-mindedness, or letting go*. The care-givers accepted that sickness is natural. Also they could tolerate when their family members who have illness or special needs presented challenging behaviours because they accepted that this illness is incurable and they continued to love and show compassion to their family members (Sethabouppha & Kane, 2005).

According to Wanset’s study (2005), the parents or family members of children with ASD in Thailand noticed their children’s condition when the children turned 2 – 3 years old but showed signs of communication delay. The parents learned from the media about the condition and then decided to see a doctor. The first three priorities of expectation the parents had for their children were to be able to take care of their daily routine, be able to live happily in society and be able to communicate with others. The two most concerning issues they had toward their children were that they could not manage their children’s challenging behaviours and they could not help their children to improve motor skills (such as learning to walk). And communication skill was one of the skills with which the parents most needed help from the multi-disciplinary team.

Furthermore, the study (Wanset, 2005) showed that the mothers appeared to handle the diagnosis better than the fathers. The mothers mainly took care of the child while the fathers took care of financial issues. In some families the mothers had to quit their jobs

to become a full time care-giver. The family usually struggled with financial issues as they wanted to get their children to have different kinds of therapy from private practices. In the families which stay together with the grandparents, the parents had much support from the grandparents. However, the grandparents struggled to accept their grandchildren's diagnosis, therefore they could not provide appropriate care and avoid revealing their grandchildren's condition to other people outside the family.

Nowadays, the parents or family members have received more education, therefore they start to react differently and understand more about their children's difficulties. Also the general population becomes more knowledgeable about people with disabilities through national media promotions and campaigns. Therefore, acceptance of disability is improving. Moreover, people with special needs are gaining more understanding and acceptance about their conditions from their family. Therefore, it has become more usual these days to see people with special needs in public in both rural and urban communities (Vorapanya, 2008).

3.4 Setting up the music therapy research investigation in the Special Education Centre, Region 9

My research at the centre is divided in to three phases, which are: setting up the clinical work, doing clinical work, and gathering data from interviews and home visits. The following section will explain the process of setting up this research project. This setting up process took about three months, which included introducing myself to the centre, organising the room, providing initial music therapy sessions, arranging a timetable, giving two music therapy assessments and having a research assistant to conduct pilot interviews.

3.4.1 Introducing music therapy and the research investigation

About six years ago before I start a PhD course, I was a volunteer in this centre as I wanted to learn and experience working with children with special needs. Therefore, I was relatively familiar with the centre before I conducted this study. At that time I found that in the setting the parents or family members had to come along with their children every day to work collaboratively with the teacher to support their children and to learn

from the teachers to educate their children. I was also able to learn how the centre encourages the parents or family members to participate in organised activities alongside their children. Therefore, it was a very good opportunity for my music therapy investigation to promote and support the centre's idea of involving the parents or family members in the sessions.

In order to re-introduce myself to the centre and obtain permission to conduct this study at the special education centre, first I sent the centre director a letter which included my project details and my plan to conduct music therapy sessions in the centre. After I got permission from the director to conduct my research at the centre, I suggested doing a presentation to the centre staff and teachers. The presentation initially aimed to explain to the teachers and staff at the centre about music therapy, my research's objectives and research plan. The presentation was 20 minutes long and included some video excerpts of music therapy work from my first supervisor. The teachers appeared to be interested in my project and referred some of their children right after I finished my presentation. The referrals included children with ASD, physical difficulties and learning disabilities. The teachers referred these children to me with different aims in mind, namely, improving concentration, developing social skills or simply because they felt that the child showed very good responses to music.

3.4.2 Room setting

The music therapy sessions were conducted in a small room which was attached to the Early Intervention classroom. In the beginning I was not sure how to arrange the room so I experimented and adjusted the way I laid out all the instruments, chairs, mat and shelves in the most suitable way for the children. Firstly, I laid down some instruments for the children to choose. Some children seemed lost in a new environment and were not sure what to do. Often children wandered around the room and tried to play everything in my instrument box. After some sessions and with some suggestions from my supervisor and the family members, I kept the room tidy and put almost everything in the box. In the box, there are different kinds of hand-held percussions instrument, recorders, bells, small ocean drums, small whistles and a melodeon. I only left a ukulele, xylophone and a keyboard out. Moreover, there are many kinds of educational materials

in the small room. Therefore, I covered all the equipment with a cloth in order to prevent the children from getting distracted. While the sessions were progressing, I asked the children to choose one instrument at a time from the box.

3.4.3 Initial-Music therapy session

Before I started my clinical music therapy research sessions, I ran music therapy sessions for two students at the centre. These sessions did not include the parents or family members. My purpose was to spend time at the centre and familiarise myself with the students, their parents or family members and the teachers at the centre before I started to collect data. I also wanted to regain confidence in music therapy work since I had not done clinical work for many months and I had never conducted music therapy work with Thai students before; especially working with parents or family members was very new to me. As I stated before, music therapy in Thailand is still in its infancy, and the parents were not very familiar with music therapy, therefore I did not know what to expect from the parents' or family members' perceptions. My supervisor suggested to me to start working with two individual children without the parents or family members to again familiarise myself with clinical music therapy work.

I decided to start working with children with ASD first because before I started this initial music therapy I was allowed by the teachers to observe in the classroom of children with ASD. Therefore, I felt most familiar with the children and the teachers there. I asked the teachers to refer two children from the class who regularly came to the centre and showed interest in music. After I received referrals, I gave the parents or family members a letter to ask for their permission to allow the children to participate in the initial music therapy sessions. The letter explained how I would work with their children in the music therapy sessions and how beneficial it would be for their children to participate in the sessions. At first the parents or family members seemed to be uncertain if their children would benefit from participating in the music therapy sessions and they did not much know what their child would do in the sessions. I talked with the parents or family members about the work I had done after each session. After a few sessions, I felt that I gained some trust from the parents or family members. They were more relaxed and talked more freely with me after each session. Other parents or the

other family members seemed more enthusiastic to bring their children to the music therapy session after I had provided initial music therapy sessions to two boys. These music therapy sessions enabled me to gain a good reputation in the centre and to gain the parents' or family members' trust. Also, I felt much more at ease after the first few sessions with the two boys. I started to realise how much more comfortable I felt using Thai language in music therapy work. After some sessions, I felt more confident and familiar with the boys, therefore I invited their parents or family members to join in the sessions. I continually provided these initial music therapy sessions once I started research investigation. However, one of them stopped coming to the centre because of their family problems. The case vignette below will be used for explaining how the work of initial music therapy sessions enabled me to regain confidence and prepare myself for conducting music therapy sessions for the research project.

3.4.4 Case vignette

Poom was six-year-old boy with ASD. He was the first child I worked with at the special education centre. The teacher was concerned that he always appeared to be in his own world and preoccupied. This prevented him from listening to the teacher's suggestions and engaging well in the classroom. In the music therapy session, I initially aimed to encourage Poom to engage with others longer, to provide a positive time, in order to decrease time when he was in his own world, and to encourage him to learn to listen to other people's signals. He hesitated to come to the sessions in the beginning. His grandmother took him to the session and stayed for a brief time until he started to engage with me. He showed much interest in music, especially in the ukulele. He sometimes sang along with me. Especially when I sang his favourite songs, he would hold the ukulele and play gently along, with me playing a keyboard. Also he liked to play the start-stop game which was when he and I took turns playing the ukulele and giving a signal of start and stop. He loved giving me signals but I found it was challenging for him to accept my signal. As the sessions progressed and I tried different musical activities with him, I found he was able to respond to my signal better. He seemed to respond better to signals when I gave him a clear signal (not only word but also slowing down and softening the music) and used more gestures (touching him on

his arm to see me when I gave a signal). Moreover, I avoided giving him an instrument which made a louder sound than the one I used when I wanted him to learn to listen to another's signal; nevertheless I would not be able to contain him and it would be more difficult for him to listen to my signals. These initial music therapy sessions allowed me to try out small but useful tricks, which were important in the later part of my clinical work. Moreover, I felt less anxious and able to let myself be more explorative with different kinds of musical games or musical activities.

Later, his grandmother who is his primary carer, seemed to be interested in what happened in the session. She came and waited in front of the music therapy room. She showed herself enthusiastic to know how Poom doing in the sessions. So I decided to invite her to join in the sessions. I was very pleased when his grandmother seemed very surprised to see Poom very active and well engaged with me in the sessions, as she said normally Poom was on medication which made him sleepy and slow responding. She gradually joined in the activities and was willing to try new musical games with her grandson. She liked to sing along with Poom and always gave him very lovely support. She told me that Poom very much enjoyed his time in the session and he often told the family about what he did in the sessions. His grandmother also shared a very impressive moment when Poom brought his guitar to play and sang his favourite song to his mother at home. His mother was very surprised and impressed. This event brought tears of joy to his mother. These positive comments and his engagement in the sessions helped me to regain confidence in conducting music therapy sessions. His grandmother's comments reassured in me the benefits of music therapy for Poom. Additionally, involving his grandparents in the sessions enabled me to understand his condition more because we always discussed Poom's improvements which could see from both in the sessions and at home. Therefore, I was able to provide him with more suitable music therapy sessions.

3.4.5 Arranging the timetable

Arranging the timetable for the clinical music therapy sessions was not easy. The teachers at the centre suggested to me that I should provide music therapy sessions in the afternoons. The centre normally provides lessons and activities in the morning so it was

felt that it would be better not to disturb the students' school routine. I was quite worried in the beginning that the children would be tired or sleepy in the afternoon and concerned because on Tuesday and Thursday afternoons the students went horse riding. Also, some parents or family members wanted to take their children back home directly after their children finished the centre programme, especially on Fridays. In addition, it was not easy to get chances to talk with the parents or family members about arranging timetables for the treatment because they were always busy taking care of their child. So when I did get a chance to discuss this with the parents or family members I had to do it very quickly. Nevertheless, I was able to create a rough timetable where I would be available at the centre and asked the parents or family members what their preferred time would be. Luckily, some parents or family members were very flexible which meant that I could provide more options for the parents or family members who wanted specific times.

3.4.6 Music therapy assessment

Once I had received the referrals from the teachers, obtained consent from the families to be part of the research investigation and organised a timetable, I did two music therapy assessment sessions with each child. Each session took 30 minutes. The sessions firstly aimed to confirm that music therapy was suitable for the child. Then I was able to learn the children's strengths and weaknesses (Oldfield, 2004) and also learn about the children. For example, I could find out about children's preference of music, their social skills, their physical skills and their communication skills before including the parents or family members in the sessions. This enabled me to set appropriate music therapy goals for them.

After these two assessment sessions were finished, I provided the parents or family members with a short written report which explained what the children did, what I learnt about their children in the sessions, and suggesting some music therapy goals for their children. This report was helpful for starting out our discussions. After the parents or family members read the report, I asked them to share their thoughts or concerns about their children. Therefore we were able to get to know each other and I could learn something about how the parents or family members thought and felt about their

children and what they expected from the music therapy work. Besides that I was able to see how music therapy would support the parents or family members themselves.

3.4.7 Pilot interview

My research assistant conducted two pilot interviews with parents or family members of the children to whom I provided initial music therapy sessions. These aimed to ensure that questions in the interview would become more appropriate and more able to gain the most important information from the parents or family members. The first pilot interview was quite short, about 15 minutes long. So I suggested to my research assistant that she should encourage the parents or family members to give examples of their children's behaviour as the questions were asked. Also, I felt that the last part about the parents' or family members' opinion about music therapy was too short so I added more specific questions which were broken down from the pilot interview questions. With more questions, the research assistant could help the parents or family members to answer the question in more detail. Also, I thought it was necessary to explain to the parents or family members about my aims to involve the parents or family members in the music therapy sessions with their children and how beneficial it would be for both the parents or family members and the children to be in the sessions together. Therefore, I explained to my research assistant about music therapy with parents or family members and their children with special needs so that she was able to explain to the parents or family members before the interview started. Importantly, I noticed that the parents or family members seemed to talk about the children even when the questions were about the parents or family members themselves. They tended to relate most of their concerns to their children's wellbeing as they devoted their life to take care of the children. I emphasised to my research assistant that the research was also focused on the parents' or family members' needs. So I suggested to her that she should encourage the parents or family members to talk about themselves more. For example, both parents in the pilot interviews gave up their careers to take care of their children, but neither of them mentioned how stressful this decision had been. Therefore I suggested to my research assistant to emphasise how their lives have changed since their children have been diagnosed. However, Thai carers appeared to be not very familiar with this kind of

interview. According to the two pilot interviews, which were conducted with the carers who did not participate in the study but had the music therapy sessions with their children, I found they tended to answer with short responses and it seemed difficult for them to respond to these open-ended questions. It might be because of Thai culture. They appeared to be reluctant to express their thoughts without specific questions. In order to help the carers feel more comfortable and engaged in the interviews, I suggested the research assistant give the parents or family members more directed questions. Moreover, I gave more suggested questions to the research assistant to use during the interviews (Appendix 9). However, the research assistant was allowed to be flexible with the interviews. The suggested questions were used as a guideline and she did not have to follow the order of the questions. She could use her own words to phrase questions and to skip some questions if the parents or family members had explained about the issue earlier. In addition, I suggested to her to concentrate on the objectives of the interview.

The pilot interviews helped me to realise what issues needed to be emphasised more and what issues I had missed out. This experience also gave my research assistants a chance to adjust to working with the parents or family members. Moreover, the research assistants could be more familiar with the question before conducting the interviews with the research participants.

3.5 Music therapy at the Special Education Centre, Region 9

In this section, I will explain my approach to music therapy with the children and their families at the Special Education Centre in Thailand and my roles in the music therapy sessions for both the children and their families. Moreover, the video reviewing process and home visits will be described, as they are also part of this therapeutic process.

3.5.1 Characteristics of my approach

The main features of my music therapy approach which I used during the course of this study are a) being flexible, b) using improvisation, c) employing different kinds of musical game, d) being playful and active, e) involving the children's families and f) focusing on healthy relationship between the children, their carers and myself as a

music therapist. These features will be explained more in detail later in this section. In each section I will also explain briefly why this particular feature is important in this setting. My approach is influenced by many models such as client-centred humanistic theory, psychodynamics and especially Oldfield's work (2006a). There are many aspects in my approach which are similar to Oldfield (ibid), namely, employing improvisation, being playful and interactive and including family in the sessions. However, my approach is different because I am not working in a multidisciplinary team in the way described by Oldfield (2006b). This is partly because I was new to the school although the staffs were supportive and helpful to one another. A true multidisciplinary approach has not been developed yet at the Special Education Centred, Region 9, Thailand.

a) being flexible

Children with special needs are very different from one another. They also may have unpredictable behavior which may change from session to session. Therefore it is necessary for a music therapist "*to be flexible and not get frustrated by any unexpected events (Oldfield, 2006b, p. 23)*". I put the children's needs, emotions and their interests as the first priority factors.

b) using improvisation

Improvisation is useful because it gives me enough flexibility to be able to follow the clients' leads and to respond appropriately to the clients, and also for me to reflect and express my thoughts to the client at that time. An example of this can be seen in the attached DVD (excerpt 16)¹. Similarly, Oldfield stated that "*it is through the non-verbal improvised musical exchanges that I can engage and capture children's and parents' interest and attention. The music-making is a means to an end. The therapeutic objectives are non-musical but the way to engage the client is through the music (ibid, p. 20)*". Improvisation does not only help me to engage with the children but it also enables me to extend the children's cues to make them more meaningful and to provide a starting point for our music making (Nordoff & Robin, 1977 and Sorel 2004).

¹ This is elaborated more in 4.4

c) employing different kinds of musical games

In my music therapy work at the centre, I work toward many different goals. Having goals helps to give a clear focus and direction to my work, and also allows me to fit in with the goals set by the class teachers. Each goal is achieved through musical games, musical conversations, and musical instrument explorations. In my musical games, I normally have a very simple rule, such as whose it is turn to play, playing the music in different positions, moving along with different tempos of music, or copying games. While the work was progressing, they were also willing to participate in more challenging tasks with me. Then it leads to the interactive phase where turn taking, sharing, and listening to each other can start to emerge. We take it in turns to be a leader and follower. Sometimes I followed the child's rules in order to make them feel more at ease and then I set simple rules for both of us to follow. Occasionally the children found it was difficult for them to follow my suggestions as some of them have ASD and might not want to engage with others. Therefore, I return to follow and copy them again until they show interest in me and I can use their ideas to create a moment where we can play together. Similar to Thompson's (2012) way of working with children with ASD, she responded to the child's initiations and then introduced new ideas to the child in order to extend the child's initiations into a new experience.

Sometimes two children have similar activities but they might be working towards different goals. For example, a child with ASD found it difficult to wait for his turn to play on the lollipop drum. In the music therapy session the child, parents or family members and I sat in a circle where I held the drum. First, I sang a simple song to indicate whose turn it will be and then I left out the name and let the child choose whose turn it will be to play. The song helped him to listen to others and feel more relaxed. In this way he did not feel that he was forced to wait for his turn. The predictabilities of the song helped him to realise when his turn was coming. I used the same musical interaction with another child also with ASD, but he did not show any interest in engaging with others and was more by himself. He normally wanders around the room instead of interacting with others. In this music interaction, he increased his concentration and participation in the game. He seemed to enjoy watching me dancing

along with the song. During this interaction he anticipated his turn on the drum and also his turn to call out whose turn it was to play. The anticipation of excitement of playing helped him to maintain his engagement with others.

Maslow and Erickson's psychology theories help me to set goals and gain more understanding about each child. Although each person is different and unique, they do have the same basic needs as Maslow's theory stated. Children with special needs find it more difficult to achieve these basic needs than other children. Maslow's hierarchy of needs helps me to focus more on people's needs. Sometimes when working with people with special needs, my perception of them as a human is hindered by their difficulties. So his hierarchy of basic needs (figure 1) reminds me that no matter what difficulties people might have, they still have the same basic needs as others.

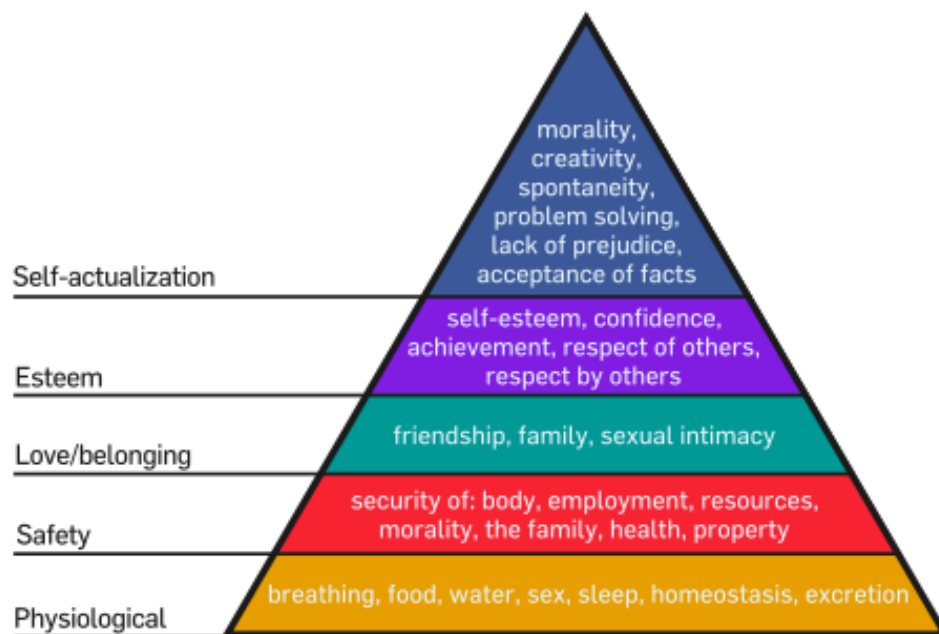


Figure 1 Maslow's Hierarchy of Needs (Maslow, 1970)

I also use Erikson's development theory in my work because children with special needs often have difficulties in reaching "usual" milestones. The theory helps me to understand the children at different stages of development and also helps me to set appropriate goals for each child to achieve. Moreover, the children's individual education plans (IEP) were very helpful in giving me a clearer picture about the children. IEP showed the results from the teachers' evaluations regarding to the children's social skills, cognitive skills, physical skills and language or speech skills. All this information provided me with a basic understanding of the children's strengths and weaknesses. Therefore I was able to set more suitable goals for them.

d) being playful and active

In the sessions I found myself active and playful because most of the children I worked with, appeared to be in their own world and did not show interest in engaging with me. Therefore, it was important to be enthusiastic and active in order to gain the children's interest and engage them in what we were doing. The children found me funny when I was very playful and actively playing with them with my exaggerated acting and facial expressions. The children have a good time in the sessions and this is a key to my work. This is because the positive time can encourage the children to come back to the session again in the following weeks (Oldfield, 2006a). However, in the sessions I was not active all the time because I wanted to leave some space for the child to respond and some children enjoyed soft and gentle music.

The children are full of playfulness and they experience the world and learn new things through play, therefore being playful could allow the adult (like the carers and myself) to enter into the child's world in order to foster closeness, confidence, and connection (Cohen, 2002). There were many occasions when I saw the children resisting to engage with me and they would get upset if they were forced to do so; these caused frustration for the carers. Instead of forcing them to participate in the session, turning the children's interest into a game playfully could turn these situations into fun and enjoyable moments. As in Oldfield & Haire (2009), they employed humour to distract the children who are becoming challenging in their behaviour.

e) involving the children's families

One of the important characteristics in my work is involving the parents or family members in the sessions. There were many reasons why I asked the parents or family members to be involved in the session with their children. When I first did my volunteer work in the Special Education Centre, Region 9, I was inspired by the fact that family members attended the centre with the children. This was one of the reasons why I wanted to investigate music therapy with families. I felt this was important as I believe the parents or family members have such a big influence on their children as was shown in the earlier literature (2.4). The way in which the parents or family members' react and respond to the children in the music therapy sessions was able to help me understand the way the children are. Furthermore, many studies including Oldfield (2006a) which I explored in the previous chapter (2.4.1), showed that having both the parent and child present might provide them with a platform to have a positive time together. During these times they engaged in a more positive way. These experiences provided a good memory for them both, which was very helpful for them to think about at more difficult times. Also, the parents or family members could see their children in a different way, and they could see the way I engage with their children through music. In addition, by the end of the process I hoped the parents or family members were able to use some techniques from the music therapy sessions with their child at home. Lastly, I expected to work collaboratively with the parents or family members.

However, there are some occasions where it might be appropriate for a child not to be seen in music therapy with their parents or close family members. At the Croft Child and Family unit for example (Holmes, Oldfield, & Polichroniadis, 2011) where children with severe emotional and behavioural difficulties and their families are provided with day and inpatient mental health care, the general aim of the unit is to assess the child holistically in his/her family context. Nevertheless in some cases the child's needs could be dominated by the adults' opinions or difficulties and the child would need to be seen on their own in order for the therapist to gain the true picture of the child's needs. However, the children in this study did not present severe emotional or behavioural difficulties and none of the family members accompanying these children presented with

overwhelming needs of their own. It was therefore entirely appropriate for the children to be seen with their carers particularly as the Special Education Centre had a philosophy of including the child's family in the child's treatment as much as possible.

This work is also influenced by Shoemark's family-centred music therapy in playgroups (1996). Underlying thoughts of her work are relevant to my work. She included families in the sessions and she extended her focus on the individual child to consider the family as a unit. Similar in a way to my work, the family's needs lead the way. Shoemark noted that not all the families were ready to take responsibilities, which suggested a family-centred model. The music therapist and the family members needed to work as a team. This thought is helpful in my situation where most of the carers were not familiar with initiating their own ideas. However, my approach is less structured and uses improvisation more often than Shoemark's pre-composed and familiar songs. Unlike in my work, Shoemark mainly used familiar songs in order to provide an acceptable starting point for the group members regardless of their background and culture.

f) focusing on healthy relationship between the children, their carers and myself as a music therapist

When working with children who are mostly non-verbal, it is particularly important to start with building up a relationship with the children. In order to do that my first aim is to make the children comfortable and relaxed enough to extend their interaction with me. This is similar to the client-centred humanistic approach which was developed by Roger (1979). Client-centred therapists regard highly the quality of their relationships with their clients. Roger believed that therapeutic relationships enabled the therapist to gain the insight into the clients' challenges and maintain the positive changes in clients. He proposed three key elements which affect the growth of the relationship namely: genuineness, a non-judgmental stance and empathic attitude. Through this relationship, the client could feel being accepted and safe from judgment and this enabled him to have a healthy attitude toward himself and toward the world. The client-centred therapist considered the client and the therapist as having equal position rather than the therapist is an expert treating the patient. Roger also stressed the power of the client himself to

overcome his difficulties and to control his life. This is unlike the psychoanalytic approach where the result of the treatment depends on a therapist's interpretations of a client's unconscious material.

However, there were other aspects of psychodynamic theory which were relevant to my work. Transference and counter-transference were concepts at times useful to consider in my critical practice. Bunt and Hoskyns (2002) explained the idea of transference by saying that it refers to patients' feelings and attitude about their past experiences, as well as their feelings toward a person earlier in their life which transfer to a current relationship and a therapist (ibid). Counter-transference refers to the feelings of the therapist which he/she has toward the patient (ibid). This concept helped me to be aware of the carers' understanding and feelings that they might have about music therapy and my role in the sessions. It also helped me to recognise my feelings toward the carers' situations and the children's behaviours and emotions.

3.5.2 Communicating with family members

It was very important to regularly communicate with the parents or family members, especially at the beginning of the research process. Initially, I was concerned about the parents' or family members' expectations for music therapy and their children. Some parents or family members were concerned that their children would not be able to "perform" or "learn" music. They did not know what they and their children were expected to do. The parents or family members did not have much experience or knowledge about music therapy work. They were used to the directive, adult-led style which was the teaching style at the centre. However, in music therapy sessions, the children are normally free to do things. Adults become their followers instead of being the leaders. Some parents or family members seemed anxious at seeing their children running around the room while I ran around with them. They tried to get the children to sit properly and behave well. However, my aims in the sessions were to give the children freedom and to allow them to express themselves in a positive way. As the sessions progressed, I kept reassuring the parents or family members that it was fine for the children to explore this new environment and that I could explore different ways to interact with them. In some cases of shy or quiet children, some parents or family

members seemed to find it difficult to wait until the children responded to me. Therefore, the parents or family members would help the children by holding their hand and playing together. In this case, I first explained that it was very nice to see the parents or family members supporting their child. However, I suggested that it would also be nice to see how the children wanted to respond to music. After some sessions together, we were more relaxed and familiar with each other. Nevertheless, regular contact with the parents or family members was still needed to be maintained in order to keep our understanding about the children and the music therapy work at the same pace and offer chances to the parents or family members to share their thoughts and concerns all through the course of the study.

3.5.3 The music therapist's roles

There are many different roles that I had during the music therapy treatment. Each role was employed according to the children's needs and the parents' or other family members' characters.

A leader

During a first few sessions, I mainly led the session because I wanted the parents or other families to see what the music therapy sessions are. Also I wanted to get them to feel more familiar with the activities in the sessions, and did not want to give them a feeling of being pressured into participating, when they may not be ready to do so.

A follower

From my observation, when the parents or other family members started to feel more familiar with the activities, and after they tried a few things with their children, they seemed to be more confident. I found many of them unconsciously adding their opinions into the activities, and leading the children naturally. When this happened, I followed their structure and enjoyed the occasion with them.

A supporter

While I was following the parents or other family members' lead, I still kept supporting them through my music. The music was able to create a playful and relaxing environment, so that both the children and the parents could explore ways of engaging with each other and extending the interaction between them. Also, being there, giving them encouragement and listening to their suggestions was a way of gaining trust from them too.

An educator

During the clinical work, I made an offer to the parents or other family members that I would be happy to show them how to play some simple chords on the guitar, or keyboard, and also was willing to discuss how to use music at home with their children. There were some of the parents or other family members who showed interest in learning to play music. Some of them brought their instruments to the centre and asked me to teach them how to play. Although they were always busy with their children and did not have much time to practise, they seemed to be enthusiastic to use music at home.

A friend

After the relationship between the parents and me was established, the parents were more open about sharing their stories and concerns with me. They made me feel as if I was their friend, ultimately treating me as they would a family member, someone with whom they could share their feelings, and their concerns.

3.5.4 Video reviewing

At the end of each session, I always discussed with the parents or family members so as to get some feedback from them, to know them better and to share my thoughts about the children. Initially, I aimed to review the video in order to improve my own practice and to look for more detail in the children and their parents' responses and interactions with them. This video reviewing was used to increase my confidence and increase my skills, as I did not have much experience in working along with the children. During the video reviewing time, I learnt to adjust my approach for it to be more suitable for the

children and their parents. For example, I found myself not giving enough space for the children to respond and the parents or family members did not have enough chance to participate in the activities. Reviewing the video showed the atmosphere of the sessions in each day, and it is very helpful because usually I tend to focus on the children and do not have the chance to observe my own music and the parents' feelings much. Most of the parents or family members did not know much about music therapy work. Therefore, I decided to share the video with the parents or family members as I wanted to use the excerpt to explain my work and to enhance the parents' understanding about the music therapy. During reviewing the video excerpt with parents, I intended to encourage the parents or family members to share their thoughts about the children's responses and also about my approach. I aimed to enable the parents or family members to take part in the work as much as I could. We both shared our thoughts, experiences, appreciation and concerns. Their comments were very encouraging, and their suggestions were valuable as they helped me to understand the children more. Listening to them and encouraging them to bring their suggestions into action could show my respect for them and help them to feel more confident to work with me. This led us to work collaborative later in the process. I believe that with more communication and understanding we can both help the children to achieve the same goals. For some parents or family members reviewing a good time from the sessions could be looked back on to act as a supporting time for them in the future. As most of the time they might experience a difficult time with their children, to repeat the good moments again provides them with encouragement. Besides that the video excerpt could be used to explain the children's responses from my perspective, which might be new for the parents. This allowed the parents or family members to see their children differently. Also, they saw themselves with their children and in the music therapy they might act in very playful and childish ways. They could have chances to see themselves differently too. I mainly used the video reviewing as a mirror to reflect on our actions so that we can re-think, change and adjust to be more suitable with for children.

However, it was challenging having a video recording for the first few sessions. The children were distracted by the video camera and it was more difficult to engage them in

the sessions. Also, the parents or family members might feel uncomfortable and not completely be themselves. Some of the parents or family members appeared to avoid being spotted by the camera. Eventually, when we all became used to the new environment and parents or family members knew what to expect in the sessions, the parents or family members seemed to forget about the video camera and enjoyed the music therapy sessions with their children.

The process of video reviewing

A short video excerpt was taken out from the music therapy sessions. I brought the video excerpt from the previous sessions. Therefore I had chances to choose a meaningful moment to review with the parents. In this study, when a meaningful moment occurred, I referred to

- The moment that the children seemed to enjoy the music
- The moment that the parents or family members seemed to enjoy the music
- The moment that the children appeared to be very engaged with the music
- The moment that the children interacted with the music therapist and their parents
- The moment that the children showed some difficult behaviour

After I reviewed the video, I wrote down the details of the moment that I wanted to show the parents or family members. Before I showed the video clip I briefly told them I would like to show the clip that I found very impressive, and I wanted to share it with them. I wanted to make the parents or family members feel relaxed and not worry about me highlighting their children's difficult behaviour. I preferred to use the video clip as an encouragement for them. I used it not only to show my appreciation of the children but also to show how the children responded to the music. Sometimes I showed the moment that I found challenging to engage with the children. I showed it because I wanted to ask their ideas of how to make it better. Also, I had the opportunity to show the parents or family members how music can bring positive behaviour from the children. After we watched it together, I started the discussion by telling them how I felt, and what I thought about the moment, and then I asked the parents or family members

“how did they feel after they saw the clip?” I tried to encourage the parents or family members to discuss what they think about my approach to the children, what they would like me to change, and what they think is good for their children. First, I focused on the children, as I did not want the parents or family members to feel like they were the targets. I initially discussed with the parents or family members about the children’s behaviour then I discussed what input in the sessions influenced the children to behave in this way. Also I hoped that the video reviewing would identify the parents’ role. So the parents or family members might be more aware of their inputs which might influence their children’s actions.

I found it was challenging to get the parents or family members to tell me what they thought and to get them to comment on the work. It was not very often that the parents or family members shared their opinion and thoughts. Even when they appeared to be very open and relaxed with me, they might have felt uncomfortable to discuss the work directly. There were a few barriers that kept the parents or family members from telling me what they really think, these were:

- They might not be familiar with me during the first period of the work
- If they have a different opinion, they tend to keep to themselves because it is Thai culture that to be critical is seen as an impolite thing to do, and we tend to compromise rather than having an argument
- They might think that they did not have enough knowledge and experience to make any comments.
- They found it embarrassing watching themselves in the video clip, therefore they seemed to avoid taking a careful look at the clip.

Moreover, it was more challenging than I expected to organise both the time to discuss with the parents or family members and to provide a music therapy session for the next student. Ideally, I wanted to have someone to take care of the children while I was talking to the parents. Although I got someone to help me with that on some occasions, some of the children did not want to be separated from their parents or family members. Also the parents or family members themselves appeared to be worried if they lost sight

of their children. Therefore, most of the time when I was involved in a discussion with the parents, their children would be around, and so an interruption was inevitable.

3.5.5 Home visits

As the research aims to study the parents' experience of using music with their children both in the sessions and outside the sessions, so visiting the children at home enabled me to explore more about the family and also to provide more support to the family. The parents or family members and the children were able to feel more relaxed and express their feelings during my home visits. Also, on some occasions I was able to meet other family members and see how they engaged with the children with special needs.

The process of home visits

Before I visited the research participants at home, I was offered chances from the centre to visit other children's homes with teachers. I observed how they work in many different aspects, such as how the teachers communicated with the parents, learnt the objectives of their home visits, learnt how they created a friendly atmosphere, and learnt how they brought help to the family. The home visits from the teachers aimed to help the parents or family members set the learning atmosphere at home and to find out what resources the children may need at home. The teachers checked what should be changed in the home atmosphere in order to improve the children's skills and their wellbeing and whether the lessons from the school had been applied in the home situation or not. Did the parents or family members have enough learning resources, and was the resource they had sufficient enough to use? This experience enabled me to get some pictures in my mind and helped in the process of how a home visit should be conducted. I visited the research participants' homes twice during the course of this study. The first visit was conducted one month after the last session finished and the second one was two months after the last session finished. Home visits were conducted one month apart from each other because this duration should give the parents or family members sufficient time to settle down, and to experiment with the way they could employ music. Also one month was not so long that the parents or family members felt a distance from the therapist.

After the second interview finished, I provided the parents or family members with some guidelines of how to use music at home (Appendix 16). In the guidelines I put some very simple examples of music activities which we did together in the sessions. These were given in order to encourage the parents or family members to employ music at home. Only telling them to use music with their children at home might be too vague, and some parents or family members might not have any idea of how to use it. Therefore, these guidelines would be able to give them a starting point, and later the parents or family members might be able to apply their own way of using music in the family context.

The home visits usually took one to two hours. I had a few expectations of what I wanted to achieve which were: a) to see how the children are in the home setting b) to see whether music was used or not after the clinical work ended c) to spend time talking with the parents or family members in depth about themselves and to strengthen the relationship with both of them d) to do music briefly with the children and their parents or family members and support the parents or family members in using music with their children at home and f) to meet other family members and see how they interact with the child.

As during the first home visit the children were having their school break for two months I usually started off the conversation about what they have been doing. I tried to use a similar approach to the teachers from the centre when doing the home visit, which is asking the parents or family members what the child normally does when they are at home. How do the parents or family members help the child to practise their tasks from school, and what their typical day is like I intended to make the parents or family members feel comfortable and not to feel worried if they could not show me anything.

Some children behaved similarly to when they were in the music therapy sessions. They were slightly different because at home they were in their comfort zone and I could not put on rules or structure them as much I did in the sessions. They appeared to be very relaxed, however they did not want to participate with me as much as they normally did in the sessions, as they have their own things that they wanted to do. They know how

and where to get what they wanted. Moreover, I did not want to intrude upon their private space.

Initially, I planned to do the video recording briefly during the music interaction but it was too challenging to do it alongside without making myself familiar with their family's house. Also I felt that the parents or family members might feel uncomfortable to have a camera set in their first guest visit. Also, I aimed to do too many things at one time and it was difficult to manage them in one visit by myself. Also it was difficult to set the camera to be able to catch the children because they liked to run around, as they got more freedom at home than in the music therapy room. Also some children did not sit still alongside their parents or family members but they tended to play and move to a different room most of the time. However, I was able to record a brief music interaction between the children, the parents or family members and myself in the second home visit. These brief video recordings were employed to explain how the music was used in family context. Therefore, I was able to learn what was needed, and how to support the parents or family members to use music in the future.

Conclusion

This chapter provides an overview of the context of the study which influenced my clinical work, namely the special education system in Thailand and the beliefs of Thai people toward children with special needs. Furthermore, I have explained in detail how the music therapy was provided to the children and their carers or other family members. The approach is informed by the literature in the previous chapter. The therapeutic process in this study concerned the needs of both the child and their families.

Chapter 4 Methodology

Introduction

This chapter discusses the selected methodology, used in order to accomplish the research's aim of investigating parents' or other family members' experiences in participating in music therapy sessions with their children with special needs. Moreover, it explains how the methodology is able to address the research questions. Other related issues are also covered, namely the recruitment criteria of participants, research design, data collecting, data analysis and related ethical issues.

4.1 Overview of methodology

A qualitative approach is employed in this study because the study is intended to explore the participants' subjective experiences in participating in music therapy sessions with their children with special needs. According to Bruschia (2005), studying experience is one of the main foci of qualitative research: "*An experience encompasses many different layers and facets of the person, including body reactions and emotions as well as thoughts and perceptions (p. 88).*" This kind of research focuses on how a person apprehends, perceives, feels and thinks about something or how he/she makes sense of the events (Bruschia, 2005; Willig, 2008). Although in qualitative methodology there may be a smaller number of participants than in quantitative methodology, the qualitative methodology allows the researcher to have an abundance of descriptive data and information on the particular families (Smith & Dunworth, 2003). The data or phenomena are concerned with both observable and unobservable events (Amir, 1993; Bruschia, 2005) including the interactions between the parents and their children and any changes in both parents and their children. A researcher who employs qualitative methodology focuses on a process and is open to the possibility of unexpected results, in contrast to a quantitative approach which tests hypotheses or investigates an expected outcome (Smith & Dunworth, 2003; Willig, 2008).

I chose a qualitative approach because I wanted to keep an open mind about what I would learn from the families, rather than attempting to prove an established hypothesis. However, I am aware that there are limitations to this qualitative approach. The absence of a control group in this investigation means that results will not be able to be generalised. It will also be more difficult to definitely state that progress or change is due to the music therapy intervention rather than the child's development maturation.

As a qualitative research focus on studying a process or an event in people's lives, the researchers tend to gather very rich and in-depth data, so that they could apprehend all the components of the process or the event as it happens (Sandelowski, 2000). Analysing rich and detailed data can take a lot of time and money and so the qualitative research investigations usually have a small number of participants. Findings tend to be to small groups of people in specific contexts. Consequently, compared to quantitative research, qualitative research findings can be less easily generalised to different contexts (Atieno, 2009).

In this type of investigation, the research is very dependant on a researcher's skill, experiences and interpretation. Throughout the course of this study, I also acted as a music therapist conducting music therapy sessions for the research participants; therefore I was also a main research instrument. I was involved in every step of conducting this study, and my thoughts, feelings and beliefs were an important part of this study. During a process of data gathering and analysis, a qualitative researcher's insights, hunches, feelings, intuitions and thoughts are employed in order to understand the meanings and to analyse the data (Amir, 1993; Willig, 2008). Therefore, the results can be easily influenced by the researcher's bias. It is important for the researcher to be aware of their background and their feelings toward a research topic which may interfere with vigour of the data collection and the analysis process (Morrow, 2005). There are however strategies, which could minimise the bias of the researcher and which I have followed. These are: a) keeping a research journal to record ongoing experiences, reactions and awareness of any biases which emerge along the course of study, b) identifying the role of the researcher in the investigation, c) consulting with peers and d) gathering feedback from the participants regarding the quality of the researcher's

interpretations of the interviewee's stories (ibid).

In addition during the collecting of the data, qualitative researchers spend a lot of time with participants and become very close to these participants. It is therefore hard to avoid the influences that the researcher can have on the participants and vice versa. However, this could be seen as a positive thing as the more the researcher gets to know the participants, the better their understanding of the participants (Carr, 1994).

There are a variety of approaches to qualitative research. Interpretative Phenomenological Analysis (IPA) is chosen because this study mainly focuses on investigating the parents or other family members' experiences of participating in the music therapy sessions. Both phenomenology and IPA are concerned with examining the experience of individuals (Smith, Flowers, & Larkin, 2009). IPA is originally developed from the phenomenological approach. Husserl, who was a leading figure in the field, was originally concerned about exploring the essence of experience, while IPA moves the focus towards attempting to capture particular subjective events as the experiences of particular people (ibid). Interest in the phenomenological approach is growing within the music therapy discipline (successful music therapy research includes Comeau, 2004; Forinash, 1990; Jonsdottir, 2011; K. Lindenfelser, Grocke, & McFerran, 2008). For instance, Forinash (1990), explored the essences of the phenomena of music therapy with terminally ill people, employing the approach to investigate complex interactions between a music therapist and patients. In this approach a term *bracketing* is used which refers to the "laying aside" of the researchers' everyday perceptions or previous knowledge of the topic. While the researcher is making any reflection on their past and present experience relating to the topic, the term bracketing is used for separating the researchers' reflection from any data revealed by the participants (Griffiths, 2009). Thus the researcher is able to apprehend and understand the research participants' experiences more effectively (Elliot, Fischer, & Rennie, 1999) because fresh meaning can be attributed to the phenomena being studied (Crotty, 1996). While using IPA, the researchers engage all the thoughts and feelings which were bracketed during the interpreting stage. The researcher using IPA believes that *"one cannot get access to the participant's personal world without the use of the researcher or*

interpreter. That is, access is dependent on the researcher's ability to conceptualise and make sense of the participant's personal world through a process of interpretative activity (Griffiths, 2009, p. 39).” To understand the participant's experience the researcher has to engage with and interpret the participant's account. IPA allows the researcher to get close to the participant's lived experience and also acknowledge the implication of the researcher's interpretation. *“In IPA, our attempts to understand other people's relationship to the world are necessarily interpretative and will focus upon their attempts to make meanings out of their activities and to the things happening to them* (Smith et al., 2009, p. 21).”

4.2 My roles in a research process

In this research, the researcher is one of the research instruments for his/her own study, therefore their roles in the process should be acknowledged. Qualitative research recognises the researcher's influence and shapes the research process (Willig, 2008), increasing its aptitude for this study. During the entire course of the study, I was not only the researcher who analysed, designed, and gathered all the information for the research, I also performed as the music therapist who conducted 24 music therapy sessions with the research participants. Care was therefore required to give awareness to each task, so that my roles did not interfere with one another. The relationship between the parents and myself as a music therapist was developed during the course of 24 music therapy sessions, and I was part of the parents' experience. I had to be responsible in my position in the research as an insider given that my involvement in the process directly influences the parents' perceptions and feelings about their experience. Additionally, my insider position could have affected my perceptions toward the parents. Finally, our relationship that had ultimately developed could have affected the way we both understood and perceived each other.

While I was conducting the data analysis, it was very difficult to cut myself off from interpreting the parents' responses and their interaction in the sessions as well as their responses in the interviews. In order to do interpret correctly, I needed to clarify my roles in the research process, and also to state how my role influenced the parents'

experiences and responses. Reflexivity is necessary during any research process, but especially this one- *“Reflexivity means more than acknowledging personal biases; reflexivity invites us to think about how our own reactions to the research context and the data actually make possible certain insights and understandings (Willig, 2008 p.18)”*. Therefore it is important to be aware of how my own perceptions or my background influences how I think about my research data. “I” is used when I represent my role as a researcher. When I discuss my role as the “music therapist” who works in the sessions with the children and their parents, the term “music therapist” will be used.

4.3 Participants

Eight children who are attending the Special Education Centre, Region 9 in Khon Kaen, aged four to twelve years old, were invited to participate in the study with their parents or anyone in their family who is their primary carer. However, only six children and their family members were able to complete 24 music therapy sessions. Brief information about the children and their family members are explained in the research participants’ background. This study invited a small number of participants because a qualitative research aims to explore in-depth an individuals experience rather than to generalise the result. Each case or situation has individual characteristics as the qualitative researcher analyses and strives to understand each case instead of making generalisations (Wheeler & Kenny, 2005). Moreover, Eathough and Smith (2008) suggested that if there are many participants in IPA, it would be a large amount of data to collect and to transcribe so that it is more possible to have small numbers of participants in IPA research. Finally, a small number of research participants enabled me to develop a close relationship with and deep understanding into each participant (Crouch & McKenzie, 2006).

The main inclusion criteria of participants are:

1. The children were regularly attending the Special Education Centre, Region 9 with their parents or other family members
2. The children showed interest in music

3. The parents or other family members were able to commit to regularly attend 24 music therapy sessions with their children
4. The parents or other family members were willing to be interviewed three times and also to review and validate the transcript and the researchers' interpretation
5. The parents or other family members were willing to allow the researcher and research assistant to visit their home twice after the treatment process was completed

(Ethical questions surrounding these criteria are explained in the Ethical Issues section 4.8)

This study initially aimed to explore parents' experiences of participating in the music therapy sessions with their children with special needs. However, all the referred children were accompanied to the Special Education Centre by their grandparents or aunts. As the children's parents were mostly busy at work, they rarely had the chance to be involved in this process. Throughout the therapeutic process, I met mothers of two children once or twice and they did participate in the music therapy sessions with their children and the carers. However, it seemed that the carers took a major role in taking care of the children. From now on in this study I will refer the children's grandparents or aunts as their carers. The carers have been taking care of the children at least one year, and almost all live with the children and have developed a good relationship with them.

4.4 Research Design

After the referrals (4.3) had been made, there were two music therapy assessments for the children only. These two assessment sessions were 30 minutes long and held once a week for two weeks. The sessions aimed to assess whether the children would benefit from music therapy sessions, and if it was of benefit to the children then their carers were then invited to participate in the study. The carers received the information sheet and consent forms (appendices 2, 3, 4 and 5) before the treatment process began.

Six children with special needs and their carers were provided with 24 music therapy sessions over a period of eight months from September 2011 to March 2012. Each session was 30-45 minutes long. At the end of each session I reviewed the session with

the carers. Each session was videoed and the video recordings were discussed at the end of sessions with the carers approximately every two weeks, focusing on their interactions and their children's responses. The videos were reviewed when I found meaningful moments (3.5.4). During the last year of my PhD, after all the clinical work was finished and I had analysed all the interviews, I created a DVD which included excerpts from the music therapy sessions. The DVD was made in order to show firstly the impact the musical interactions had on the children, secondly, the different ways of working with the carers in the sessions and lastly, some important characteristics of my music therapy approach at the Special Education Centre, Region 9, Thailand. Some of the excerpts illustrated specific points made in the thesis, which will be made clear in the text. All the carers gave permission for these excerpts to be included on the DVD. The permission form used is shown in appendix 8.

Additionally, there were three interviews with the carers focusing on their experiences of using music with their children during the research process. The first interview was conducted after the assessment sessions and before the music therapy sessions with the carers started. Then the carers were interviewed again after the 24th session was finished- the last interview was held two months after the 24th session was finished. A research assistant conducted all the interviews, other than myself. The data from the interviews was then reviewed (4.7). Furthermore, I went to visit the children at their home twice (3.5.5)

Table 2: Overall research timeline

Activities	Month/Year
Research proposal approval	September – November 2010
Ethical application approval	February – May 2011
Setting up (Before any music therapy session)	January – September 2011
<ul style="list-style-type: none"> – Making contact and gaining permission from the Special Education Centre Region 9 – Reviewing literature regarding conducting semi-structured interviews – Preparing questions for semi- structured interview – Reviewing related literature (music therapy and children with special needs and their families, parents’ experience of having children with special needs, children with special needs in Thailand) in order to prepare suitable music therapy sessions in Thailand – Developing resources for doing clinical work in Thailand such as songs, musical games, musical instruments – Performing the presentation about the study for the teachers and the staff in the centre – Collecting the referral forms – Finding research assistant – Setting up timetable for music therapy assessment – Conducting pre-music therapy sessions for children who were not research participants 	
Two music therapy assessment sessions	September 2011
First Interview conducted by a research assistant	September 2011
24 Music therapy sessions	September 2011- March 2012
Second Interview conducted by a research assistant	March 2012
First Home visit	April 2012
Third Interview conducted by a research assistant	May 2012
Second Home visit	May 2012

4.5 Data collecting

Semi-structured interviews are the most common tools used in Interpretative Phenomenological Analysis (IPA) (Eatough & Smith, 2008; Willig, 2008), and I chose this method. This tool was used for exploring the research questions which emerged from the aim of this study: “To investigate the family’s experience of using music with their children with special needs both in music therapy sessions and outside music therapy sessions”. The research questions were:

1. Can music therapy help to achieve aims set out for individual children with special needs and their carers?
2. What are the functions of music therapy in nurturing communication between the carers and their children?
3. How can the music therapist develop ways in which the carers can use music to help their children?

Semi-structured interviews allow the researcher to be flexible in either leading or following the conversation with the participants. The interview mainly aims to assist the participant in expressing and describing their personal experiences in their own words. Therefore the open-ended questions are employed to encourage the participants to tell their story rather than lead them to giving yes or no answers (Willig, 2008). The semi-structured interview puts the experience in the centre while also being aware of other influences on any experiences such as culture, history and language (Smith & Eatough, 2006). *“The advantage of the semi-structured interview format for IPA is that the researcher is, in real time, in a position to follow up interesting, important and even unexpected issues that emerge during the interview (ibid, p.330)”*. Prepared questions were given to the research assistant to be used as a guideline and possibly used as questions, and the order of these questions depends on the participants’ responses. In general, the interviewer started with very broad questions in order to allow the participants to tell their own stories. The more open the questions, the more the researcher and the participant can feel relaxed so that the rapport and trust between them can be established (ibid). However, the carers who participated in this study were not familiar with open ended questions so the questions were adjusted to be more suitable

for them (This is elaborated more in 3.4.7). All interviews were audiotaped and conducted by my research assistants. This was to prevent any bias that might come up if I conducted the interviews, and to give the carers the chance to express their opinions freely without feelings they needed to please me as a music therapist. The interviews were recorded, and each one lasted around 20-90 minutes. Additionally, ongoing data from my regular clinical notes and ongoing research journal was employed as a further data source. These data were mainly used to describe each child and their carers in the case reports which will be shown in the Findings chapter.

The literatures regarding music therapy are widely described through a case study. A case study allows a researcher to stay close to the nature of the study without attempting to change the behaviour of those involved (Yin, 2009). However, this study does not utilise case study research. Six case studies are included together with findings from the analysis of the interviews because they can provide rich and insight into the experience and process of music therapy (Derrington, 2012). Each child and carer is treated as an individual and was therefore approached in different way according to their needs. A case study is employed in order to convey the story of child and the carer in the therapeutic process. Their stories in the therapeutic process are crucial aspects in this work as they help explain their therapeutic processes in an individual way. These case studies enabled me to form my approach in this context and to explore how each child and his/her carers respond to this process.

The clinical notes were used for recording actions and responses from the children in music therapy sessions according to normal clinical practice. This was able to explain how the children made progress toward the goals and how the children benefited from participating in the sessions. The clinical notes also recorded my own spontaneous reflections immediately following the sessions regarding how the session had contributed to the child's wellbeing (Kaenampornpan, 2010). The format of the clinical notes was replicated from Oldfield (2006a) (appendix 14). The child's aims were put on the heading and I then recorded the events when the child presented behaviour relevant to the aims. This allowed me to capture meaningful moments and to provide evidence to respond to the therapeutic treatment aims of each child. In addition, the children's

challenging behaviour or the carers' concerns regarding the children were recorded in order to review and find ways to provide more suitable sessions for them. These clinical notes also provided sources of data to assess the children's development. I used research journals to record my thoughts as a researcher during the course of this study, and classified these thoughts into three categories: a) my observations of the carers' responses and reaction with their children and with me as a music therapist; b) my observations of my own feelings and thoughts toward the children, their carers, and my own approach; c) the variety of ideas in related literature; and d) reflections on supervision meetings.

4.6 Selecting questions for the semi-structured interview

The content of the interviews emerges from the objectives of the research and the research questions which were stated earlier. In order to understand the carers' experience of using music with their children with special needs both inside and outside music therapy sessions, it was firstly crucial to understand the carers' backgrounds. The carers' backgrounds enabled me to understand their feelings and thoughts toward the experiences they had, and helped me to better interpret what lay behind their reaction toward both the children and me as a music therapist. Also their background influenced the way the carers perceived and responded to the new experiences of music therapy. The aims for the first interview were as follows:

1. To learn about
 - The carers' background
 - Their experience of having a child with special needs (their life at home together)
 - How they cope with difficulties, general outlooks, feelings, acceptance of the child's special needs.
 - Their general ability to cope, and their general state of mind
2. To understand
 - Their needs and concerns
 - Their expectations of music therapy

3. To discuss the goals for future music therapy treatment together

The first research question “*Can music therapy help to achieve aims set out for individual children with special needs and their carers?*” is broken down to be objectives in the second and third interviews which were:

1. To study and understand the carers’ perception about music therapy
2. To study the carers’ opinion about benefits and things to be addressed in the music therapy service
3. To study the carers’ opinions regarding their children’s interactions and responses in the music therapy sessions
4. To evaluate whether the carers think the goals set before the treatment have been achieved
5. To assess the carers’ opinion toward their interactions with the children
6. To understand the carers’ experience of being in the music therapy sessions with their children, and their involvement in the video reviewing process

The data required to answer the second research question “*What are the functions of music therapy in nurturing communication between carers and their children?*” was mainly gathered from the interviews after the treatment process was finished. The objectives were:

1. To explore the carers’ opinions regarding my roles as a music therapist during the music therapy sessions, during the video reviewing, and during the home visits
2. To study the carers’ perceptions about working together with the music therapist in the music therapy sessions in order to improve their children’s wellbeing
3. To explore the carers’ own roles in the music therapy sessions

The last research question “*How can the music therapist develop ways in which the carers can use music with their children?*” was answered through the third interview after the home visits were finished. During the time before the third interview, the carers were encouraged to experiment in the way they use music with their children and to see how

their children used music at home. Therefore, the carers were able to share their experience regarding the last research question. The questions in the third interview aimed:

1. To discuss how the carers and other family members use music at home
2. To discuss the benefits of home visits
3. To discuss how the carers can use music in the future

Moreover, the questions were influenced by related literature on subjects such as music therapy and family, family involvement in children with special needs, and a study regarding the experience of carers with children with special needs (Dunst & Trivette, 1987; Oldfield, 2006b; Sasnett, 2008). I prepared the questions for the research assistants so that they could use them as a guideline to interview the carers in order to address the research questions. The set of guideline questions allowed the research assistant to be flexible to change the questions to be more suitable for each carers' situation. The questions were carefully written in order to be simple and open-ended and to avoid jargon and researcher-leading (S. Carter & Henderson, 2005). The example of guideline questions is shown in appendix 9.

4.7 Data analysis

The data analysis process in this study is influenced by guidelines from Smith et al. (2009). The guidelines for Interpretative Phenomenological analysing (IPA) are employed in order to reduce the novice IPA researcher's anxiety and to reduce the risk of overwhelming feelings arising from the process of analysis (Smith et al., 2009). However, previous studies (Baharom, 2011; Brocki & Wearden, 2006; Eatough & Smith, 2006) recommended that the process of data analysis in IPA is adaptable and is used as a guideline to foster the accessibility of IPA. If researchers are new to IPA, it is suggested that they begin by working closely with the suggested set of steps and then adapt them when and where they feel comfortable to do so, and as the data requires (Smith et al., 2009).

In this study, each interview was transcribed and each transcription was read a number of times. This enabled me to engage and become familiar with the original data, thus I

would be able to start finding ways to explain the participants' stories (Smith et al., 2009). Additionally, re-reading is important because it allows the researcher to gain new ideas and insights (Hunt & Smith, 2004). During the reading and re-reading stage, I highlighted any striking and important sentences, phrases or events relating to the study. Along with reading and highlighting, I started making notes and comments about the data: Table 3 showed how I recorded my notes alongside with the transcriptions. Smith et al. (2009, p. 84) suggested that it is important in this stage to ask what the words, phrases and sentences mean to me as a researcher and to attempt to check what they mean for the participants too. The next stage of data analysis was to identify emergent themes. Keywords were used for explaining the important stories which emerge during the analysis (Hunt & Smith, 2004) and they were also used for identifying categories for the emergent themes (Pothoulaki, MacDonald, & Flowers, 2012). Usually, the keywords came from the notes, which were kept during re-reading. It was very important at this stage to turn the notes into themes which were able to condense the work into a concise and clear statement of what was important in the various comments from the transcription (Smith et al., 2009). When a set of emergent themes was produced, I looked for connection across emergent themes and produced a structure, enabling the most important and interesting aspect of the participant's story to be shown (ibid).

Table 3 Example of how the notes were recorded along with the transcriptions.

	Transcription	Comments
1	<p><i>“Nina always likes music. She has had experiences with the keyboard and recorder before. The music therapist brought her to sing along without any force and she had fun. Nina doesn’t like to do things when she is forced to do them. The music therapist allowed her to do things in her way but before she moved to a new thing MT asked her to say “finish”. And the music therapist will bring instruments one at a time, and put them back when we finish. This helps her to learn about boundaries more.” Jan (Nina’s aunt 2/14/3)</i></p>	<ul style="list-style-type: none"> - Nina’s music background - MT was well engaged with N because she did not push N too much But there were some rules and later N was able to understand and follow - Benefit/changes from participating in the sessions – learn to accept boundary
2	<p>RA: After participating for some time, did you feel any changes in your roles? And how or what made things change? Did you do or respond to things any differently?</p> <p><i>Jan: “My role had changed. When we were all together participating in the activities in the session, I felt like I am also a teacher. Sometimes the music therapist led the sessions first and then we took turns. Also sometimes Nina led us. We all helped each other</i></p> <p>RA: What did you think made your role change? From an observer to a teacher (leader), what made things change?</p> <p><i>Jan: “I think because when Nina started to get more engaged and show more interest in the sessions that made me feel enjoyment not boredom. For example, in the beginning when she didn’t engage well I felt discouraged but later when she appeared to be enthusiastic, that gave me so much encouragement to be more involved in her life.” Jan (Nina’s aunt 2/25-28/5)</i></p>	<p>Changes of her roles</p> <ul style="list-style-type: none"> - Teacher (Leader) - Follower - Co-therapist? <ul style="list-style-type: none"> - Nina is Jan’s support too. - Jan wanted to be cheerful because N was very well engaged when Jan supported and engaged in the session too. - Jan’s support encouraged Nina to engage. (Nina’s engagement influenced the way Jan participated in the sessions.)

After many times of re-reading, I created a Mind Map (appendix 11) by putting the emergent themes from my comments on each branch so that I was able to see the overall important data. The map has allowed me to find and categorise similar emergent themes together. Besides that, the map also enabled me to see which themes should be discarded. I then brought similar emergent themes from the mind map into tables, and paired them with their quotes that related to the research objective and questions. Table 4 illustrates how similar emergent themes and quotes were put together in order to capture the quotes' essences. In Table 4, I kept important phrases of comments with the quotes because at this stage, the important comments or phrases were reviewed again and transformed into even clearer themes. From doing that, later it allowed me to choose which quotes best represented the themes because there were many times when the carers repeated similar information in different ways.

Table 4 Example of how the keywords were developed into the themes

“The carers’ experiences of seeing their children in the music therapy sessions” category	
<i>Themes</i>	<i>Quotes</i>
1. Understanding signals and accept other's requests 2. Increasing concentration 3. Improving motor skills	<p><i>“Nina always likes music. She has had experiences with the keyboard and recorder before. The music therapist brought her to sing along without any force and she had fun. Nina doesn't like to do things when she is forced to do them. The music therapist allowed her to do things in her way but before she moved to a new thing the music therapist asked her to say “finish”. And the music therapist will bring instruments one at a time, and put them back when we finish. This helps her to learn about boundaries more.” Jan (Nina's aunt 2/14/3)</i></p> <p><u>[learn to accept boundary]</u></p>
	<p><i>“...After the long weekend or school holiday, I worried that she was not able to engage well like before, but it turned out that she engaged very well. Some sessions she could concentrate for an hour. When there is no other kid waiting to come to meet the music therapist</i></p>

	<i>outside the room, Nina would not get distracted and could engage with the music therapist in the sessions for quite a long time.” Jan (Nina’s aunt 2/30/5) [Engage longer]</i>
	<i>Her concentration span has increased since the first session. She started to learn to wait and became more able to follow the rules (accept boundaries). For example she learnt that she had to return the instrument when she finished playing, before she could get another one. Jan (Nina’s aunt 2/86/13) [Increasing concentration and being able to wait and accept other's suggestions more]</i>
	<i>We know more about music. Today N showed much interest in playing keyboard. She started to play with each finger separately. Before, she didn’t know how to play with one finger at a time. She normally played with all five fingers together. From the first session until now, she has been better. Jan (Nina’s aunt 2/119/17)” [Improve fine motor skill]</i>

The next step is to move to the next participant’s interview and repeat the process. During this step, I found that I was influenced by what I had discovered in the previous analysis. I decided not to create a mind map for all the participants because after I created two mind maps, I started to see similar categories that emerged across the participants, and began to employ some patterns from the two mind maps as a guideline for the rest of the participants. However, it is important to remember that the IPA researchers should “*treat the next case on its own term, to do justice to its own individuality (Smith et al., 2009, p. 100)*” and to allow new themes to emerge with each case.

After I finished organising the themes from each carer’s interviews, I asked the carers to look through the themes which were already categorised (appendix 13). All the themes are linked to the carers’ words, phrases and sentences from the interviews. Then the

carers were asked to validate the data in order to ensure that they were in agreement with the comments. They were also allowed to add more comments themselves to respond to the data. The next stage was to look for the connection across the participants' data by comparing themes across cases. Sets of themes from each participant were combined and new themes might emerge while other themes were discarded as less important (Hunt & Smith, 2004). Table 6, 7, 8, 9 and 10 in the Findings chapter show the connections between the themes and each carer, which derived from this data analysis process.

Data analysis in IPA is a cyclical process as shown in Figure 2. The IPA researchers are able to return through the stages many times and they are able to change, discard and add more themes. Therefore, by the end of the process the themes which emerged are relevant to all participants in the study (Hunt & Smith, 2004).

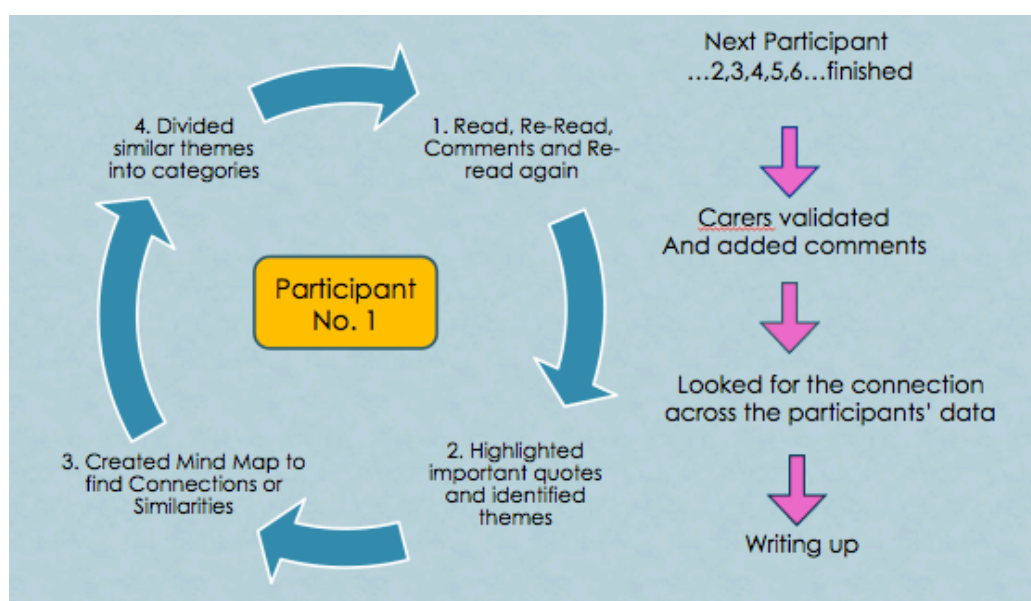


Figure 2 The cyclical data analysis process

The aim of this data analysis was not only to explain the carers' experience in participating in the music therapy with their children, but also to see the benefits of the music therapy sessions for the children with special needs. In order to do that I looked for the carers' comments in the interviews which related to their perceptions about

changes in their children according to the music therapy aims. Then I compared their comments from all three interviews.

All the interviews were conducted in Thai and I also derived the interview analysis in Thai, then translated some quotes into English if they represented the themes. However, in order to show the process of data analysis to the supervisors and the examiners at Anglia Ruskin University, I additionally translated the interviews from two carers (appendix 10). These translations will be used as examples to show how the original data becomes the research findings.

4.8 Ethical Issues

Before any data collection started, the Anglia Ruskin University ethics procedure was completed. In order to complete the application procedure I needed to consider the potential risks to the research participants and to myself as a researcher, as well as consider how to protect or minimise these risks. Dileo (2005) encouraged anyone involved with human research to be concerned about a) respect for persons (respect for individual autonomy and protection for individuals with reduced autonomy); b) beneficence (maximising benefits and minimising harm); and c) justice (fairness in distribution of research burdens and benefits). Three principles were from The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1979 cited from Dileo, 2005 p.226). I was aware that there was a very slight risk that carers might use the music therapy sessions to review or voice concerns they might have about the Centre and this could affected their relationship with the Centre. Special care was taken to ensure this “splitting” did not occur and the carers were aware that the music therapist and the Centre were working as a team. If necessary, I would try to mediate between the Centre and the carers. Also, names of children and their carers were changed while writing up the project, and every effort was made to ensure confidentiality. All personal material (video recording, audio tapes and music therapy notes) were kept in a locked cabinet.

I was also aware that the carers, children or school staff might criticise the music therapy interventions because music therapy is a new service, and misunderstandings about

music therapy were likely to occur. Every effort was made to communicate with the children, carers and staff about the aims and progression of the study as well as about music therapy in general. Moreover, the researcher remained in close contact with her supervisor for advice on this matter.

Furthermore, there were chances that some carers would refuse to be part of this study but still want to have music therapy sessions with their children. In this case, their decision on participation in the study would not affect both the carers and their children's chances to have music therapy sessions. However, during the course of data collection the carers whom I invited to be the research participants were all willing to be research participants and had no condition of allowing their children to be part of the study.

Participation Information sheets were provided for both the children and their carers before any music therapy session was started. The sheet contained aims, backgrounds and methodology of the study. I then explained all the risks that might occur as honestly as possible, highlighting how I would minimise the risk during the course of data collection. These sheets included my supervisor's and my contact addresses, and telephone numbers and email addresses, which the participants were able to use to ask any questions about the study. Consent forms and information sheets were provided to the participants before they participated in the music therapy sessions, and the participants were given a copy of a consent form to keep. An information sheet with pictures was provided for the children and in some cases help was provided from the carers or staff who know the children well enough to explain this information. On all documents, children and their family's name, school staff names, as well as the facility's own name (where the study was conducted) were not mentioned. A different name is used to protect their identities.

The consent forms and information sheets for the carers were given in order to invite them to participate in the study and also to ask their permission in allowing their children to take part. If there was any doubt whether the child wanted to take part in the sessions, they would not have been included in the study. During the assessment

procedure the music therapist determined whether music and or music-making motivated the child. This was one of the factors which determined whether or not the child was suitable for music therapy. It was explained to the carers that, should the music therapy sessions at anytime cause the child distress, it might be necessary to consider changing the approach or ending the work. During the process of this study, I was aware of protecting the participants from any harm or loss and aimed to preserve their psychological wellbeing and dignity at all times (Willig, 2008).

Conclusion

In this chapter I have explained the overview of the methodology I chose and how this project was designed. In addition, I have described how the semi- structured interviews were conducted and analysed using Interpretative Phenomenological Analysis approach. From these data collecting and analysing processes, there were two main findings as described sections in the next chapter. The first section will explain the data from review clinical notes, research journal and video recordings. The second section will explain the data from the interviews analysis.

Chapter 5 Findings

Introduction

This chapter presents all the findings of this study related to exploring the parents' or carers' experiences of participating in music therapy sessions with their children who have special educational needs. The first part employs case studies to describe the therapeutic process, the children and the carers' experience. These case studies mainly emerged from reviewing the clinical notes, research journals and reviewing video recordings after the music therapy sessions. The case studies aim to respond to one of the research questions - "Can music therapy help to achieve aims set out for individual children with special needs and their carers?" Moreover, the case studies demonstrated music therapy practice in this project. The second part of this chapter presents findings from all three interviews with the children's carers. Interpretative Phenomenological Analysis (IPA) is used to evaluate the data collected from the interviews.

This study aims to answer the following research questions:

1. Can music therapy help to achieve aims set out for individual children with special needs and their carers?
2. What are the functions of music therapy in nurturing communication between carer and their children?
3. How can the music therapist develop ways for carers to use music to help their children?

5.1 Case Report

Six children and their carers completed the study. Five children were accompanied by only one carer and one child was accompanied by either his grandmother or grandfather, or sometimes both. Table 1 shows the demographic information for all participants.

Table 5 Demographic information of the research participants

	Case No.1	Case No.2	Case No.3	Case No.4	Case No.5	Case No.6
Children's information						
Name	Nina	Aden	Pita	Mark	Paul	Nathan
Age	12	4	4	6	4	5
Special Needs	Learning disability	Learning disability	Learning disability and ASD	Learning disability and ASD	Learning disability and ASD	Learning disability and ASD
Carers' information						
Name	Jan	Pat	Tam	Bam	Rita	Sue/Dan
Age	40	46	33	58	40	54/58
Education	Diploma	Diploma in Thai traditional dancing	Bachelor degree	No education	Bachelor degree	Both finished school at the age of 10
Relationship with the child	Aunt	Aunt	Aunt	Grand mother	Aunt	Grand parents
Duration of being a carer	3 years	2 years	2 years	6 years	2 years	5 years
Occupation	Full time carer; used to work in an electronic factory	Small business owner; used to be a Thai traditional dance teacher	Full time carer; used to work in computer hardware	Full time carer; used to be a farmer	Full time carer; used to be a nursing assistant	Farm-owners and full time carers

Each case study is divided into nine sections which are; background information, referral process, assessment, music therapy objectives, treatment process, carer's involvement, video review, home visit and music at home, and discussion and conclusion.

5.1.1 Nina and Jan

Background information

Nina is a twelve-year-old girl. She has moderate intellectual difficulty. Her language skill has not developed fully. She is able to understand simple requests. She cannot differentiate colour or understand the concept of number or shape. She can use one or two words to express her needs, such as hungry, sleepy and toilet. According to her aunt's comments, her condition is rare but it is very similar to Down syndrome. When I first met her, I thought she was a boy because of her short hair and her clothes. Her aunt said that it was safer for Nina to look like a boy to avoid interest from men. She originally comes from a nearby province. Now she has moved to Khon Kaen to stay near the centre and lives with her aunt. They have been coming to the centre for three years. Before that she went to the special education centre in Bangkok, then they moved to Khon Kaen because it is easier to live near her family.

Jan, her aunt, was not involved much in Nina's life until Nina was two years old. As a result, Jan was not sure about Nina's early history of treatment and how the rest of her family recognised Nina's difficulties. However, Jan reported that Nina's father started to notice Nina's differences from other children. He could not do anything much because of lack of information, and he was busy with his work. Fortunately, Nina has her extended family which helps her parents to support and take care of her. When Nina was born, her grandparents took care of her and a few years later her aunt took over the role of Nina's primary carer. Therefore, she cannot form a special relationship with her mother. Although, Nina spends most of the time with her aunt, she has a good relationship with her father and her little sister. Her father usually calls her, and during the school break she stayed with her father.

When she was two years old, the doctor referred her to the special education centre in Khon Kaen. However, after her grandparents brought her to the centre for a few months,

they decided to take her back home because they could not afford to stop working. Therefore, for almost a year she was raised at home by her grandparents. Her aunt commented that Nina did not develop much because her grandparents were busy with work and they lacked understanding about Nina's condition. Later her aunt, Jan, quit her job to become Nina's full-time primary carer. Nina's family financially supported Jan while she took care of Nina. Then she brought Nina back to the centre and since then they have been attending the class at the centre for three years. Jan commented that Nina has been doing very well and developing in many ways at the centre. Jan is a very caring and loving person. She is eager to learn and try different things that can help her niece. She devoted her time and life to taking care of Nina. She attended different kinds of seminars or workshops in order to help her niece. Also she brought Nina to receive different kinds of help. Besides going to the centre, Nina has experience of attending speech therapy sessions, music lessons and physiotherapy sessions.

Nina has been regularly attending speech therapy for a few years and she also knows some sign language. However, now Jan is trying not to use sign language and focuses more on encouraging Nina to use simple words or sentences. It is clear that Nina can understand some simple and short questions and instructions. Also she can imitate some words but not always accurately. According to Jan, Nina needs a lot of encouragement to use verbal communication. She normally uses body language or even if she tries to speak, it is not very clear. When Nina was in her music lesson, Jan commented that Nina appeared to be very much enjoying the lessons. She liked to do actions along with the songs. Also she was able to sing a few words along with the music teacher.

Referral process

Nina was the last child who was referred to music therapy in this project. She is the oldest child I worked with. A teacher who referred Nina to me said that Jan heard the information about music therapy from other parents and she was interested to get Nina to join. So Jan asked the teacher to refer Nina to the music therapy. Also before her classroom teacher referred her to me, Jan came to ask me about the details regarding the project, and she briefly commented to me that Nina loves music and she was having

music lessons at that time. She thought it would be very helpful for Nina to participate in the sessions. The teacher who referred Nina to me was her previous classroom teacher. She suggested to me to work with Nina because Nina showed interest in music and she regularly comes to school. Also her aunt is always enthusiastic to participate in the school activities.

Assessment

My first impression of Nina was her liveliness. She confidently entered the room with her big smile. It was not difficult to establish a relationship with Nina because she showed an interest in many musical instruments in the room and was willing to try different things with me. However, she moved from one thing to another quickly. During the assessment sessions she was very excited to be in the room but I found it was hard to keep her engaged in one thing for a very long time. While I was inviting her to participate in a music game together, she was busy exploring the musical instrument. She wanted to try every instrument she saw in the room. When I sang the 'Hello' song to her, she always smiled and tried to pluck the ukulele along with me. I noticed how easy it was for her to learn from imitating another's actions. Apart from her short concentration span, it was challenging to get her to listen to my suggestions. She was good at initiating her own ideas. Even though she could not use verbal communication properly, she was able to express her ideas by using body language and some simple words. She clearly wanted to be a leader, when we did a conducting game where each of us had different instruments and a leader would give signals to start and stop. I found it was hard for her to wait for her turn and also difficult to take turns being a leader with me. However, she was very good at understanding and following simple requests.

Sometimes she asked to sing the songs she knew from her music lessons. She also wanted me to do the actions along with her. Even though she could not sing most of the words properly, she was able to catch the end of some simple and repetitive words and sing these along with me. I invited her to play an ocean drum while I played the ukulele. She was very excited and fascinated by the beads inside the drum. I observed that her

playing often accelerated, however when I slowed down she was also able to follow my tempo.

She was willing to engage with me on the keyboard. During this playing I noticed her motor skills were not fully developed. She could not stretch her arms up as high as normal and it was hard for her to control her fingers to play on the keyboard. She moved awkwardly along with my improvisation and I noticed that she did not like to move much. She needed a lot of encouragement to become actively involved physically. It was not obvious which instrument she was most interested in. She could not engage long in any activities with me. She appeared to be too excited and wanted to explore everything in the room at once. During our assessment sessions, I felt that I mostly tried to follow her lead and help her to feel familiar with the environment. The only request I made was to say: “1-2-3 and finish” after each instrument she played.

Music therapy objectives

After the assessment sessions were finished, I gave Jan a report to describe Nina's responses to music and made suggestions regarding how music therapy might benefit her. The following weeks, at Nina's third session but the first family session including Jan, we discussed the report. Jan agreed with the goals I had suggested. She briefly stated her concerns about Nina's short concentration span. Jan did not know much about music therapy therefore she did not know what to expect her niece to do. She said she was afraid that Nina would fail to learn a musical instrument. Therefore, I felt that she was relieved that the music therapy goals did not include Nina learning to play any musical instrument. There were two goals at the beginning of the treatment process. Six weeks later we decided to add one more goal.-

1. To engage with the music activities longer
2. To listen, accept another's requests more and to play in group
3. To vocalise and use more verbal communication

Treatment process

1. To engage with the music activities longer

After the assessment sessions, I re-arranged the room and put cloths to cover most of the instruments, in order to avoid Nina being distracted. Nina also started to get familiar with the new environment and me. Initially while we were improvising together, she was able to join in but would quickly try to look for another instrument in the box or on the shelf. Her concentration gradually developed throughout the therapy process. Eventually she was able to allow me to finish the Hello song without trying to take the ukulele from my hand and also she was able to fill words in the Hello song I left out. While we were singing together, Nina seemed to be very concentrated; she always looked at me and waited for my signal. She always clapped along to the music but I felt she liked to speed up the tempo. However, when I slowed down and signalled this to her, she seemed to be aware of the tempo change. Later, she could match my tempo. She was also able to wait for me to bring out another instrument without interrupting me and helping herself to several instruments at once. As the sessions went on, I felt that she appeared to be calmer and was able to engage with me longer.

We often played a ball game, where we sat in a circle and turned the music on. At the same time as we played the ball we moved and danced to the music in a playful way. According to Jan, Nina did not like to do much physical movement so she was not willing to join in at first. However, when Jan and I started to play for a few rounds while Nina lay down on the floor, she then wanted to join in herself. I felt that Jan's involvement encouraged Nina to take part. In this activity, she was able to wait for her turn and able to pass the ball at the correct signal. However, it seemed difficult for her to move rhythmically to the music. She always looked at Jan or at me for signals and she seemed to try to copy our movements. Sometimes she wanted to finish the activity but when I invited her to join in for longer she was able to accept this and wait until I brought the activity to an end.

2. To listen, accept another's requests more and be able to play in the group

I intended to provide freedom for Nina to explore and an opportunity for her to express her thoughts and feelings. Therefore in the music therapy sessions, I tried to be flexible with rules during the music activities. This meant that Nina could have space to be herself, to be able to initiate her ideas and to be a leader while having two adults following her. This enabled her to feel that she was accepted and gained respect from adults. With Jan's and my help, Nina was able to give the signal "start and stop" for the music making. I observed that she participated better in the activities that she initiated. However, sometimes Nina needed boundaries (or structures) because she found it was difficult to wait or accept another's requests.

For example, I improvised a song on the ukulele and invited one person to sit on the chair with the drum. Then I asked the person who sat on the chair to beat the drum as a signal to stop. Nina seemed to be very pleased to be the person who gave the signal because she liked to see two adults following her signals and she did not like to move. It was challenging to ask her to take turns to be a leader with Jan and me. When it was time for Jan to sit on the chair, Nina resisted taking turns with her. At this point she took the instrument away from Jan's hand without waiting for Jan's permission to do so. I therefore allowed her to become the leader a few more times and then gave her more time to prepare for the fact that it would soon be Jan's turn to lead. I felt that she was becoming an adolescent. She wanted to be accepted by others. Adolescents are very influenced by what others think about them because it can reflect what they feel about themselves (Erikson, 1995). I discussed this issue with Jan; we decided to emphasise to Nina that her opinions were as important as adults' opinions. Also when Nina resisted following adults' opinions, both Jan and I would remember that Nina had become an older girl who could lead others rather than this behaviour being seen as a naughty habit.

3. To vocalise and be able to use more verbal communication

Jan requested that I should encourage Nina to vocalise. Jan told me that Nina had difficulty in moving her jaw to produce words. Her condition was similar to Down's syndrome. *"Children with Down's syndrome have differences in anatomical (structural) and physiological (functional) in the mouth and throat areas that make it more difficult*

for them to make precise movements... Some anatomical differences that are seen include a small and narrow upper jaw, and a high palatal arch. Physiological differences that are seen include low muscle tone, and weak oral facial muscles. A combination of anatomical and physiological difficulties results in open mouth posture and tongue protrusion (Kumin, 2012, p. 2)." This caused Nina to have difficulty in the development of speech skill. In the sessions, Nina was encouraged to see Jan's or my mouth when we were singing so she could copy the movement and produce the sound. Also she enjoyed vocalisations with me when I was playing the keyboard and invited her to vocalise. I took turns with Jan to create the different mouth movements from different vowels. Nina responded very well, she could engage for a long time and imitated naturally. In addition, I improvised a song about animal sounds and brought animal picture cards to encourage Nina to make the sounds of the animals on the cards. She sometimes wanted to take turns to be the leader and request that the two adults make the sounds. Sometimes I encouraged her to do the movement of the animal along with the vocalisation in order to bring out her excitement. Besides copying and repeating the animals' sound which Jan and I made, she was also able to recognise some of the animals and able to say their names. Although she could not produce clear sound or words, she seemed to have so much fun making sound along with the movement with Jan and me. During this activity, she was willing to make a big effort to vocalise difficult vowels or sounds. For example, Jan showed a picture card of a cockerel to Nina and I improvised the song asking her how a cockerel would sing, and paused in order to allow space for Nina to fill in the sound. She responded well and with help she was able to make a chicken sound and its movements. She always looked at Jan's or my mouth and face carefully in order to copy. Jan naturally imitated the ways I exaggerated the mouth movements. She appeared to be very pleased with how much Nina was willing to accept such a challenging task.

The aunt's involvement

When I first met Jan, she was very open and eager to learn new things to help Nina. During the first few sessions, she mostly observed what Nina and I were doing and did not engage actively much. Also she helped me to encourage Nina and manage difficult

behaviours Nina presented. She helped me to better understand Nina's condition and her needs. After focusing on engaging Nina in one thing for longer and allowing some time for Jan to be familiar with the activities, and with me, I noticed that Jan became more engaged in the activities too. This also helped Nina to learn because Nina always looked at Jan for support. Jan was a model for Nina and she learnt from following Jan. When I offered the instrument to Jan, she did not seem to be reluctant to join in. She quickly responded to the music I improvised. Also she imitated the movements along with me to encourage Nina to join in. In the later session, without my encouragement, Jan naturally led Nina to move along with my music. She was more confident with her voice and expressed her opinion to me freely. She sometimes initiated her own ideas such as what instrument we should play or what movement we should do. Also she always made observations and give me very helpful comments on Nina's behaviour. Jan was also a music partner because her participation encouraged Nina to join in, and was also very supportive to me. When Jan seemed to be enjoying the sessions, it encouraged me to feel I was going in the right direction. Having Jan to support my music also stimulated Nina to engage and learn from imitating Jan. Jan also helped me to avoid Nina's resistance by engaging in the music making.

It was very important to give Jan a good memory about Nina and herself together. Jan told me that in the classroom, normally, Nina was quiet and timid. Therefore, this memory was able to help Jan to see Nina in a different light. Also Jan knew the different ways to engage with Nina, she was able to recognise new abilities in Nina and in her ability to help her niece. This enabled her to become more hopeful about Nina's development.

Reviewing video

The first few times I showed the video to Jan, I felt that she seemed to feel quite uncomfortable seeing herself on the video. She said that she was shy about watching it. Sometimes while we were reviewing the video, she talked about Nina's behaviour outside the music therapy sessions and stopped focusing on watching the video.

However, it was good that the video excerpts reminded her about how Nina was engaged in music activities at home.

Later when she was more familiar with me, she started to give me more comments regarding the session. Sometimes she had different opinions from me. She found it hard to see Nina resisting my proposed structure. However, it was a good chance for me to share my opinion with Jan that Nina's challenging behaviour could be acceptable. Reviewing the video helped us to see why Nina presented challenging behaviour and therefore helped us to discuss ways of managing. This helped Jan to feel more relaxed and more open with me.

Jan commented on how she saw Nina differently when she was in the sessions with Nina, and when she reviewed the video. Seeing the video lessened her worry about Nina's difficulties with concentration. It helped her to see how long Nina was able to engage with others and how much fun Nina had. Moreover, Jan was pleased to see herself able to engage with her niece playfully and be very creative.

I was surprised at how pleased Nina seemed to be to see herself able to do things with adults. She always smiled and pointed at herself while we were watching the video. For me it also helped to encourage Nina to present positive behaviour in later sessions.

Home visit and music at home

The first visit took place at her grandparents' house. Nina's little sister was also involved in this visit. Nina seemed to be very excited to have a guest to visit her at home. She showed me her toys and also her musical toys. We had a small musical interaction together between Jan, Nina and her little sister. Her sister showed interest in participating in Nina's activities. She was able to engage well with Nina. They played together and took turns playing the instruments. I noticed that her sister tended to follow Nina's lead rather than take control of her sister.

Jan continued to use music naturally. She said that she adjusted to a new way of talking to Nina using more intonation in her voice. Jan explained to me how Nina's day was organised. Jan involved music in many of Nina's activities. For example, Jan brought

the ball game to play with her two nieces and in the morning Jan encouraged Nina to do some exercise and she always turned the music on to accompany the exercise. Also Nina herself still remembered some phrases in the songs she used in the music therapy sessions and she asked Jan to sing her these songs when she was at home. Nina imitated the way we played keyboard together in the sessions on the staircase at home. It seemed that Nina still remembered good moments in the sessions and brought them to her home environment. Jan commented that she was able to spend more quality time with her niece through music. However, it was more difficult to get Nina to engage for as long as she had done in the music therapy sessions.

Discussion and conclusion

Nina's lively character made me feel very comfortable and made it fun to work with her. Her love of music was a good start in our music therapy sessions. Involving Jan in the music therapy process had many advantages for both Nina and myself, as a music therapist. Jan and I worked very well together in the sessions.

It was clear to me that Nina had achieved the music therapy aims. It would have been more difficult for Nina to achieve these without Jan's support. Also I felt that from these experiences Jan learnt how to interact with Nina differently. She showed her creativity in movements and also was willing to apply my techniques or activities in the home setting. She naturally got along with the music activities with Nina. This enabled Nina to gain more confidence because she knew that her aunt always supported what she was doing. For Nina to see Jan's smile meant that Nina felt valued and knew she was able to make someone else happy.

5.1.2 Aden and Pat

Background information

Aden is a four-year-old boy who was diagnosed with Down's Syndrome. He was a small boy compared with other children of his age. He seemed to understand some simple and short questions and words (phrases) (such as "are you hungry?" or "do you need to go to toilet?"). He could not use much verbal communication. He could say or repeat some

short and simple words but not precisely. He appeared to be a very lively and energetic boy but he has asthma. According to his aunt, Pat, he was ill quite often which caused frequent hospital visits. Initially, Pat was concerned that Aden might miss the school and the music therapy sessions often.

When I first met Aden, he had just started coming to the centre for a few months. He is the only child of the family. Originally Aden's family comes from a province nearby and during the term time, he lived with his aunt (his father's sister), Pat. His parents came to see him every weekend. When Aden was first born, his parents were devastated about his diagnosis. According to Pat's report, she said they sometimes had arguments and blamed each other. It was a very stressful time for the rest of the family. Especially when Aden's grandmother who had helped his parents to take care of Aden when they went to work, could no longer take care of Aden because of her health problems. This made Pat decide to become Aden's primary carer. Before that, Pat lived abroad and visited Aden's family once a year. When Aden was born, she visited more often because she wanted to support her brother (Aden's father). Pat is married and has one 16-year-old daughter living abroad. Pat was a traditional Thai dancing teacher. When she moved back to Thailand to take care of Aden, she owned a hair salon in a province near Khon Kaen. She went to check the salon every weekend when Aden's parents came to stay with him in Khon Kaen. Before Aden attended the centre, Pat used the Internet to find information about educating her nephew and provided him with home-schooling. She did not come to the centre until she met a parent of a child with special needs at the hospital who recommended her to bring Aden to the centre.-

Before Aden started the music therapy sessions, I observed him in a classroom and he appeared to be very attached to his aunt, Pat. He engaged very well with the class activities if Pat joined in with him. However, when his teacher tried to engage directly with him he would shy away and hide behind Pat. When Pat encouraged him, he would be willing to join but he always looked for Pat's support.

Referral process

When the research project had been set up, Aden had just started attending the class in the centre. Therefore, his classroom teacher did not know him very well. She referred Aden to me because she felt that Aden's aunt, Pat, had a background in Thai traditional dancing and already used music with Aden at home. Therefore, Pat would very willing to participate in the music therapy sessions. Moreover, in the classroom Aden responds to music very well. The teacher said she hoped music could encourage Aden to vocalise and then develop to verbal communication.

Assessment

In the first assessment sessions he appeared reluctant to come into the room by himself, therefore I brought the ukulele and gently played it to him outside the room. Pat also encouraged him to come in the room and she attended the sessions with him for a while until he started to engage with me. When he came in the room but he just sat still, tried to avoid eye contact with me and did not show any interest in playing music. I offered him the ukulele and I softly brought his hand to pluck on the ukulele. Then when I let him play by himself, he stopped. He seemed to want to explore the instrument but he was too shy and wanted to wait until I played with him. In the first sessions, I was very careful not to intrude into his space. I brought rainmaker, ocean drum and keyboard out for him to choose. However he still did not engage much with me. I played on the keyboard and invited him to join in. He barely made eye contact with me all through the session. When I sang the Hello song to him, he would shy away from me. However, if I gave him some more time to respond and I approached him gently, he could engage well. I felt that he was interested in music because he did not show any resistance to exploring the instrument I gave him and also did not reject me when I held his hands to show how to play instruments (such as rainmaker, ocean drum and keyboard). He was able to stay on the chair all through whole sessions and followed most of my requests. I was not sure how much he could understand my requests. However, if I used simple, short words and also clear gestures he was able to respond correctly. In the second assessment session, he showed more of his feelings. He smiled and laughed while we

were playing the rainmaker together. I firstly held his hands and we played together because the rainmaker is quite big for his size and he still seemed unfamiliar with the instrument so I was not sure that he knew how to play. After he was familiar with the instrument, I let him play by himself. He seemed to enjoy this, and I accompanied him on a keyboard. Then I offered a bongo drum. He would not start playing or exploring the instrument until I started or gave him signals. I noticed that his sense of tempo was very good. When I played the keyboard I gradually changed the tempo and Aden was able to match me. Although he did not show initiative to play any musical instrument when I invited him to join he was able to engage with me for a very long time.

Music therapy objectives

After the assessment sessions, I wrote a report to Pat about what we did in the sessions and also how Aden responded to the music. Initially, Pat was concerned that Aden was too young to understand verbal communication and would not be able to learn anything. It was important to emphasise to Pat that at the beginning of the process, I would aim only to help Aden relax and find ways to engage with him. I briefly shared my opinion on what Aden's strengths were, and his challenges. Pat was surprised that I thought Aden was a very shy and well behaved boy. She agreed with me that he was very shy but when he was at home or was surrounded by his family, Aden was very playful but sometimes he would not listen to her and resisted following her requests. She commented that when he was at the centre, he was not himself so it would be good if music therapy sessions could bring Aden's playfulness out when he was outside his comfort zone.

1. To build trust and increase his self-confidence
2. To encourage him to vocalise
3. To encourage him to express himself (feeling/thoughts) and to provide him with chances to be creative

Treatment process

- 1. To build trust and increase his self-confidence*

In the first few sessions, Aden was still quiet and tried to avoid making eye contact with me. However, he did not resist my requests to try different kinds of instruments. When I offered him the instrument, he gently accepted and waited until I started to play on the keyboard or ukulele. Sometimes I improvised a gentle song to invite him to pluck the ukulele with me. In the first few sessions Aden did not respond to me directly but he would hold Pat's hand to pluck the string. He smiled to her and seemed to enjoy doing it. I felt that Pat was a bridge for me to connect with Aden. Asking Pat to join in playing music with me first would encourage Aden to engage in the sessions. For example, when I improvised the song on the keyboard and invited Aden to play on the small recorder along with me, he seemed reluctant and looked at Pat for support, therefore I invited Pat to play along with me first then Aden to gradually play along with another recorder. I was very impressed by his effort to try to make a sound on the recorder. He is a small boy and according to Pat, he had just learnt how to blow so he was not yet proficient in that yet. However, he was able to produce loud and long sounds from the recorder after a few tries. Aden seemed to enjoy making his own sound and interacted with Pat. It seemed like Aden and Pat talking through the recorder. I was surprised by how confident he was when he expressed through music. He would turn the recorder to Pat and they both would blow to each other. They laughed and seemed to have a good time together. As the sessions progressed, Aden became less shy with me and wanted to do more and having his aunt witness his ability was able to develop his confidence.

2. To encourage him to express himself and to provide him with chances to be creative

It was clear that Aden enjoyed music very much. He had a good sense of rhythm and always listened to other signals very well. While I improvised a song on keyboard and invited Aden to play along on a bongo drum, he would play very confidently and carefully listened to my signal and was able to match my tempo and dynamic. Also he learnt things from imitating very quickly. When I was on a drum we were doing the copy game, he seemed to wait for me to start then he tried to copy my pattern. After I led him in the game for few rounds, I invited him to initiate his idea. In the beginning, he seemed to be shy but I gave him some space and when he did a short beat on the drum, I copied so that he recognised that I wanted to follow him. He started to smile after I

copied his drum beating. My facial expression was to look very pleased and I think this encouraged him to be more expressive with me. He less often brought Pat's hands to play an instrument for him. He was able to make music interaction with me directly. Moreover, when he engaged very well, sometimes he surprised Pat and me. He liked to find different ways of playing the instrument. He sometimes played with a recorder while another hand beat on a bongo drum and still also listened to the signal from my music. Usually he naturally vocalised along and moved with music. I felt that music brought him away from his shyness and encouraged him to be creative.

3. Encourage him to vocalise.

Normally, outside musical engagement, Aden would not use his voice or try to vocalise much, except when I encouraged him at the beginning of each time we started to play music together, to give the signal 1-2-3 to go and 1-2-3 when we finished. He would look at either Pat or me carefully and tried to imitate our mouth movement although he could not say the signal very clearly. Moreover, I noticed that when we moved along with the music, Aden seemed to more naturally vocalise along and looked more confident. For example, in one session that we marched around the room, I played a ukulele and Aden had a recorder while I asked Pat to beat the drum to give us the tempo whether to walk, jump or run (we had played this game before so Pat knew how to give different signals on a drum). Although I was not sure if Aden could recognise different signals, he was able to observe and follow my movement and change along with me. While we were moving around the room and he had the recorder in his mouth. I noticed that sometimes he did not blow but he vocalised with different vowels such as "wo wo wo", "aow aow aow" and "ah ah ah". He appeared to be very relaxed and his vocalisation was louder than when he sat and played with the instrument.

His aunt's involvement

During the first two months, I felt that Pat preferred to drop Aden off then she would leave the room. When we discussed the needs of her involvement, she said she wanted to know how Aden was doing without her presence. Also she stated that she felt having her in the sessions forced Aden to play. She felt that she wanted Aden to be free from her so

he was more able to do what he wanted. I noticed that sometimes Pat went straight to direct Aden to do things that I requested. She did not wait for him long enough to respond. I thought the way she encouraged Aden helped him to get started. She did not push him to do something he did not want to. She would stop if Aden started to show resistance. I think having someone he was familiar with around and encouraging him in this way was helpful. Close proximity with a stranger probably made Aden feel uncomfortable and subsequently resistant to participating. Also Pat was the role model for Aden. I thought when he saw Pat participating with me this helped him to feel safe and he wanted to experience it by himself.

Pat's support affected Aden directly. He always looked at her for support and he appeared to be very pleased to see his aunt join in with his activities. He shouted out for Pat and sometimes would not start until she participated. Moreover, he seemed to be very proud when he saw that Pat smiled and clapped along with his music.

Video reviewing

When I first showed Pat the video excerpt, I felt that she was little bit embarrassed to see herself being very childish and playful with Aden. She said that what she was doing was silly and she laughed to see herself being like that. However, it was good to know what she felt about herself being childish in the sessions, so that I was able to point out how being childish and playful with his aunt could affect Aden positively. As sometimes she did not attend the sessions, it was very good to show her Aden's difference between when she was in the session and when only Aden and I were in the session. This helped me to persuade Pat to see that involving her in the sessions was not only for Aden's company but also her participation encouraged Aden to join in freely and her input made the sessions become more familiar to Aden because Pat brought the songs they both sang at home to use in the sessions.

While we were reviewing the video together, Aden always sat and watched himself in the video. He appeared to be very pleased to see the video. He smiled and called out his name and his aunt's name. Also Pat liked to point out to Aden the moment when Aden presented positive behaviour (such as when he was able to blow the recorder and was

able to move around the room and vocalise along). It was as if the encouragement was a reward for him that his aunt was very proud of him and acknowledged his abilities. Moreover, she was very pleased when I pointed out how much he could do in the sessions. I felt that sometimes she did not recognise that these abilities were important. Also she did not recognise that her involvement in the sessions had so much influence for Aden and also in the therapeutic process. This video reviewing helped her to shift her thought from only focusing on Aden to be more focused on her interactions with him too.

Home visit and music at home

The family environment supported Aden to use music often. Pat showed me Aden's music corner at home. There were two guitar toys, small shakers, and a keyboard. Pat said every day Aden watched a music channel on television and brought his guitar to play along (pretending that he was a singer). Although he could not speak long sentences, he was able to catch the last word of some sentences of his favourite songs. Pat said that music brought family and him together. When he played his instrument, his parents wanted to join in with him. He was a leader who directed his parents in which instrument to play. I was very surprised because usually in the sessions, he did not always initiate his ideas.

During the first home visit, at first I tried to engage him to participate in music; he did not respond much although Pat sat with us. Later I asked Pat to play the ukulele with me. This enabled Aden to be more relaxed and he engaged very well. When I visited them I also met Aden's grandmother; during our music interactions his grandmother gave him praise and encouraged him a lot. I brought the songs and activities we used in the sessions at the centre such as me playing on the ukulele and I improvised the song to encourage Aden to vocalise. Pat has a background related to music, therefore she usually sang songs for Aden. She said sometimes at home she did the actions along with the music and encouraged Aden to join in. During the visit, I asked her to show me how they sang and danced together at home. Moreover, Pat said when he was at home and played a keyboard with her, he pretended that he was a teacher (a music therapist) who

directed Pat to play on a keyboard. It appeared that Aden was involved with music activities very often and Pat said that when he engaged in any kind of music activities he became lively and this made his parents very happy.

Discussion and conclusion

I had a very good time in the sessions with Aden and Pat. Aden enjoyed music so much. It is very important to see how Pat balanced giving him freedom with structure. I learnt from observing her that Aden needed simple and directed structure before he could be explorative and initiate his ideas. He was able to understand my requests but he was shy. Therefore I felt that I had to wait longer for Aden's responses longer than for other children I worked with.

I was very pleased to see Aden vocalise more and freely. Also he appeared to be very confident when he enjoyed playing music. It seemed that he forgot about his shyness and naturally became himself. Having Pat, whom Aden trusts, was a very important factor because Pat's presence was able to make Aden feel safe in the environment and this enabled him to establish a new relationship with me.

5.1.3 Pita and Tam

Background Information

Pita is a four-year-old boy. His family was aware of his condition when he was one year and eight months old. According to his aunt, Tam who is his primary carer, she explained that when she went to visit Pita's family during the holiday she noticed his behaviour. He liked to curl himself up in a small area and he liked to spin a wheel or anything that can be spun. Also he liked to spin himself around and he would not be aware or recognise it when someone called him. These were obvious behaviours that made Tam decided to consult her friend who is a special education teacher. Her friend suggested Tam see the doctor in a local clinic. However, the doctor does not specialise in children with special needs, therefore he recommended Tam to bring Pita to check with the doctor in Khon Kaen which is a two hour drive from their home town. After the doctor diagnosed that Pita has ASD, Tam took Pita to receive different kinds of

treatment including traditional treatment, oriental treatment, also music healing. (According to Tam, music healing aimed at using relaxing instrumental music to stimulate a child's brain.)

When Pita turned two, he attended the class in the special education centre in his home town. At that time his condition did not obviously show, so other parents at the centre suggested to Pita's family to put him in the normal nursery. When Pita was in the nursery, Tam usually went to observe him in class. She noticed how Pita always appeared to be isolated from his classmates. One day after school, he could not stop crying and Tam found out that his arm was dislocated because of an accident in the nursery. Then the family decided to provide him with home schooling instead. At that time Tam decided to quit her job and become a full time carer. After Pita left the nursery he stayed at home for a year and met the doctor regularly, Tam could not see much progress, then, when Pita turned three, Tam decided to bring Pita to the Special Education Centre in Khon Kaen where the doctor recommended her to go. At the centre, Pita learned to improve his social, fine and gross motor skills and Tam was pleased with his progress.

Referral process

Initially, Tam approached me after I talked to Pita's classroom teachers about the project. She said that she was very interested in having Pita participate in the project. Therefore, I discussed with the classroom teacher and she also recommended having Pita part of the project. She thought it would be beneficial for Pita to have music therapy. She hoped that music would bring Pita out from his world and encourage him to interact with others. Also, Tam's enthusiasm to participate in the school activities would keep her coming to the music therapy sessions regularly.

Assessment

In the first assessment session, I went to collect Pita from his classroom. He appeared to be very much in his own world. I was not sure if he was aware of my presence. He refused to come with me. He held on to Tam tightly and could not let her go. Therefore I

asked Tam to take him to a music therapy room. When we got to the music therapy room, he still could not let Tam leave the room and started to cry. I started singing the Hello song with a ukulele to him. He was very interested in the instrument and it seemed that the instrument was able to distract Pita from his fear of Tam's leaving the room. Later, Tam quietly left the room. Pita appeared to be calmer and allowed me to finish the hello song. During the song, he tried to explore the ukulele by knocking it. I offered him the instrument, he accepted it but he would not play in the way I suggested. He liked to spin the ukulele and other instruments I provided. I was not sure if he could understand my signals or if he was listening to me. However, when I vocalised along with playing the ukulele and left some space he would make a one word utterance sound, but not look at me. It was clear that he was interested in a ukulele but with other instruments such as xylophone, shakers or drum he did not show any resistance but he just played briefly.

In the second assessment session, I aimed to engage him more and allowed him to explore more instruments. This time he allowed me to bring him to the music therapy room without Tam. When he got to the room, he ran straight to a corner of the room and refused to play with the bongo drum I offered. It seemed that he wanted to leave the room. Then I brought a ukulele out, he turned to me and seemed to be very interested in the instrument. He looked carefully at the instrument while I was singing. However, he barely looked at me or made eye contact. At the time I was not sure he knew how to play with the instrument, therefore I always showed him how to play, but it was difficult to get him to look at me. I offered him shakers, and instead of shaking, he tried to hit the shakers, one with another. I worried that he would hurt himself with the shakers so I removed them from him and he returned to the corner of the room again. Then I played on the melodeon, he turned to me once in a while and during this time he gave me a few eye contacts. I left some space for him and waited a little longer; he would make a one word utterance sound. He moved closer to me and seemed interested in the mouthpiece for blowing the melodeon. From that, I noticed that instead of sitting in the corner and being in his world, Pita showed more interest in exploring other instruments. However, it was challenging to invite him to play the instrument properly. I held his hands to hold the beater to play the xylophone, he did not resist me but when I let him hold the beater

himself, he would play it in his own way, which was quite dangerous. Therefore after we explored the xylophone for a while I returned to the ukulele. I held his hand gently to pluck the ukulele and I improvised the song on the ukulele, and he seemed not to be aware of my music; he allowed me to do that for little while then he tried to resist and take the ukulele from me. Although I found it was difficult to engage with him, it was a good start to see that he showed interest in musical instruments._

Music therapy objectives

After I gave Tam the report, she did not have many comments on it. The only concern Tam had was that Pita would not engage in anything with me. Therefore I emphasised that in the music therapy sessions, I would initially aim to find ways to engage with him. It was necessary to assure the carer that I too initially started with not difficult, achievable aims. These aims would lead Pita to other things. The basic aim I set was also important and would affect the rest of the process. This helped to lessen Tam's worries.

1. To encourage Pita to engage with others and spend less time in his own world
2. To encourage Pita to listen (or accept) another's signals
3. To encourage Pita to communicate and express himself

Treatment Process

1. To encourage Pita to engage with others and spend less time in his own world

During the first few months, it was very challenging working with Pita. He came to the sessions without much clue of what he was interested in. It seemed like he grabbed most of the things I offered. Then he appeared to shut other people out. Also he did not show many facial expressions.

It was very helpful to have Tam actively participate in the sessions. I felt that he was aware of her presence more than anyone. Also, her involvement encouraged him to participate with us rather than to play by himself alone. He preferred to look at her for signals and encouragement. For example, when I played the ukulele and improvised the song to encourage him to dance along to the music, he briefly smiled and looked at his

aunt. Tam danced along with me and her involvement much encouraged Pita to join in. Tam clapped along with the music to encourage Pita to dance. Even then he did not look at me so much but I felt that he listened to the music and waited for his aunt to give signals. When he stopped dancing briefly, I also stopped my music. Then when I started music again he would dance along with Tam and me. He appeared to enjoy dancing with me and was more aware of the music and other people. Sometimes he did not look at anyone and just danced. His eyes wandered around, therefore his aunt and I had to try to dance in front of him in order to maintain the engagement.

A ukulele was the first instrument that he showed interest in. When I sang the Hello song he usually looked at me and tried to grab the instrument. Initially, I gently held his hands to pluck the strings. He could be very focused on looking at me playing the ukulele. Sometimes he quietly vocalised along with me. Also when I paused in order to see if he still listened to me or not, he would make a sound and push my hands to continue playing the instrument. I was very pleased with his small signals because from the first session when he did not show any awareness of my presence, his awareness had increased until the last session. He came to the sessions with a clearer sense of direction of what he wanted to do and spent less time in his own world. Moreover, Tam said that he showed more of his emotions and his needs and he was able to request what he wanted.

2. To encourage Pita to listen to (or accept) another's signals

In Pita's case, when he first came to the sessions, I did not know clearly what he wanted to do or what he did not like to do. He was very much in his own world and it was challenging to get him to listen to another's signals or requests. During the first period of the treatment process, before he was willing to engage with Tam and me, sometimes Tam had to help me hold Pita's hands to experience proper ways of playing the instrument.

For example when I invited him to play on a bongo drum, while I was playing on the keyboard to accompany him, first, Pita tried to turn the drum over, and lifted it up. Then he tried to move away from where we sat. I improvised the song to match his actions

and followed him. Then I improvised a song to invite him to play the bongo drum with me. I was not sure if he was listening to my music or not. Later, Tam held his hands to beat on the drum. At first he resisted playing and tried to move away from it. Later, after he started to be familiar with the drum and having Tam play with him also encouraged him to play along. I used the song to match his tempo and also followed his lead at first. He started to smile and tapped on the drum without much encouragement. Later, I stopped my music to see if he could be aware of the change. Although he did not respond to the change of music suddenly, he gradually stopped. In one session, he was able to stay on the bongo drum for a long time. It seemed as if he listened to my music too because we took turns playing, I improvised on the keyboard while leaving him space to fill in. Although he did not give me many eye contacts, he was able to fill in the space and smiled to Tam many times.

3. To encourage Pita to communicate and express his needs

After he appeared to be aware of my presence, and showed more interest in engaging with me and familiarity with the session routine, I tried to follow him less and challenged him by requesting him to use a gesture to request what he wanted to play with and when he wanted to finish. It was not only a gesture that Tam and I encouraged him to use; sometimes we also encouraged him to use a short word, such as “please” or “say Tam’s and my names”.

For example, I asked Tam to sit in the circle and let Pita sit by himself (without anyone holding him). I used an ocean drum and held it together with Tam. We swung the drum gently while I improvised a song to encourage us to take turns beating the drum and left some space for everyone to say whose name it was to play next. In Pita’s case, Tam and I encouraged him to use a gesture to state his turn. At first, Pita tried to grab the drum and not wait for the signal, or when it was his turn, he was not aware of it. We both struggled to have him sit with us and also to not let him grab the drum from us. Tam had to hold his hands to play when it was his turn the first few times. Later, he started to smile, and when we left him a longer pause on his turn, he was able to respond back to us. It took some time to get him used to the game, and having him watching Tam participating in the game with me could help him to follow the rule. In one session when

we were playing this game again, Pita engaged very well. He was able to wait for his turns and used his gesture to ask for his turn to play. Moreover, sometimes he slipped out a short word too, but it was not consistent therefore Tam and I were aware that Pita's use of words could be a coincidence. However, Tam was very pleased and surprised that he was able to use the word in a suitable context at those times. It seemed that this musical game could create a lively and fun atmosphere, so the child could engage for a long time without being forced to do so. This enabled him to feel safe and comfortable to communicate his needs at his own pace.

The aunt's involvement

Pita has a strong relationship with Tam. He always smiled at Tam and showed affection for her through cuddling, always tried to grab Tam's arms and smell her hair. However, Tam said that when he cuddled, he did not want to let her go, and she worried that this would prevent him from engaging with others. Having Tam in the sessions and participating with Pita and me was very helpful. Pita appeared to prefer looking at and copying Tam. Also she helped me to understand his behaviours and prevented difficult behaviours such as wandering around the room. Moreover, she was very open and willing to learn and try new things. We shared our opinions very often.

Tam was very enthusiastic to learn new things to help her nephew. Sometimes she brought her ukulele to the session and asked me to teach her some simple chord. She said that she wanted to try different ways of spending a good time with Pita. She was always eager to know my opinion of Pita in each session and she always took my ideas to try at home. Having her in the sessions helped Pita to feel safe and have support when he needed it.

Video reviewing

She was very enthusiastic to watch the video and did not appear to be embarrassed to see herself in the video. She very focused on Pita's responses rather than on herself. Sometimes she asked for a copy of the video excerpt. She said the video gave her so much encouragement and she liked to re-watch it many times. Moreover, she was able to

notice many small things because he did not give obvious signals whether he listened to us or not. Small signals from him were very important, such as shaking less or his eyes moving to follow my hands when I played on the keyboard. These movements were difficult to notice when we were in the middle of music interactions. Also when she noticed Pita's signals, she was able to tell that the signal was significant and not just random reflections. After she reviewed the video at home, she sometimes made comments and gave me suggestions. This video reviewing gave us more opportunities to work together because it brought us into the same pace and the same expectations.-

Music at home and home visits

It was my first time meeting the rest of Pita's family. Tam was also there. They gave me a very nice welcome. His parents are successful tutors in the area. Three months before this home visit, his father had just been diagnosed with having cancer. Fortunately, his condition was better when I met him. It was my first time talking with his mother, I started to understand why they are quite distant from Pita. She had so much hope for Pita and when they found out that he had ASD, this broke their hearts and his mother blamed herself for his condition. In Pita's first few years, his parents could not cope well with the feeling of guilt and sadness, and they struggled to accept their son. However, his parents are caring and work very hard in order to provide good financial support. Therefore, they do not have much time for Pita, especially when his dad was in hospital. They only met Pita during the school break, which is once in three months. I noticed that the parents could not manage Pita's difficult behaviour or understand his needs very well.

My music interaction's aim was to show the family how Pita was doing in the music therapy sessions and how well he could engage with music, also to encourage the family to use music at home with him. When I started the Hello song and offered each of them a turn to pluck the ukulele, everyone appeared to be very well engaged and no one seemed to be reluctant to do it, even they do not play any music. During the music interaction where the parents, Tam, Pita and his little sister all engaged together, I could see how his father was very playful and was willing to try new things with his son.

During the music interaction at his home, Pita appeared to listen and follow Tam more than any other. When Pita seemed disengaged, Tam was the one who stepped in and was able to bring him back. It was harder than in the sessions, to structure the music interaction between Pita and his family. This was the only music interaction we had with his parents. Therefore we did not have the chance to discuss much about how music therapy works and what to expect to see in the music interactions. Both his father and his mother tried so hard to gain Pita's interest and encouraged him to engage with me. I wanted him to engage too but also wanted to give Pita enough freedom so he could feel at ease to respond to music in his own time. Sometimes I felt as if his mother did not understand her son's signals. She did not wait long enough before Pita could respond, so she would get Pita's little sister to take over his turns. During the visit, I felt that Tam appeared to be fading back from the family. I felt that she wanted to allow Pita's parents to take control more and experience music interaction with their son. Although it was very nice to see that everyone in the family enjoyed participating in music with Pita, it probably appeared to be challenging for Pita's parents to engage with their son without Tam's help.

After finishing the music interaction, I discussed with Pita's parents and Tam about how music was used in the family. Tam said that at home Pita liked to play with a microphone and vocalise while adults (his parents and Tam) were singing karaoke. Also Tam still tried to learn to play the ukulele. She said a ukulele could distract him from being in his own world very well. He would run to her when he saw Tam bringing out the ukulele. However, Tam was worried that her music skills could not gain his attention as much as when he was in the music therapy sessions.

Discussion and conclusion

Pita had been making good progress during the treatment process. He appeared to be more aware of music and me. He was able to wait on the chair and play with one instrument longer. He spent less time sitting by himself in the corner of the room and showed more interest in communicating his needs to others. Sometimes he avoided engaging with me but later he would come back when he saw Tam was engaging with

me. He showed more facial expressions, especially with Tam. Tam played very important roles in the sessions. Her presence in the sessions made Pita feel safe and he wanted to engage more with Tam. Having her in the sessions helped me to collect small signals from Pita. These signals were very important for a child like Pita who did not show obvious clues of how he felt towards music or other persons. Tam's enthusiasm to participate in the sessions created a feeling of trust between us easily. It showed that she was open to accept my opinions and also felt free to share her thoughts with me.

5.1.4 Mark and Bam

Background information

Mark is a six-year-old boy who was diagnosed with ASD. He does not have verbal communication but he appears to understand a good amount of language. He usually presents repetitive behaviours (such as flapping his hands) and hurting himself (such as pinching himself every time he makes any sound). However, he did not display any aggressive behaviour to others. He appeared to be quiet and showed little interest in others and his environment. According to his parents, when he was very young he always cried without any specific reason.

He stays with his parents but they both work. Therefore his grandmother (his father's mother), Bam, is his primary carer. He comes to the centre with Bam almost every day. When I asked Bam about Mark, she appeared to be worried and anxious about his behaviour. I was aware that her perception toward Mark focused more on his challenging behaviour than his positive behaviour. Bam did not realise Mark's ASD condition until he almost turned two, and the doctor referred him to the centre. At that time she was devastated, because she had so much hope for her grandson, and she was so proud of him. According to Bam, she said that Mark was born perfectly healthy and could recognise his parents, and cried out for them when he was almost one year old. One week before his first birthday, he was very sick and in shock. The doctor said that he had a brain anoxic condition. After this admission to the hospital, he appeared to be in his own world and interacted less with his parents.

Bam thought that her son and his wife could not afford to provide Mark the best treatment, because their financial status was not very good. Therefore, Mark could not make any good developments. Also Mark had been going to the hospital on and off. Consequently he could not attend school regularly. Bam is his primary carer, who is working along with me. Initially, Bam was going to help Mark's parents take care of Mark until he turned two. However, she had to give up her plan to return to her home town and continue working on her farm as Mark's condition was not improving.

Although during the weekdays Mark was spending most of the time with the grandmother, he developed a good relationship with his parents. They did many things together with his parents after their work. After the parents finished work they would go out shopping together or his dad took him on a motorcycle ride. His father or his mother came to collect him from the centre almost every day. It seemed like each family member took part in taking care of Mark and sometimes if Mark's mother was off work, she would take Mark to school.

Referral process

His classroom teacher recommended me to work with Mark because she felt that he had not made too much progress in the past few months. His teacher felt that if Mark could participate in a new experience, it would help him to learn new skills. The teacher showed a lot of concern about his communication skills. She stated that some days Mark would be able to respond to her requests very well, while other days he would not show any awareness of or reaction to her requests. Also, comparing him to his classmates, he appeared to have uneven improvement. His teacher hoped that music therapy would provide him with different ways to engage with others.

Assessment

When I first met him, he resisted coming into the music therapy room by himself. He held his grandmother Bam's hand and seemed as if he wanted her to be in the session with him. I asked Bam to walk with him into the room and sit with us to sing a Hello song. Later when Mark started to show an interest in a ukulele, she quietly left the room.

Mark appeared to be a quiet boy, who likes to be in his own world. While I played the ukulele and sang a song, he was interested in my hand plucking the string but he did not give me much eye contact in the first few sessions. He did not use any hidden language skills yet, but with some gestures he could understand many simple requests (such as wait and please sit on the chair). He usually presented self-stimulation behaviours such as making unusual sounds, which were mostly one-word utterances such as “Aa Aa”. He seemed unaware of the dynamics of his vocalisation. I was not sure whether Mark made the sound because he wanted to avoid the music I made. However, when I stopped the music, he still made the sound. Therefore I felt that he made this voice in order to stimulate himself or to communicate with others.

He appeared to show an interest in music and he was able to sit on the chair for almost the whole of each session. He usually accepted my requests. However, he would not engage with one instrument for long. He would try to grab a new instrument from me and also when he was playing, his eyes usually wandered off to something else. I offered him a tambourine while I was improvising the music on a keyboard; he accepted it. I noticed that he tended to use his fingers to tap on it, rather than using his palm to beat, and he tapped on the drum with me but un-rhythmically. It was not clear if he was aware of my music or not, because he did not show a lot of facial expressions, and made eye contact with me only a few times. However, when I tried to stop and wait for his turn to respond back to me, he looked at me briefly before tapping on the drum and sometimes he pushed on my arm, as if giving me a signal to continue playing. If we did something he did not want to do, he would not be upset or cry out, instead he just moved away from me and pushed the instrument out of his sight. During these two assessment sessions he did not show obvious signs of which instrument he liked; he was happy to explore everything I offered, but many times I felt that he was not aware of my presence and my music. It was important for him to be reminded and encouraged to return to join in the activities, once in a little while.

Music therapy objectives

Mark was clearly interested in music. Initially, it was important to find a way to engage and bring Mark out from his own world. In the report I explained to Bam that I would focus on making him feel more familiar with being in a new environment and with a new person. After he became more familiar with the sessions and me, and he could stay with one thing longer and was willing to engage with me more, then other aims would be emphasised more. Bam agreed with the plan and did not give many comments. However, she was pleased that her grandson could be part of the project because she said he likes music so much. She hoped that participating in the sessions would relax Mark.

1. To encourage Mark to engage with others and spend less time in his own world
2. To decrease some inappropriate behaviour such as pinching himself and flapping his hands
3. To encourage him in taking turns and imitating other's actions

Treatment process

- 1. To encourage Mark to engage with others and spend less time in his own world.*

During the initial sessions, he came to the room and always accepted my requests to sit on the chair well. He sat quietly and his eyes wandered around the room. When I started singing the Hello song, he would look at me briefly before moving away from me to play with other things. I followed him along and improvised the song to encourage him to pluck the ukulele with me. He did not look at me too much. Bam encouraged Mark to join in with me by holding his hand to clap along with the music and later she held his hand to pluck the strings. Mark would do this, and looked at the ukulele. Even when he did not give me a lot of eye contact and engaged in fewer facial expressions, he could engage with the ukulele for quite a long time. Once in a while I held Mark's hand to pluck the ukulele a few times, then I let go of his hand. After that he tried to hold my hand back to the string when I left space for him to play. It seemed that he listened to the music I made and wanted me to continue playing. He was willing to engage but his eyes would not stay in focus with the instrument or with me for very long. However, he

sometimes could recognise the signal of start and stop, but he would not recognise the tempo or dynamic changes if I did not give him a gesture or a verbal signal.

2. To decrease some inappropriate behaviour such as pinching himself and flapping his hands

Usually he showed repetitive patterns such as flapping his hands. Bam said that when Mark was sick, he always appeared to be stressed and he usually pinched himself when he wanted to make a sound. This pinching seemed to me that he wanted to stimulate himself. Also once in a while he liked to flap his hands when he seemed to be excited. In the sessions I attempted to bring these behaviours into something more meaningful or get Mark distracted by playing music. For example, when he was flapping his hands, I would improvise the song to encourage us all to clap along with music. Sometimes I had to hold his hands to clap with me because he could not recognise my signal.

It was stressful to see him pinching himself most of the time in some sessions. He appeared to be very stressed and frustrated. I felt as if he wanted to express and communicate with others. Playing a musical instrument such as a keyboard or ukulele could keep his hands from pinching himself. Moreover, playing an instrument could allow him to express his feeling. The music I improvised probably allowed him to feel supported and also could reflect his feeling. Later, the music could bring him out of his frustration. I usually improvised playful music in order to invite him into a playful moment instead of withdrawing into his own world too. For example, in one session when I invited him to play on a keyboard, he was able to sit on the chair and play with me for a long time. He sometimes moved his body, and vocalised while he was playing on the keyboard with me. I copied his movements and also vocalised along with him. His playing influenced the music I improvised. His playing appeared to be random but not chaotic. It was quite rhythmic and accompanied his body movement. He generally played on repetitive clusters of notes on the black keys when he moved up and down the keyboard. Sometimes he stopped playing and pinched himself, then I gently held his hand back to the keyboard. Without any resistance, he continued to play on the keyboard with me. However, sometimes I ignored it when he pinched himself; I stopped playing

on the keyboard and gave him some space, then I started to play again while I copied his vocalisation. Later he would return to the keyboard. Although he still pinched himself while we were playing the keyboard together, I felt that during the time in the sessions, he was more interested in putting his hands on the instrument than in pinching himself.

3. To encourage him to participate in taking turns and imitate another's actions

After Mark was getting used to engaging with me, I started to invite him to join music activities, which encouraged him to play with others. Also Bam said to me that she wanted him to learn to imitate other people's actions. I noticed that he was not aware of my music when I changed the tempo or left a blank. He would not try to match the changes. Moreover, when we played the musical instrument, he sometimes had strange ways of playing. For example, when Bam and I encouraged him to clap while I was improvising on the ukulele, Bam held his hands to clap properly first. He would imitate the way we clapped briefly before changing to his own way, un-rhythmically. However, having music playing could create a lively and playful atmosphere. Therefore, Mark did not feel being pushed to do what other people asked him to do all the time. For example, he tried to move away from me after we played on a keyboard together. When he stood up and started to walk away, I followed him and walked along with him. Bam encouraged Mark to move along with me while I was improvising a song to match his movement tempo. Mark moved awkwardly in a robotic way. Initially, I copied the way he moved and he seemed to be very excited for us to move along together. Later I changed the way I moved by lifting my legs up a bit higher. So Bam tried to encourage Mark to imitate the way I moved with the music. Bam helped me to remind Mark to lift his legs a little higher and also reminded him to imitate me, Mark was able to lift his legs up, in the same way I did. Later when he appeared to be more familiar with moving along with the music, I challenged him by changing the music tempo from walking tempo to jumping tempo. According to Bam, Mark could not jump properly. He was practising jumping on a tambourine in his classroom. Therefore, she suggested to me to encourage him to jump with the music. I started by inviting him to walk along with my music then I improvised a song "Jump Jump, let's jump and jump". Initially, I held his hands and we jumped together. Later I let him jump by himself. He was enjoying

moving along with the music and me, however he still needed some help to remind him of the change of music and movement. After some time, he would gradually adapt his actions along with others.

His grandmother's involvement

In the first few sessions, his grandmother, Bam, appeared to be very anxious about being in the sessions with Mark. She was afraid that Mark would not be happy to have her participate in his activities and she thought that Mark would behave better without her in the sessions. She mainly left me to lead the sessions and sat beside Mark, not participating too much. She initially just observed and gave Mark praise. She did not participate or initiate her ideas much in the first few months. However, when I invited her to join in with Mark, she was willing to participate and was very supportive. She sometimes sang along with me in order to encourage Mark to engage in the activities. When Mark presented any challenging behaviours or disengaged, I was worried that Bam would get very disappointed. It was very important that I emphasised that Mark's behaviour was acceptable. In my opinion Mark's behaviour was not as difficult as Bam thought.

It was probably because of her age that made her less actively engaged and act less as a music partner than other carers. Although she could not move or dance along with Mark and me, she usually joined in the activities by clapping or singing along and sometimes she would hold his hands to play on the instrument. Moreover, she helped me to manage his challenging behaviour. Besides that she tried to model how to play a musical instrument to him. After she was more familiar with the activities and me in the sessions, she seemed to be more relaxed and started to share her opinions and information about Mark's behaviour at home. Working with a carer like Bam, it was crucial to focus on positive behaviours or moments and emphasise Mark's achievement. This enabled her to feel less anxious about Mark doing something wrong and it also involved her in the sessions, showing her how much of a good impact she could give to Mark.

Video reviewing

Bam accepted my opinions very graciously, but did not share many of her thoughts about the videos during the first period of the treatment. I thought she was not sure what to expect from the music therapy and she did not know what to look for in the music interactions between Mark and me. Therefore during that time I employed the video to explain how Mark responded to music and how music helped me to engage with Mark. The video helped me to emphasise what the music therapy aims were for him. I could explain my perception of his difficulties in a less scary way for her. The video could capture a moment when Mark could engage with me, well. Consequently, Bam and I were able to come to the same expectations and directions during the treatment process.

The video did not only encourage Bam to share her thoughts about the sessions, but it also led Bam to share her experiences of taking care of Mark at home. This enabled me to understand Mark's behaviour and also Bam's situation more. During the discussion, she sometimes expressed her own worries and shared her opinions regarding Mark's behaviour at home. It was important for her to feel she was being listened to and being accepted, because Mark's parents were usually busy so I felt that she could not talk or express her concern to them much. This also enabled her to be more open to discuss with me about the sessions. She started to look at the same thing as me and be more pleased with Mark's behaviour and less worried about him being "naughty".

Because of Mark's health, he missed the school and also the music therapy sessions often. Therefore, the video was very helpful in this situation, because after he missed the school for a long time, his progress had declined. The video could remind Bam and me of what he had achieved before and this could bring back Bam's hopes. Also it reminded us of what he did and how he responded from the previous sessions and which step Mark was at last time.

Home visits and music at home

On the first home visit, I met Mark and Bam. Mark appeared to be very pleased to see me visiting him. He seemed to remember me. He was watching television with Bam

when I arrived at his place. Therefore, it was challenging to engage him with music when Bam turned the television off. I felt that I had interrupted his routine. He briefly engaged with me when I brought my ukulele out and sang the Hello song with him. He plucked the string and seemed very excited. He ran back and forward in the living room where we were, and then in the kitchen. He appeared to be unsettled. I felt it was not appropriate to follow him into the kitchen, therefore I spent sometime talking with Bam. She told me how she used music at home. Although she did not actively engage with him through music, she seemed to give more value to the music in Mark's life. She was more aware of Mark's responses with music. She said when the music is on the television, she liked to encourage Mark to move and dance along, while she clapped her hands with the music.

On the second visit, I met his mother. This was my second meeting with her since I met her once when she came to pick up Mark. It was great that I could talk to her and get to know her better. She appeared to be a supportive mother as she showed interest in what Mark did in the music therapy sessions. When I first got to his place he appeared to be shy and hid under the blanket. I then had a chance to talk to his mother and learnt about Mark at home from her perspective. She was very open and helped me to encourage Mark to engage with me. While I talked to his mother, Mark sometimes peeked out from the blanket to see his mother and me. I brought a ukulele and invited him to play, but he moved away from me. I followed him to the sofa where he still hid under the blanket. I first improvised the song into a greeting to him, and gently held his hand to pluck the string, while he was still hiding under the blanket. I held his hand to play a few times and then left some space for him to respond back by himself. He tried to move the hand to find the ukulele to pluck the string. It was very nice that even while he was shying away from me he still wanted to engage. His mother was also very supportive. She was very cheerful and was willing to accept my request to join in our music interactions. From small plucking of the ukulele strings under the blanket, Mark came out from the blanket and moved along with his mother while I improvised the music for them. Although the interaction was not as long as we had in the sessions, Mark seemed very happy and enjoyed moving along with his mother. I was impressed with her engagement

because this was her first time engaging in the music at home with Mark. She was very lively and followed my lead naturally.

Discussion and conclusion

Mark was clearly motivated to interact with others by using music. He was very explorative and always enthusiastic to participate in the music activities. Working with a child like Mark, it was difficult to see obvious signals to show his improvement. However, it was very pleasing to see how music could bring him out from his world and that he was able to share interest with others. Although there were many times he did not look at me, he was able to respond to the signals. He was always willing to participate and accept my requests. His quality of engagement was developed from briefly exploring with different instruments to listening and then imitating others. Bam was very helpful all through the treatment process. From being an observer in the sessions, she became one of the participants. Her engagement encouraged Mark to join in. Also this enabled me to feel more confident that my approach could lead her grandson in the right direction. She helped me to understand his condition very well. It was challenging to bring her to the same expectation as me and lessen her worries and stress, however having her in the sessions, and allowing her to witness Mark's achievement was very important for her. Placing the emphasis on the positive side of Mark helped her to see his condition in a more manageable perspective.

5.1.5 Paul and Rita

Background information

Paul is a four-year-old boy. When I first met him, he had just started attending the centre for about a month. He did not have a clear diagnosis as having ASD. However, he presented many behaviours which were similar to children with ASD. He had a very short attention span and was very active. He was afraid to touch anything dirty and wet. His language/verbal communication was delayed. He was able to understand some simple requests and able to say and repeat some simple and short words, but not very accurately. According to his aunt, Rita, she said that when he was about one year old he started to say some words but at the age of two years old, he had a high temperature

fever and had a seizure. After that, his development started to delay and he stopped talking. Moreover, he has asthma and sinusitis.

His mother started to notice his condition when he was two. It was difficult to keep him still. He always ran around all over the place. During that period, he was taken care of by his grandmother and it was hard for her to look after him. He mainly spent time in a small room and watched television with his grandmother. He would cry and appeared to be very scared of going outside the room, and meeting people. His family originally comes from a small town nearby Khon Kaen. His parents both have full time jobs therefore they do not have time to take care of him. Rita was asked to take care of him because Rita lives in Khon Kaen, so it is easier to go to the special education centre than living in his home town. Rita is a full-time housewife, and before that she used to be a nurse assistant. She has two daughters and they are 14 and 16 years old. They were also helping their mother to take care of Paul. Although Paul's parents cannot take care of him, they financially support Rita. According to Rita, before he started attending the centre, he had difficulty in leaving the house. It took Rita two months to prepare Paul to be ready for encountering a new environment.

Because he was very active and barely stayed still, in the first few weeks at the centre he was accompanied by Rita and also her sister. Her sister and Rita had to take turns accompanying him, to participate in the centre's classes. After Paul was familiar with Rita and the class routine, he made so much progress that Rita was able to bring him to the classes by herself. His parents themselves found it was hard to manage his challenging behaviour. So Paul mainly spent time with Rita's family. He usually stayed with his parents during the school break.

Referral process

When I first met him, he was in the early intervention class. Children who attend this class are new to the centre and they are in the middle of evaluation, in order to plan their IEP. Although the teacher who referred Paul to the music therapy did not know him very well, she found that he responded positively to music, as he liked to move and dance.

She hoped that the music therapy treatment could help him to increase his concentration span and to encourage him to use verbal communication.

Assessment

In our first assessment sessions, Paul had no hesitation in coming to a music therapy room. He had a big smile and was very cheerful. He appeared to be very excited and was very enthusiastic to try everything in the room. He seemed to enjoy playing almost every instrument I offered him, especially a bongo drum. Sometimes he walked around while he was beating the drum, and I improvised a song on a ukulele. Also he always smiled and looked at me. However he did not stay on one instrument very long. He flitted from one thing to another. I also noticed that he played on the drum and xylophone quite hard and I found that sometimes it was dangerous for both him and me because after he finished with one instrument he would not act gently enough when putting it aside; instead he would throw it away. He also usually led me into a quick tempo. He was also unaware when I slowed down the tempo.

He was able to respond to my requests but I found it was challenging to get him to listen to my signals. He seemed to be too excited with this new experience and could not pay attention to others, so there were many moments that I noticed that he was in his own world and did not show any awareness of my presence or requests. However, he did not present any aggressive or wailing behaviour; instead he always smiled.

Music therapy objectives

During the assessment, Paul showed great interest in musical instruments. After our first family music therapy sessions, I provided Rita with a report, explaining Paul's responses to the music and what strengths and challenges he presented in the assessment sessions. Rita was clearly concerned about his concentration span being so short, and about him being too active. She agreed with all the objectives I suggested, but she emphasised very much the need to keep him focused on one thing at a time. I suggested to her that we would aim to keep him focused on one thing for thirty seconds first, and then we could extend the duration while the treatment process was progressing.

1. To improve his concentration span
2. To develop his social skills, such as turn-taking and listening to another's requests, or signals
3. To encourage him to express his needs appropriately in both verbal and non-verbal ways.

Treatment process

1. To improve his concentration span

It was very challenging to get him to engage with me in the first few months of the treatment. He was excited to try everything. He resisted sitting on the chair or joining in the activities I initiated. I initially followed his leads and his interests then tried to extend his initiations to be our interactions.

For example, I offered him a rainmaker while I was playing on a ukulele. I first wanted to copy his playing. When he shook the rainmaker, I would play the ukulele, and jump at the same time. He appeared to be very amused to see me doing that. I gradually made it into a conducting game. He was able to engage with the game for quite a long time without trying to move away to other instruments. He recognised that I was waiting for his play then I would move and play along. He smiled and laughed all along through these interactions. He would beat the rainmaker on the mat. If he tapped it with a big movement, I would jump. Also if he tapped it quickly, I would stamp my feet quickly, to match his playing. Sometimes I felt as if he tried to chase me around the room. Also he usually seemed to wait for me to play, then he would follow my lead. Rita also could join in with us, by beating a drum following Paul's lead. It was very nice because he normally appeared too interested in finding other instruments in the room, rather than interacting with me.

Moreover, he appeared to enjoy the waking-up game. I was very surprised that he was able to engage, in a quiet and less lively activity, compared with the conducting game. I invited him to play on a keyboard and pretended that I was asleep. I asked him to sleep on the keyboard with me, and wait for my signal to wake us up by playing on the keyboard. In the beginning it was challenging to get him to sit quietly and still. The first

few times we played this game, I only counted from 1 to 5 then we played on the keyboard. I gradually increased the duration by counting slowly from 1 to 10. He was able to wait without my help or his aunt's. We took turns to be the person who woke each other up. He was very good at the game. Moreover, he was very pleased that his aunt joined in and followed his lead.

2. To develop his social skills such as turn-taking and listening to another's requests or signals

Paul tended to choose the musical instrument and play by himself. He often showed resistance to sharing the instrument or letting me play with him. Also when I accompanied him on my ukulele, I was not sure if he was aware of my presence or my music. Therefore, when he showed an interest in any musical instrument, I progressed into the turn-taking game which employed the instrument. For example, I asked Rita to sit in the centre of the room, while Paul and I ran around her. Rita held the drum for Paul and me to take turns beating it. I gave signals to Paul whose turn it was to beat on the drum. Also while Paul and I moved around Rita, I improvised a song to accompany a different tempo, to match our movement from a walking state, into running and hopping around Rita. Paul was able to change his movement to match my music, and sometimes, I felt that he looked at me, and tried to copy my movement. Moreover, Paul could carefully listen to my signal, while he was doing something else. He was able to wait for his turn to play, in almost every round.

Moreover, sometimes when we were playing on instruments together, Paul was able to wait for my signal to start and stop the music. For example, when I was on a keyboard with Rita, Paul played on a melodeon by himself. He appeared to be enjoying playing the music together, and did not look at me often. However, he was able to show awareness of my music; when I stopped, then he stopped too. Also he could wait for my signal to start playing together, although sometimes he still needed help from Rita, to remind him to wait.

3. To encourage him to use verbal communications

Although Paul's verbal communication was not fully developed yet, he usually tried to speak, but not very clearly. However, he enjoyed vocalising along with my music sometimes. Rita encouraged him to use not only gestures to express his needs. In the sessions, Rita and I normally asked him to use verbal communication such as "finished", "1-2-3- start" and "Yes/No"

For example, I invited him to blow a bubble while I improvised a song "Blow Blow, let's blow together...and 1,2,3 whose is the next turn to blow?" then I left some space for Paul to say whose turn it was to blow. I encouraged him to sing along with me. With Rita's and my encouragement, Paul was able to catch a repetitive word such as "blow" but he could not say it clearly. Also he was able to wait until the right time to say the name of whose turn it was to blow.

Moreover, during the last phase of the treatment when I sang the Hello and Goodbye songs, I would leave some words out and wait for him to fill them in. For example, we normally sang the Goodbye song and beat the drum. Paul would fill in the words I left out, and beat the drum on each word he sang. It was very pleasing for both Rita, and myself to see Paul was able to finish the song by himself. Moreover, he was able to say the word more precisely while the process progressed.

His aunt's involvement

In the first few months, Rita usually sat on one side of the room quietly. She tended to let me lead the sessions and did not engage very much. She mainly observed while Paul and I were interacting. However, when I asked her directly to participate in the activities she would do so. She still seemed to be shy to be playful with Paul. She always smiled and asked Paul to engage with me. She would not follow him around the room or hold his hands, to do things. She rather allowed him to explore this new environment himself.

I noticed that Paul was more aware of Rita's presence and accepted her requests. Therefore, I tried to directly ask Rita to engage with us. I created a game where we all joined in together. Also as Paul's communications skills had not fully developed, Rita

was very helpful in explaining his behaviours to me. Moreover, when we were playing a musical game, Paul preferred Rita to sit and play with him. She became more active, participating in the sessions. She would clap along. It seemed that Paul appeared to be feeling proud when he saw Rita smiling and hearing her praising him.

She also helped me to manage his challenging behaviours. As I mentioned before, sometimes Paul could not play carefully on the instrument; Rita would help me to remind him and directly encourage him to play gently. Working with Rita helped me create more suitable music therapy sessions for Paul. She suggested to me to use only a few instruments and, therefore, I removed the rest out of his sight. Also she asked me to work with him alone for a few sessions because she felt that having her in the sessions distracted Paul from the activities with me. Moreover, she wanted Paul to be more familiar with me. We had three sessions alone, although it was not clear that he could engage better without Rita's presence. However, I felt that it prevented us from creating group activities which I felt Paul seemed to enjoy more when two adults engaged in his activities.

Video reviewing

I first planned to review the videos with Rita alone, because Paul would distract both Rita and me from discussing. Normally, with other children I could allow them to stay and also watch the video with their carers. In the first few months, it was very difficult to show Rita the video properly because Paul would not want to stay away from Rita, even sometimes when another aunt came and took him to play outside the room; he would run back to Rita.

While we were reviewing the video, Rita liked to point out to Paul the precise moment he presented good behaviour, in order to keep him engaged with us. I also felt that Paul appeared to be very happy and proud to receive such positive feedback from both Rita and me. He always smiled and laughed when he saw himself in the video. Rita usually just listened to my comments and smiled when she was watching herself being very childlike. She seemed to be quite shy to see herself like that.

In a case like Paul, who was a very active boy, and moved all the time, video could capture his responses and actions in the sessions very well. Working with him did not allow Rita and me to discuss with each other during the sessions. It was more important in the sessions to catch Paul's interest and to find ways to engage with him. Therefore, it was very important for both Rita and me to be able to review carefully how Paul responded to the music and what kind of approach could engage and hold his concentration. Both Rita and I worried about not being able to get Paul to engage with us, as he was usually flitting from one thing to another, but the video showed that during the sessions he was very happy and always excited. He was able to engage in the games that he liked longer than I thought. I could not recognise all of his eye contacts and his facial expressions until I reviewed the video. I was more confident to share good moments with Rita and also Rita appeared to be very surprised by his reactions. These small positive actions reduced both of our worries. Therefore we could enjoy the sessions more, as well as improving his concentration span.

Home visits and music at home

On my first visit to Paul's house, he had just returned from staying with his parents. Rita said that his behaviour had changed since he came back from his parents' house. According to Rita, during a month at his parents' house, his parents could not manage his challenging behaviour and they tended to spoil him because they could not spend so much time with him. So he spent most of his time playing, and did not maintain any training from the school lessons. Rita appeared to be worried that he did not make any improvement during the school break and she was concerned that he would not be ready to go back to school the next month. Also Rita said that while he was with his parents he did not get involved in any music interactions.

On the second visit, he seemed to be very excited to see me. He appeared to concentrate a lot and seemed more grown up. When we had music interaction, singing and playing a ukulele together, he could wait longer and listen to others more carefully. However there was a short moment when he was very distracted by the video camera and he stopped engaging with me, and turned to play with the camera. After I put the camera away, he

could join in the music interaction again. He was able to wait for his turn to pluck the string and clap along. Although he seemed to be calmer, it was hard to set a boundary in their home. Once in a while, he would walk away from Rita and me, to go to a different room to play with his toys. Rita stated that she did not have much of a chance to use music with Paul. Mostly, her daughter, who had guitar lessons at school, brought music into Paul's life. Paul would show so much interest when Rita's daughter brought a guitar out to play. Although Paul could not play the guitar very much, he liked to dance and clap along when Rita's daughter played her music.

Discussion and conclusion

I found it difficult to engage with him in the first few months of the treatment process, as he appeared to be very excited by the new environment. It was very important to balance between freedom and structure in the sessions with Paul. The music therapy sessions did not have many rules and they also provided him with chances to bring his own interests into the games, and activities in the sessions. Starting off from some things he enjoyed, and having brought his initiations into playful and interactive musical games, we were able to gain his attention to engage with others. This encouraged him to have longer concentration levels on one thing at a time. Also he showed less resistance when he was asked to follow another's requests. Therefore, I could challenge him to follow more of another's requests. In the sessions, the music created a friendly and non-directive environment, which he would not have felt; he was told to do so.

Having Rita in the sessions helped provide me with a balance in providing Paul freedom and structure. She appeared to be very firm to Paul when he presented challenging behaviour, and also he tended to listen to Rita's requests. She sometimes acted as a role model for Paul. During the games, he naturally joined in with Rita and me by copying what Rita was doing.

5.1.6 Nathan, Sue and Dan

Background information

Nathan is a five-year-old boy. He looks very healthy and energetic. He was diagnosed with ASD when he was three and a half years old. According to his grandmother, Sue, he did not speak, rarely made eye contact and also appeared to be not aware of other people. His parents were separated. He lived with his grandparents (on his mother's side) and they had been taking care of him since he was born. His mother worked in another province. She normally came to visit him during the long weekends. Therefore, Nathan's care plan and his life were taken charge of by his grandparents. However, his mother was trying to find a new job where she could return to her home town and be able to take care of her son more. She did not get paid very much, therefore her parents (Nathan's grandparents) also financially supported Nathan.

Nathan's grandfather, Dan, has just retired from factory work and now they both (his grandparents) are farmers. Sue and Dan devoted their life to taking care of Nathan. On weekdays, both of them take him to the centre, but normally Sue was the one who accompanied him during classes (which are provided by the teachers at the centre) while Dan waited for them outside in the car until the school finished. Before Nathan came to the centre, he attended a normal school near his place but when he received the diagnosis, the doctor referred him to the centre so that he can receive special care and education according to his needs.

Nathan has come to the centre for a year. Sue said that since he attended the classes at the centre, he had learned to say his name, make greetings and he also appeared to be calmer. Before that, he easily got upset and always cried when he could not get what he wanted. His verbal communication started to develop. He could count from 1 to 10 and also could write some of the alphabet. His grandfather, Dan, said that he could recognise the English alphabet and also had a good memory. He was able to take care of himself in many ways, such as toileting and taking showers, and sometimes could help Sue to prepare food. Even in some situations when he could not explain by saying, he held adults' hands to do things for him and he tried to use gestures to explain.

Also during the centre's term break, he attended the normal school near his place. Sue said that he could adjust himself well in the school. From that, he could learn to be among normal children and play with them. Sue thought that this enabled him to improve his verbal communication and social skills.

Referral process

His classroom teacher referred Nathan to me. She said that Nathan's verbal communication had developed so much and he could understand most of the requests. However, he usually threw tantrums in the classroom. The teacher thought that music would help him to lessen his frustration and also to keep his focus on one thing at a time.

Assessment sessions

The first time I saw him, he was reluctant to come to a music therapy room. Therefore, I invited Sue to accompany him to the first assessment session. He appeared to be less anxious about not knowing what would happen in this new environment. Also he did not make many eye contacts with me. However, when I started the Hello song and offered him to try plucking a ukulele string, he accepted my request. He started to smile and became more relaxed. He could use some simple sentences to explain what he wanted to do. However, he did not naturally use verbal communications. Sue usually had to encourage him to say what he wanted.

He appeared to be interested in most of the instruments I offered but he seemed to prefer the recorder most. Even though it was difficult for him to produce a sound from the recorder, he put so much effort in playing while I was improvising on a keyboard. He smiled and seemed to be very proud when Sue clapped and gave him praises. He was distracted by the mirror in the room sometimes. When he was playing with something he liked, he appeared to be very focused and calm. However, when I suggested to him to do things different from what he wanted, he would get upset easily. As he was new to the environment in these first two assessments, I felt that he could not concentrate very long except when he played with a recorder.

Music therapy objectives

From two assessment sessions with Nathan, I felt that he found it was hard to listen to my signals, as he was so distracted by the new environment and new musical instruments in the room. After the assessment sessions were finished, I made a report for Sue to explain what Nathan did in the sessions. Sue did not comment much on the report. She was only concerned about Nathan's throwing tantrums when things were not as he wanted. His mood would affect the way he responded to the music therapy. She mentioned that if he was in a good mood, he would behave very well and listen to others. Therefore, I explained to her that the music therapy sessions were designed to be suitable to Nathan as much as possible in order to meet his needs and his condition on each day. Moreover, I emphasised to her that Nathan was allowed to show some resistance to engaging sometimes in the sessions. One of the initial aims in the music therapy sessions was to find different ways to engage with him for a good amount of time. Later the music therapy objectives below emerged.

1. To regulate his mood and emotions
2. To encourage him to listen to others' requests and accept boundaries
3. To encourage him to use verbal communication

Treatment process

1. To regulate his mood and emotions

There were some times when Nathan came to the sessions with tears on his face or being moody. According to Sue, before he came to the sessions, sometimes he played with his friends so he had to leave his play and come to the sessions. He sometimes cried and refused to engage with anything. From my observation, Nathan appeared to get upset when things did not go as he wanted, and when he felt anxious for not knowing what would happen (similar to when he first came to the sessions). In the sessions, there were very few structures and I occasionally followed his needs. I tried to create a friendly and relaxed atmosphere in order to make him feel that no one wanted to force him to do things. This could enable him to choose himself when he wanted to engage. I usually gave him space to sit down and waited for him a little bit until he stopped crying. Then I

started making music. I started with gently strumming a ukulele and sang the Hello song. Usually when I started singing, he appeared to be distracted by the music and then he seemed to forget his feelings of being upset. Moreover, I allowed him to lead me and I would extend the activities from his interest. For example, when Nathan showed resistance to engage with me, I would allow him to explore the instrument box and let him explore the sound of the instrument he chose. I would respond to his music on a keyboard, a ukulele and my voice. Initially, the musical interactions were led by his musical signal but later I gradually added some structures and challenged him to follow my musical signals. I initially provided him with quite a lot of freedom, as I wanted him to feel in control and safe in this environment, so he could be more relaxed and have fun in the sessions.

2. To encourage him to listen to another's requests and accept boundaries

Before I started working with Nathan, I observed him in his classroom. I found that Nathan struggled to wait for his turn to engage in the classroom activities. While the rest of the students waited for their turns to respond to the teacher's requests to put animal pictures on the board, Nathan would just walk to the teacher and grab the picture and put it on the board without permission. From this, I felt that Nathan should benefit from participating in a group activity, in which he could learn to listen to others' requests, and learn to take turns with others.

For example, on one session when both Sue and Dan attended the session with Nathan, I invited them to sit in a circle and I improvised a song to engage everyone to throw a ball. I was on a keyboard to give them signals. These different signals were for changing directions and ways of passing the ball. This game required Nathan to listen very carefully to the music. I played a short phrase of high melody to tell them to change the direction of passing the ball and I changed the tempo of the music to tell them to change the way they passed the ball. He could not follow the signal very well in the first few rounds. However, with Sue's and my support, he was able to follow, wait for his turn and accept our suggestions.

Moreover, he was much enjoying engaging in a conducting game. He was able to stay in this game for a long time. For example, I invited Sue and Nathan to choose the instrument they wanted. I did not explain the rules to them but I started by following Nathan's leads. I moved along with his playing on a rainmaker. Nathan seemed to be very pleased to control my movements from his playing. Also, sometimes I improvised the song to encourage Nathan and Dan to take turn beating a lollipop drum and indicating whose turn it was to play. It was challenging the first few times because he struggled to wait for the right moments in the songs to get him to say whose turn it was to play. He wanted to grab the lollipop drum and play by himself. I sometimes challenged Nathan by giving Dan many turns on beating the drum so Nathan had to wait longer until his turn. At the end of the process, he was able to sit on the chair and wait for his turn. Additionally, he helped me to give signals to Dan by pointing at Dan for his turn to play. I felt that sharing control in the sessions could enable him to share his control with me too.

3. To encourage him to use verbal communication

Nathan was able to use verbal communication but he normally did not naturally use it. He seemed to prefer using gesture, so Sue and Dan usually had to remind him and encourage him to speak. Although in the music therapy sessions, I mainly used music to engage with Nathan, I constantly encouraged him to communicate verbally with me. For example, in the first few sessions, he did not give many eye contacts when I sang the Hello song and the Goodbye song to him. I was not sure if he listened to me. After many sessions, I challenged him by singing the Hello song but left out words and waited to see if he could replace the words for me. He was able to fill in the words and also could sing along with me if I slowly sang with him. Especially at almost the end of the treatment process, he was able to sing the Goodbye song almost by himself and held my hands beat on a bongo drum with him.

Moreover, his grandparents and I encouraged him along the way to verbally ask permissions and to give us signals when we took turn playing on the instruments. For example, I improvised the song "Da da dee daa ...let's beat the drum... Let's beat the drum, now it's time for NAME to beat on the drum – 1 2 3". I sang that to Nathan and

asked him to say the name and with gesture to point out whose turn to play. Although he could not say it clearly, he started to remember my name and he needed less help and encouragement to say the signals.

His grandparents' involvement

In the first few sessions, his grandmother took Nathan to the sessions. She was very smiley and accepted my suggestions well. Even though she normally did not initiate her ideas, she appeared to be enthusiastic to join in the music therapy activities. She always smiled and clapped along the way. Although she attended the sessions not as often as Dan did, every time she came she always actively joined in the sessions. She did not seem to be shy or nervous to join in.

During the first few months in our music therapy sessions, Dan always sat in the corner of the room and only observed what Nathan and I did. When I asked him to join in, he would join in awkwardly. He was willing to accept my requests to join in but after Nathan moved to other activities, he would return to the observing role. He seemed to be quite uncertain what he was expected to do. He did not playfully engage like Sue did. While the sessions progressed, Dan gradually got involved in the session by clapping, giving Nathan encouragement and becoming more eager to be part of the activities. I initially invited him to take turns playing a musical instrument with Nathan. Therefore, having Dan in the sessions was very helpful in encouraging Nathan to play in a group. Nathan could learn to wait for his turn while Dan played. Also Dan himself could explore a new way of engaging with Nathan, as in the sessions I invited Dan to interact with Nathan on a musical instrument while I accompanied them. Also I noticed that Dan became more playful with Nathan. He talked and interacted with Nathan in a more gentle and lively way. I noticed that Sue mainly took care of and played with Nathan at home. Dan seemed to be busy with his farm therefore at home he could not spend much time with Nathan. The music therapy sessions at the Centre allowed Dan to have a fun and relaxed time together with his grandson.

Video reviewing

As it was difficult for me to predict who would accompany Nathan to the music therapy sessions, sometimes I prepared the video from the previous sessions that Dan attended with Nathan but then Sue took Nathan to the next session. Therefore, Sue watched Dan interacting with Nathan instead. In that circumstance, I still reviewed the video with Sue and pointed out how Dan's involvement in the sessions could influence Nathan's behaviours. Also, I focused on Nathan's responses to the music and the activities in the sessions. Although it was challenging to keep a regular update with one carer, it was still helpful to show either Sue or Dan how Nathan did in the sessions regularly.

Neither Sue nor Dan actively engaged much in the discussion during the video reviewing. They received and accepted my comments well. Similar to Nina's aunt, the video clip reminded them of other events outside the sessions that related to his behaviour in the sessions. For example, when I showed the video clip when Nathan could give clear verbal signals to others, Sue said that nowadays Nathan could count and make a simple request more clearly and more fluently. Therefore, our discussion moved from Nathan's behaviour in the sessions to his behaviour outside the sessions. The video reviewing seemed to make Sue and Dan proud of Nathan. Dan usually commented that he was happy to see that Nathan was able to understand my requests and able to play with others. Sue and Dan always pointed to Nathan to see how good he was in the video clip. Also Nathan appeared to much enjoy seeing himself in the video. He always smiled and called out his name, his grandparents' names and mine when he saw us in the video. Sometimes when he saw himself playing music, he wanted to bring the instrument and play along with the video.

Home visit and music at home

I met Sue and Nathan at home. Sue welcomed me warmly. She showed how the musical instruments were kept in the corner of the living room. When I first came to the house, Nathan had just got up from his afternoon nap and was watching television. I did not want to disturb him so I discussed with Sue about how Nathan was doing at home. Sue said that at home Nathan could take care himself very well. Neither Sue nor Dan had to

help him get ready for school. Also he could walk to the shop nearby and buy snacks for himself. Usually, at home he brought out an instrument to play by himself however he did not play with it very long. I noticed that there were many different toys around the living room, therefore it was difficult for him to concentrate on one thing. However, Sue said that sometimes Nathan brought the instrument out and invited her and Dan to play with him. In addition, Sue appeared to be very supportive and appreciated more the value of music to her grandson's life. When Nathan brought out the musical instrument, she would join in with him more naturally. Also the musical instruments were used more often after they participated in the music therapy sessions.

After some discussion with Sue, I brought a ukulele out and invited Nathan who just got up from his afternoon nap to play music with me. He appeared not to be in a good mood. When I started to sing the Hello song, he started to get upset. However, when I left the words of the song out, he could fill the words correctly. He looked at me briefly and appeared to be excited to see the ukulele. He tried to pluck the ukulele while I sang the Hello song. Later he brought his instrument out to play. When I tried to go along and play with him, he tried to move away from me. I felt that he was on school holiday for a few weeks and he probably not used to playing with another person outside the family. I gently followed him and invited Sue to join in playing with music with me. Sue said that at home he liked to play a drum at home and also sang the Goodbye song as if he was in the music therapy sessions. Sue was very well engaged and tried to help me encourage Nathan to play. Nathan brought his small cymbal to play with me while I was on the ukulele. I had short music interactions with him. He held his instruments and played with me but got easily distracted by my video camera and by other toys. Their living room is quite big so it was challenging to set the boundary for him. He sometimes walked around the room and brought new toys. I felt that he wanted to play with me but not only engage through music. He wanted to show what toys he had and wanted me to play with him.

Discussion and conclusion

Nathan clearly enjoyed playing the musical instruments. Many of our musical interactions or games emerged from his musical instrument explorations. It was very

important to give him freedom to explore and to decide when he wanted to engage in order to allow him to feel more at ease in the sessions. So later he could accept my suggestions more. All through the process, his concentration gradually increased, especially when he played with the instruments he chose. He showed less resistance if he was asked to do what he did not want to. Although both Sue and Dad appeared to be quite quiet and did not actively engage in the sessions as much as other carers, they always gave Nathan support and praise. When they did not actively engage in the sessions, they would encourage Nathan to participate. However, when I invited them directly to engage in simple musical games, they were willing to join in. Their support and engagement helped Nathan to be more enthusiastic in the sessions. In addition, working together in the sessions with Sue and Dan enabled me to extend the musical interactions into a musical game. These games encouraged Nathan to learn in a group where he could learn to take turns being a follow and a leader and learn to wait. Having someone he was familiar with in the sessions made the atmosphere safer for him to explore.

Conclusion

All six children achieved the aims, which were set out for them individually. The most common improvement the children made was the development of their social and communication skills. In the next chapter, there will be more discussion of these developments. In addition, the case studies could reflect how the approach (3.3) was employed in these cases. Similar musical interactions or games were used with all the children, however the aims of using them were varied according to the children's needs at that moment. Involving the carers in the music therapy sessions was one of the important features in this project. These case studies present the children's development mostly from my perspective and will contribute to the interview analysis in the later section, which represents the carers' viewpoints toward the music therapy.

5.2 Themes explanation

This section presents findings from all three interviews with the children's carers. IPA is used to evaluate the data collected from the interviews. As the main aim of this study was to gain more understanding of the carers' experience of participating in music therapy sessions with their children, the interviews were reviewed many times and wordings were changed along the way in order to capture the carers' experience as well as possible. Some themes were removed or changed while others were highlighted. Twenty-eight themes emerged from the interviews. They were divided into five categories which are 1) The carers' expectations of the music therapy 2) The carers' experience of seeing their children in the music therapy sessions 3) The carers' experiences of seeing themselves in the sessions 4) The carers' experiences of reviewing the video recordings from the music therapy sessions and 5) The carers' experiences of using music at home.

This section is presented by first explaining the overview of the themes in the category. Then there will be a table showing all themes in the category, and the table also illustrates which carers commented on the themes. Later, each theme will be looked at in more detail. Some quotes from the interviews are presented in order to provide evidence for each theme. The figure in brackets, after each quote, represents the number given to the number of the interview, line numbers, and page number (e.g. Jan (Nina's aunt 2/86/10) is a quote from Jan's first interview, in the 86th row, and page 10).

5.2.1 The carers' expectations of the music therapy

When designing the initial interview for the research assistant to carry out with the families, I realised one of the key factors was finding out what were the families' expectations of the music therapy. Therefore, in the first interview, each carer was asked to discuss their needs and concerns about the children, their expectation of music therapy and to discuss the goals for future music therapy treatment together.

Learning about the carers' expectations could give the starting point that I used for evaluating the children's progress. Also the carers could comment on their understanding regarding the music therapy. Understanding their expectations would give

me a better understanding of the process and which concerns related to their children's behaviours in the sessions. Moreover, learning about what the carers expect from the music therapy sessions could explain what music therapy could provide for the children with special needs from the carers' point of view. In Thailand, where this project was conducted, there are not many music therapy practices to offer, therefore, the carers or parents have different expectations of it. This section explores what the music therapy is in Thai carers' opinions. Therefore, I can develop the sessions to be more suitable and effective, according to their condition and needs.

From the carers' responses to the first interview, seven themes emerged. They related to the carers' expectation of the music therapy treatment after their children participated in the music therapy sessions. Each theme derived from the interview analysis process, which is explained in 4.7. The table 6 shows overall themes under "The carers' expectations of the music therapy" category.

Table 6 Themes in "The carers' expectations of the music therapy" category

Category: The carers' expectations of the music therapy						
Themes	Participants (relationship to the children)					
	Jan (Nina's aunt)	Pat (Aden's aunt)	Tam (Pita's aunt)	Bam (Mark's grandmother)	Sue/Dan (Nathan's grandparents)	Rita (Paul's aunt)
A. Increasing long concentration	*	*			*	*
B. Understanding signals and accepting another's requests	*	*		*		*

C. Having more interest in engaging with others			*	*		
D. Improving motor skills	*			*		
E. Becoming less shy and expressing themselves more		*				
F. Vocalising more and using more verbal communication	*					
G. Learning to regulate moods					*	

The table shows that the first two themes “Increasing long concentration” and “Understanding signals and accepting anothers’ requests” were common among four carers. While another three themes were more specific to some carers. The translated interview quotes from the carers were chosen from the interviews in order to support the themes.

A. Increasing long concentration

These quotes from four carers who hope that their child's participation in the music therapy sessions can encourage the child to have a longer concentration.

"I definitely do not expect the child to have a music lesson. I just think if Nina can learn to listen to the music and can move along with different tempo, this might help Nina to have longer concentration and learn to listen to others."

Jan (Nina's aunt 1/70/10)

*"He is very active and it is very hard to get him to sit still...
I want him to be able to stay still longer"*

Rita (Paul's aunt 1/22/2)

"I think (participating in the music therapy sessions) will help Aden to engage in one thing for longer and to help Aden listen to my directions more."

Pat (Aden's aunt 1/70/7)

"Participating in the sessions might help Nathan to engage in one thing for longer"

Sue (Nathan's grandmother 1/68/5)

Having increased concentration enables the child to learn new skills and be able to practise the skills to be efficient. Paul's aunt stated that he barely sits still and this prevented him from listening to others, as in Nina case.

B. Understanding signals and accepting another's requests

These quotes from the carers who hope that their child's participation in the music therapy sessions can encourage the child to listen to signals and accept others' requests.

"I hope at least (participating in the sessions) would help him learn to listen to another person's signals"

Rita (Paul's aunt 1/54/4)

Question: What do you want Mark to learn from participating in the music therapy sessions?

"...umm I really wish that he could learn to follow others' requests and imitate/copy others' leads"

Bam (Mark's grandmother 1/2/179-180/28)

In the assessment sessions, both Paul and Nina were so excited to be in the room with plenty of musical instruments. They struggled to stop wandering around the room and listen to my suggestions. These events probably made their carers concerned that if their children were not able to be aware of the signals, they would not get on with the structure and could not learn anything. However music has the power to attract their attention. Also the games, which were used, could help them to anticipate and wait for the signals. The music elements such as rhythm, tempo, pitch and chord progression (cadence) were employed to provide different signals. Instead of directive verbal signals, the playful musical signals encouraged the children to listen and gained their attention more than verbal signals. Also the music created a fun and childlike atmosphere, which enabled the children to be relaxed and feel less forced by the adults.

C. Having more interest in engaging with others

These quotes are from two carers who hope that their children's participation in the music therapy sessions can encourage the child to be more interested in engaging with others.

"I do not have many expectations of him...I just hope that he will show some interest in the music therapist...this is all I hope from him"

Bam (Mark's grandmother 1/88/10)

“I think he will get out of his own world and show more interest in music which is what he likes...actually I do not expect much from this...we have been trying almost everything...I just want him to try different things”

Tam (Pita's aunt 1/48/7)

Mark and Pita appeared to be very into their own world. This behaviour kept them away from learning to communicate with others. Therefore their carers felt that having them experience different things such as music therapy would help them to be more interested in engaging with others. Also music is a non-verbal tool of communication and can reach anyone no matter what verbal skills they have. Moreover, both Mark and Pita had responded to music well from previous experience.

D. Improving motor skills

These quotes are presented from two carers who hope that their children's participation in the music therapy sessions can help the children develop their motor skills

“In the sessions, he might have chances to strengthen his muscles...he might be able to learn to hold things (in the assessment sessions) he could loosely hold something but could not keep it for long”

Bam (Mark's grandmother 1/82/10)

Question: Which of Nina's behaviours concerns you and what to improve?

I hope her verbal communication can be improved and I also worry about her body posture...when she walks and sits, she has a little hunch back. So I am not sure why. Maybe her body is quite big compared to her legs?... I have to remind her frequently and she will adjust and keep a proper posture for a while before returning to her usual posture.

Jan (Nina's aunt 1/62-66/9)

Bam and Jan believed that music could motivate physical movement and develop the motor skills in their children. Music can bring the feeling of energy and liveliness,

therefore this could encourage Nina to move, as Jan mentioned in the session that it was challenging to get Nina to move (2/36/4). Mark's grandmother said that at home when his favourite music was on the television, he liked to move along with the music (1/74/10). Also, playing a musical instrument such as a xylophone, which required the child to be able to hold the mallets, could help the child to learn in a fun way to control their motor skill.

E. Becoming less shy and expressing themselves more

This quote is from a carer who hopes that her child's participation in the music therapy sessions can encourage the child to be more active and enthusiastic

Question: What does Aden need to be improved?

"He is still shy of the music therapist. If he starts to be familiar with the music therapist more, he would be able to express more"

Pat (Aden's aunt 1/93-94/7)

According to Jan, Aden's aunt, at home Aden was very lively and was not shy, but at school he appeared to be very timid and avoided engaging or interacting with anyone in the school (1/34/3). Music therapy sessions allowed the child to have much freedom and this could encourage Aden to express himself. Also, the sessions aimed at allowing him to gain a sense of achievement. The activities were designed to be suitable to his needs and abilities. Consequently, he could achieve the goals and these allowed him to gain more self-confidence. Moreover, Jan stated that he very much enjoyed music. At home, he liked to watch music channels and Jan sang along with them. Although he could not talk properly, he enjoyed catching the last word in each phrase of his favourite songs (1/62/6). Therefore, Jan hoped that the music therapy process could bring out Aden's liveliness, to show to other persons outside his family.

F. Vocalising more and using more verbal communication

This quote is presented from a carer who hopes that her child's participation in the music therapy sessions can encourage the child to vocalise and use verbal communication more

“I hope her verbal communication can be improved”

Jan (Nina’s aunt 1/62/9)

Jan mentioned that she was worried about Nina’s ability to talk because Nina’s structure and function in her mouth and throat areas make it more difficult for her to make precise movements (2/44/9). This condition affects her speaking clearly. Nina was learning to use verbal communication, and music therapy sessions could involve her in singing which helped her to vocalise and develop words later.

G. Learning to regulate moods

This quote is presented from a carer who hopes that her child participating in the music therapy sessions can help the child to learn to regulate his moods

“I hope that (participating in the sessions) can help Nathan to learn to regulate his emotions and be calmer”

Sue (Nathan’s grandmother 1/48/4)

Some children with ASD usually throw a tantrum when they cannot get what they want and feel frustrated at not being able to communicate or express their needs. In Nathan’s case, his grandmother commented that Nathan would learn from and participate in any lesson or class activities very well if he was in a good mood. Therefore she hoped that music therapy sessions could help him find ways to regulate his mood.

5.2.2 The carers’ experiences of seeing their children in the music therapy sessions

This section presents the findings from the carers’ interviews regarding their opinions of their children’s changes after they participated in 24 music therapy sessions. The themes in this category could be used for responding to themes under “the carers’ expectation of the music therapy” category, as the carers were asked to evaluate whether they think the goals set before the treatment had been achieved. Each child had different music therapy objectives and the sessions were varied according to their needs and condition on each day. Each child presented their progress and changes at their own pace. They were not expected to present the same results from attending the music therapy sessions.

During the second interview, the carers were asked to comment on their children's interactions and responses in the music therapy sessions. There are seven themes under "The carers' experience of seeing their children in the music therapy sessions" category. Each theme derived from the interview analysis, which was explained in 4.7. Table 7 shows overall themes in "The carers' experience of seeing their children in the music therapy sessions" category.

Table 7 Themes in "The carers' experiences of seeing their children in the music therapy sessions" category

Category: The carers' experiences of seeing their children in the music therapy sessions						
Themes	Participants (relationship with the child)					
	Jan (Nina's aunt)	Pat (Aden's aunt)	Tam (Pita's aunt)	Bam (Mark's grandmother)	Sue/Dan (Nathan's grandparents)	Rita (Paul's aunt)
A. Understanding signals and accepting others' requests	*	*	*	*	*	*
B. Vocalising more and using more verbal communication	*	*	*		*	*
C. Increasing their concentration	*		*		*	*
D. Having more interest in engaging with others		*	*	*	*	
E. Relaxing	*			*	*	*

F. Improving their motor skills	*	*				
G. Becoming less shy and expressing themselves more		*	*			

The table shows that there is a theme which is “Understanding signals and accepting others’ requests” that is common among all carers. Almost all the carers except Bam raised the theme of “Encouraging to vocalise and use more verbal communication”. Jan found that her niece, Nina, presented most of the changes except “becoming less shy and expressing their needs more”. The translated interview quotes from the carers were chosen from the interviews in order to support the themes.

A. Understanding signals and accepting others’ requests

All the carers agreed that participating in the sessions encouraged their children to better understand signals and accept others’ requests.

“He starts to learn to accept my requests...such as that he would have to use gestures to explain what he wanted...before, he would just cry to get what he wanted...Sometimes he appeared to copy my mouth movements and tried to say a word”

Tam (Pita’s aunt 2/200/26)

“Nina always likes music. She has had experiences with the keyboard and recorder before. The music therapist brought her to sing along without any force and she had fun. Nina doesn’t like to do things when she is forced. The music therapist allowed her to do things in her way but before she moved to a new thing the music therapist asked her to say “finish”. And the music therapist will bring an instrument one at a time, put it back when we finish. This helps her to learn about boundaries more.”

Jan (Nina’s aunt 2/14/3)

“He learns more about social skills such as accepting others’ requests and learning to wait for his own turn”

Rita (Paul’s aunt 2/233/12)

“I am very impressed that he learns to wait and learns to explain his needs...before, he would not make a request. He usually just went straight to what he wanted without any permission...and if someone stopped him, he would cry out and become very upset.”

Dan (Nathan’s grandfather 2/156-8/10)

“(Participating in music therapy sessions) enabled him to be calmer and encouraged him to use verbal communication more.”

Sue (Nathan’s grandmother 2/212/21)

“He listens more to the signals. When the music therapist told him to stop he did. He is better at keeping the steady beat.”

Pat (Aden’s aunt 2/144/25)

When the music therapist sang the song to encourage Mark to move and dance along, he could follow her actions such as walking, jumping or raising his hands up high...sometimes I did not have to encourage him to follow the music therapist’s signals, but he could follow her...I was very pleased

Bam (Mark’s grandmother 2/182-184/26)

Music therapy sessions involved different games, which required the children to listen and to learn social skills such as turn-taking, following the signals and accepting the boundaries. In the interview excerpts, the carers commented that their children appeared to be more compliant with the rules of the games, and also they learnt to respond to the signals in an appropriate context. For Pita and Aden, who did not seem to understand verbal communications, they could recognise the music signals. For example, the

repetitive chord progressions and the changes of tempo, which led to the feeling of ending or not, helped these boys to respond to others at the right moments.

B. Vocalising more and using more verbal communication

In the quotes below, four carers noticed the changes in the way their children improved in using more verbal communication.

Question: What Aden has been improving most so far?

“His ability to talk... Aden was used to be very shy and quiet in the session. He didn’t make much sound but after a few months participating in the sessions, he started to vocalise a lot if he is in a good mood.”

Pat (Aden’s aunt 2/132/23)

“Sometimes he vocalised...hoo hoo...and shook his head, moved his legs along with the music.”

Tam (Pita’s aunt 3/114/14)

“I told her (the music therapist) about Nina’s problem that Nina cannot open her mouth properly because her jaws are not so flexible as they should be and her tongue is very big. I wanted the music therapist to encourage Nina to increase vocalisation (exercise her mouth, to move her mouth in different movement so her speech skills can be improved.) The music therapist engaged her in vocalising in different vowel such as Oo Aa Aa”

Jan (Nina’s aunt 2/44/8)

“In the sessions, sometimes he could say some words, such as giving a signal 1-2-3 to start playing music”

Rita (Paul’s aunt 2/68/4)

“The music therapist encouraged him to use verbal communication, such as giving a signal for everyone to play music”

Sue (Nathan’s Grandmother 2/220/11)

The children were encouraged to use verbal communication, and in the sessions the children did not feel that they were pushed or pressured to do things. The music could bring the children to enjoy joining in and wanting to complete the songs or to be a leader to tell others what to do. Nina, Paul, and Nathan in particular who already had some verbal communication skills, appeared to their carers to use verbal requests naturally at more times in the sessions than the others. Pita and Aden, who both did not have much verbal communication development, started to vocalise and be more confident and enjoy expressing themselves with the music.

C. Increasing their concentration

These quotes came from four carers who agreed that participating in the sessions encouraged their children to have a longer concentration span and be able to engage with other people longer.

“...After the long weekend or school holiday, I worried that she was not able to engage well like before, but it turned out that she engaged very well. Some sessions she could concentrate for an hour. When there is no other kid waiting to come to meet the music therapist outside the room, Nina would not get distracted and could engage with the music therapist in the sessions for quite a long time.”

Jan (Nina’s aunt 2/30/5)

“He likes playing on a keyboard. When he touched it, he would listen and look at the music therapist...and it seemed like he wanted to play with her...this enabled him to be calmer and concentrate on one thing for a longer period of time”

Rita (Paul’s aunt 2/112/6)

“He was able to sit on a chair longer...before, he could play one instrument briefly then move to another one...now he could engage with one instrument for a longer amount of time”

Sue (Nathan’s grandmother 2/70/5)

“I feel very pleased that he can engage with something for a long amount of time”

Tam (Pita’s aunt 2/68/10)

The musical games, which emerged from the children’s interests and on their initiative, were very important. When the children found things they liked, it was easier for them to participate for a long time. Especially Paul who was very energetic and moved very quickly from one thing to another; his aunt said that the music therapist followed his interests. She extended Paul’s interests into games, which he could enjoy playing with others for a long period of time (2/84/4).

D. Having more interest in engaging with others

These quotes are from four carers who agreed that participating in the music therapy sessions encouraged their children to be more interested in engaging with others

“These days he starts to communicate with me and asks me to play with him more. Before, he normally watched television alone but nowadays, he shows an interest in having me play with him. This morning at home, he called out for me to sit with him to play a keyboard, it seemed that he imitated what the music therapist did in the sessions. He wanted to be a teacher and teach me to play music and not only me; he also asked his parents to play along with him.”

Pat (Aden’s aunt 2/28/6)

“Pita starts to show interest in playing with others, and this made me feel I wanted to play more with him...He started to be interested in what the music therapist was doing, such as when she played on a keyboard, he would look at her hands...Now he does not try to play by himself...At home sometimes I turned the music on, he would dance

along...when I brought a ukulele out, he would come to me and tried to pluck the strings with me."

Tam (Pita's aunt 2/34/6)

"He shows so much interest in me...sometimes he would sit down and wait for the me and see what I would bring out to play with him"

Tam (Pita's aunt 2/202/26)

"There was one time without my help (signals)...He was able to follow/accept the music therapist's requests...I was just clapping along with the music...while he followed by imitating the music therapist's actions...I was very impressed with that moment...He appeared to express his emotion in the way a normal child does"

Bam (Mark's grandmother 2/184/28)

"He appears to be calmer and shows more interest in what others are doing...He starts to make eye contact with the music therapist"

Dan (Nathan's grandfather 2/150/10)

The interview excerpts show that the carers felt that their children appeared to be more interested in engaging with others. They were more aware of other persons, which could be seen from the increase in eye contact, their attentiveness to others' actions and the increase in initiation, in reacting with others. Especially Pita and Aden, who appeared to be more interested in engaging with others in the sessions; but they also showed more interest in engaging with their carers outside the sessions. In Aden's case, he was the one who invited his carer to participate in his music activities at home. Pita was more aware of music; it appeared to be a signal for him to participate in something with his aunt.

E. Relaxing

These quotes are from four carers who agreed that participating in the music therapy sessions allowed their children to be relaxed

“(Being in the music therapy sessions) enabled him to become gentle and relaxed...I feel that on the day when he did not sing or play music, he would be frustrated...he could not even speak but I feel from his eyes”

Bam (Mark’s grandmother 3/98/11)

“I feel good because Nina likes music. When she was in the music therapy sessions she was relaxed, not similar to when she was in her classroom.”

Jan (Nina’s aunt 2/38/7)

“He was very lively and appeared to be greatly enjoying his time when he was in the sessions...he always laughed and seemed to be very happy”

Rita (Paul’s aunt 2/56/3)

“When he played music, he seemed to be in a good mood...”

Dan (Nathan’s grandfather 2/94/6)

The music therapy sessions initially aimed to allow the children and their carers to have a good time together. The children were provided with a lot of freedom, compared with being in their classroom, as the sessions were designed for individual needs and interests. While the classroom was a group setting, the children needed to respect the mutual rules, in order to keep the class running. Importantly, the music, and the musical instruments were of so much interest for the children. They always became fascinated by different kinds of instruments. Also they were allowed to be a leader of adults. Seeing the adults being childish and playful with them usually amused the children. The sessions involved different musical games which normally extended from the children’s own play.

F. Improving their motor skills

These quotes are from two carers who agreed that participating in the music therapy sessions encouraged their children to develop their motor skills.

“His fingers gain strength from playing guitar and keyboard.”

Pat (Aden’s aunt 3/70/7)

“She started to play with each finger separately. Before, she didn’t know how to play by a finger at a time. She normally played with all five fingers together. From the first session until now, she has been better.”

Jan (Nina’s aunt 2/119/17)

The activities, which were involved in the sessions, required the children to be actively engaged. Playing different kinds of musical instruments required coordination of hands, fingers, eyes and breathing. The carers therefore recognised that their children automatically strengthen their muscles when they were playing a keyboard. Although in the sessions the children were not expected to learn to play the instrument, the children imitated the way I played the instrument, and were therefore encouraged to move their fingers separately. Nina did not have many chances to learn how to control her fingers. In the sessions, initially she played with all ten fingers, at the same time. She liked to imitate adults’ actions. After a while, she naturally followed the way I played on a keyboard and, with some of her aunt’s and my encouragement, she gradually played on each key, with each finger, separately. Not only playing a keyboard enabled the children to develop their motor skills, but also plucking, and strumming, on a ukulele string, enabled Aden to improve his motor skills.

G. Becoming less shy and expressing themselves more

Two carers agreed that their children’s participation in the music therapy sessions enabled their children to change. This gave them more confidence to become more expressive after participating in the music therapy sessions.

“He has changed a lot in a good way. He is able to express himself more. He gained more confidence. When he is at home, he wants to play all the musical instruments he has at home.”

Pat (Aden’s aunt 2/148/25)

“He is better. From a shy boy he now becomes more confident and able to do many things.”

Pat (Aden’s aunt 2/166/28)

“He learns to communicate with me more...when I asked him to listen to my signals, he was able to accept and follow. Also he starts to communicate his needs to me”

Tam (Pita’s aunt 2/192/25)

In the interviews, Pat and Tam felt that the music therapy sessions could encourage their children to express themselves and communicate their needs more. In the first few sessions these two boys appeared to be very attached to their carers. Pat, Aden’s aunt, stated that Aden normally would not communicate with people outside the family. When he was at home amidst his family, he would be very playful and lively. Pat felt that the session could bring out “a real him” in another context besides his home. Tam felt that Pita not only started to follow her signals more but he also started to express his needs. This was significant for Pita, because he usually did not show much interest in communicating with others.

5.2.3 The carers’ experiences of seeing themselves in the music therapy sessions

Involving the carers in the music therapy sessions was an important component in this project. The literature regarding family music therapy in the previous section has explained the impact of working with both the children and their carers in the sessions. This section explains the carers’ point of view on how they see themselves in the sessions, how they see themselves participating in the children’s activities and also how they see themselves working with the music therapist. The carers were one of the keys to

this treatment process that helped the children to achieve their goals. They largely affected the ways the children responded to the music and the music therapist, and also they affected the way the music therapist worked with their children. The carers were asked to comment about what it was like being in the sessions with their children mainly in the second interview and again in the third interview. Each theme derived from the interview analysis, which was explained in 4.7 Table 8 shows the overall themes in the “The carers’ experience of seeing themselves in the music therapy sessions with their children” category.

Table 8 Themes in the “The carers’ experiences of seeing themselves in the music therapy sessions with their children” category

Category: The carers’ experiences of seeing themselves in the music therapy sessions with their children						
Themes	Participants (relationship to the children)					
	Jan (Nina’s aunt)	Pat (Aden’s aunt)	Tam (Pita’s aunt)	Bam (Mark’s grandmother)	Sue/Dan (Nathan’s grandparents)	Rita (Paul’s aunt)
A. Involving the carers in the music therapy sessions enabled them to have a good time and a good experience together	*	*	*	*	*	*
B. Involving the carers in the music therapy sessions encouraged their children to engage more	*	*	*	*	*	*
C. Involving the carers in the music therapy sessions encouraged them to engage with their children more	*		*	*	*	*

D. Involving the carers in the music therapy sessions enabled the carers to work in partnership with the music therapist	*	*	*	*	*	
E. Involving the carers in the music therapy sessions gave them hope and allowed them to see the children in a different light	*	*	*	*		

The table shows that all the carers agreed that involving them in the music therapy sessions enabled them to have a good time and a good experience together, encouraged them to engage with their children more, and also to encourage their children to engage more. Of the six carers, Jan, Tam and Bam agreed with all five themes.

A. Involving the carers in the music therapy sessions enabled them to have a good time and a good experience together

The quotes show that the carers were pleased and felt less worried when they witnessed their children's joys and progress in the sessions. The children's joys and their engagements were a great influence on the carers' feelings. Moreover, the carers could be relaxed and happy when they saw their children smiling and laughing. Normally, the carers face managing the children's challenging behaviour so it was important for them to witness their children's enjoyment (Howden, 2008). The carers themselves were also involved in the sessions so they could be relaxed and be playful with their children with whom in their daily life they did not often have these kinds of moments together.

"...Sometimes I was tired from supporting him and in the sessions I was listening to the music, being playful and moving along with him. It was kind of relaxing for me."

Tam (Pita's aunt 2/60/9)

“In the sessions he could jump and dance with the music; it made me enjoy with him. However, when he did not engage after we had tried different ways to engage with him, this made me feel very disinterested and disappointed. It was very much dependent on how Pita responded; if he had fun, I would also have fun too.”

Tam (Pita’s aunt 2/116/16)

“I wasn’t stressed and worried whether she could do it well or not in the sessions. Nina was interested in us (me and the music therapist) so she was mostly willing to engage in the activities.”

Jan (Nina’s aunt 2/115/16)

“Mark had changed so much...this made me feel so relieved...he was able to engage and learn to play with others”

Bam (Mark’s grandmother 2/202-206/32)

“...when we participated in the sessions together, it was great fun and made me feel active (enthusiastic)...he had a chance to lead the activities”

Rita (Paul’s aunt 2/110/6)

B. Involving the carers in the music therapy sessions encouraged their children to engage more

Having the carers in the sessions ensures that the children are safe and secure. The children felt anxious about being alone in a new environment with a stranger. Having the carers around could lessen their anxiety and enabled them to connect to a new person (Oldfield, 2011). The carers know best about the children. They could explain their children’s behaviour better than anyone.

“ I would give Mark praise and clap along with the music therapist’s music...and sometimes I also sang along with them.”

Bam (Mark’s grandmother 2/98/16)

“I was his supporter, when he could do something I would give him praise...he seemed to be proud of himself and wanted to keep trying...”

Rita (Paul’s aunt 2/88/5)

“...sometimes Aden didn’t want to participate in the activities. He was shy when he was with the music therapist alone. But when I went along with him he was more confident and he was willing to do it. So I played along with him.”

Pat (Aden’s aunt 2/22/5)

“I helped the music therapist in encouraging Aden to participate. Sometimes when I just observed Aden and the music therapist in the session, Aden would not engage as much as when I also joined in with them.”

Pat (Aden’s aunt 2/58/14)

“In the first few sessions when Pita was alone with the music therapist, she did not know him that well...I have been taking care of him for a long time so I know him very well. I know that he would not give so much eye contact to someone he did not trust....So when I participated in the sessions, I helped the music therapist to gain Pita’s attention and to stop him from wandering around...he started to take interest in what the music therapist and I were doing...When Pita saw me playing the instrument, he would come to me and wanted to join in.”

Tam (Pita’s aunt 2/36-38/7)

The children usually looked for support from their carers and they tended to look at the carers as role models. It was encouraging to the children to join in the activities where their carers also participated because they preferred to copy and listen to their carers’ requests more than a new person’s. Both Tam and Pat agreed that their active involvement helped their children to be interested and engage in the music therapy activities. Some carers like Rita and Bam did not always actively participate in the

sessions but their praise and compliments greatly influenced their children to become engaged in the sessions.

C. Involving the carers in the music therapy sessions encouraged them to engage with their children more.

When the carers saw their children's improvement, they felt enthusiastic to engage in the music therapy sessions and wanted to actively participate in the activities. The children's responses had so much influence on the carers' decision whether or not to take part in the activities. When the children did not engage well or resisted participating, this could make the carers feel despair and they did not want to join in. The children were the carers' focus and they always wanted to try everything to make their children improve. Therefore it was crucial to emphasise positive responses the children made, especially when these good responses were influenced by the carers' inputs.

Moreover, participating in the sessions allowed the carers to experience different ways of engaging with their children, and usually the musical activities in the sessions employ non-verbal communication (Davies, 2008; Hibben, 1992; Horvat & O'Neill, 2008; Howden, 2008; Oldfield & Bunce, 2001). The music therapist is trained to engage by using music with the children who struggled to communicate with others (Oldfield, 1993; Woodward, 2004), so the carers could observe how the music therapist engages with the children and this enabled the carers to increase interaction with their children. Also, the music activities in the sessions were playful and childlike, thus the carers were naturally influenced by these characters and became playful and childlike with their children.

"I think because when Nina started to get more engaged and show more interest in the sessions that made me feel enjoyment and not be bored. For example, in the beginning when she didn't engage well I felt discouraged but later when she appeared to be enthusiastic, that gave me so much encouragement to be more involved in her life."

Jan (Nina's aunt 2/28/5)

“I observed how the music therapist engages Nina and made Nina interested in the sessions and is able to engage Nina for a long time. I also observe how to help Nina understand more about boundaries and learn to share and to wait for her turn...I started to understand her more and Nina asked me more often to sing for her.”

Jan (Nina’s aunt 2/121-123/17)

“No I never danced with her. Before (participating in the music therapy sessions), I normally let Nina dance by herself and I just watched her dance but now I join in with her.”

Jan (Nina’s aunt 2/160/21)

Before I participated in the music therapy sessions, I did not put so much effort into learning or playing any musical instrument...because it hurt my fingers...now I want to try harder (to play an instrument) and be able to engage with him instead of playing alone...when I brought out the ukulele, he would come to me quickly...I feel that he wants to communicate...he shows some interest in other persons

Tam (Pita’s aunt 3/94/12)

“(After participating in the music therapy sessions), I feel that I talk to him more gently and have more patience. When I am frustrated with Mark, I always think of what the music therapist would do”

Bam (Mark’s grand mother 2/220/34)

“(After participating in the music therapy sessions), I learnt more about my grandson’s behaviours and I feel more interested in him.

Dan (Nathan's grandfather 2/96/6)

When the carers were in the sessions, they saw how the music therapist engaged with their children. Also they were supported and encouraged by the music therapist to

engage with their children through music in a playful way. Later, the carers had more confidence to act or actively engage with the children in the music therapy sessions. Moreover, they could learn and adapt some techniques to use with their children at home. Besides that, being in the sessions with their children, they could learn about their children with a different perspective and this makes them more enthusiastic to be involved in the children's lives.

D. Involving the carers in the music therapy sessions enabled the carers to work in partnership with the music therapist.

The quotes show that the carers felt that their involvement in the sessions was not only helpful for the children but was also helpful for the music therapist. In the sessions, the carers were not only seen as the carers of their children but they were also seen as co-therapists. All through the project, the carers were encouraged to share their opinions after each session finished. The carers sharing their experience of taking care of their children was very valuable and helpful. This knowledge helped in adjusting the sessions and also with approaches more suitable for the children. Moreover, being in the sessions enabled the carers and the music therapist to discuss at that moment and sometimes they could decide together right on the spot. The carers were able to engage in the treatment process more and they felt respected by the music therapist.

"I think it is good (to be involved in this process) so I learn how the music therapist thinks and feels about Aden and myself."

Pat (Aden's aunt 2/62/14)

"It is good to be in the session because I can observe Nina's weakness and sometimes the music therapist didn't understand Nina's behaviours well and she couldn't respond to her properly as there are so many children and they are different from each other. So by involving me in the session, I could help the music therapist to understand more about Nina's behaviours For example, Nina got distracted, pointing at the air conditioning while we were playing the keyboard. If we told her to stop and come back to join us, Nina would just not stop pointing and wouldn't come back so I recommended to the music therapist to ignore that behaviour. So she would return to us. The music

therapist told me that was a good thing from involving the carers and the families. We can help each other to improve Nina's behaviour."

Jan (Nina's aunt 2/34/6)

"It was good to participate in the sessions because I was able to help the music therapist to encourage Nathan to join in...the music therapist might not be able to understand everything about Nathan."

Sue (Nathan's grandmother 2/206/13)

Moreover, reviewing the videos together provided chances for both the carers and the music therapist to discuss and openly share opinions about the children and their interactions in the sessions. This enabled the music therapist to establish corroborative working with the carers.

"She (the music therapist) is very open to my opinion and we help each other to adjust the sessions to be more suitable for Pita"

Tam (Pita's aunt 2/98/14)

"She (the music therapist) was willing to listen to my opinion and accepted my suggestions...also I accepted her suggestions"

Bam (Mark's grandmother 2/42/7)

E. Involving the carers in the music therapy sessions gave them hope and allowed them to see the children in a different light

On many occasions, the carers had the impression that their children were being challenging. This led the carers to see their children's negative behaviours more than their positive ones. Having the carers in the sessions and participating in the activities allowed them to see their children in a different situation. Before participating in the music therapy sessions, some of the carers had been trying different interventions and they could not see many changes in the children. As a result, they did not expect so

much from participating in the music therapy sessions. However, in the music therapy sessions, they were surprised by what their children could achieve and this allowed them to be more hopeful for their children's development.

"When Mark engaged very well, I felt very happy and I felt less exhausted...also I felt more hopeful."

Bam (Mark's grandmother 2/32/6)

"I was proud of him when he showed interest in interacting with someone even for a few minutes."

Bam (Mark's grandmother 2/90/16)

"He surprised me many times...I sometimes thought to myself "is he able to do that??" One day, he was playing the guitar while imitating the music therapist's movement and sometimes he was playing a recorder while he played the keyboard with another hand."

Pat (Aden's aunt 2/142/25)

"I am interested in her more. Before, I didn't pay much attention to her because I don't know what the point of training her was. I am not sure if Nina will get better. But when I considered again I think to participate in the sessions can help Nina to have longer concentration."

Jan (Nina's aunt 2/154/21)

The activities in the music therapy session were based on the children's interest and also they were built on some things the children could achieve. The carers had chances to witness how their children presented positive behaviours and made improvements. Moreover, seeing someone else appreciate their children's even small achievement could encourage the carers to shift their focus and appreciate small steps their children made too.

5.2.4 The carers' experiences of reviewing the video recordings from the music therapy sessions

In this section I reflect on the video reviewing process, which took place after music therapy sessions with the music therapist and the child's carers. This is different from the video analysis, which is used in some music therapy research, as in this study the use of video is part of the treatment process. There are several music therapy research studies which employ video recording as a tool to analyse the findings. A book *"Microanalysis in Music therapy: methods, techniques and applications for clinicians, researchers, educators and students"* (Wosch & Wigram, 2007) devotes one section to six studies that demonstrated how video recordings were used to evaluate music therapy effectiveness. Video recordings can provide rich and descriptive information; even a short clip could capture the music therapy approach, reactions, responses, communication processes, structures, techniques and certain aspects of the context. Therefore employing video analysis needs systematic steps so that misleading use of the video clip can be avoided. The small sections which were relevant to the research questions or to the music therapy aims were picked from the video recording (Mette Ridder, 2007). During the video analysis, the specific actions were analysed depending on what the research questions or music therapy aims were. For example one such aim could be to assess the quality of a relationship between a child with autism and a music therapist (Scholtz, 2007).

The way video recordings were used in this study was different from this video analysis process. They were employed as part of the treatment process. There are a number of parent-child interactions studies that employ video recording in order to give the parents a feedback and lead to a discussion (Fukkink, 2008; Harrigan & Nikolopoulos, 2002; Holmes et al., 2011; Kalinauskiene et al., 2009; Sharry, Guerin, Griffin, & Drumm, 2005). The parents and the therapists reviewed video segments from the previous sessions together or the segment could just contain the moment when the parents and their children were participating in a daily routine such as having a meal together (Holmes et al., 2011). The video recording enabled the therapist and the parents to discuss changes during the process of treatment (Harrigan & Nikolopoulos, 2002). The

discussion could lead the parents to reflect about their interaction with their child and this became a foundation to learn new skills. In the reviews the therapist focused more on the parents' and their children's strengths. Positive moments between the parents and their child were presented and used to explain skills and strengths that were displayed (Holmes et al., 2011; Sharry et al., 2005). Also in the music therapy treatment process the recordings were used for reviewing and promoting discussion between the music therapists and the participants. The video recording was employed in order to allow the parents to see for themselves, what their child was doing and the progress they had been making (Drake, 2008; Holmes et al., 2011). These studies influenced the video reviewing process in this study. I have explained the process of the video reviewing that was used in this study in 3.5.4.

The carers were asked to share their opinions of what they thought of video reviewing of their music therapy sessions, during the second and third interviews. From these interviews, there are three themes concerning the carers' experiences in the video reviewing process. Each theme derived from the interview analysis, which was explained in 4.7. Table 9 shows overall themes in the "The carers' experiences of reviewing the video recordings from the music therapy sessions" category.

Table 9 Themes in the "The carers' experiences of reviewing the video recordings from the music therapy sessions" category

Category: The carers' experiences of reviewing the video recordings from the music therapy sessions						
Themes	Participants (relationship to the children)					
	Jan (Nina's aunt)	Pat (Aden's aunt)	Tam (Pita's aunt)	Bam (Mark's grandmother)	Sue/Dan (Nathan's grandparents)	Rita (Paul's aunt)
A. Providing good memories		*	*	*	*	*

B. Changing their opinions toward their children and themselves.	*	*	*		*	*
C. Seeing the children's responses and their interactions in more detail	*	*	*	*		

The table clearly shows that each subordinate theme was common to most of the participants. Pat and Tam stated all three themes. Sue, Dan and Rita agreed on the same themes.

A. Video reviewing provided good memories.

A good memory is particularly important when the children and their carers usually struggle to have quality time together. Carers who always encounter challenging events with their children can be very stressed and have little confidence in their parenting skills. Seeing a moment of enjoyment and receiving positive feedback from others can make a big difference to them.

All carers except Jan agreed that video reviewing brought a good memory from the previous sessions. Also the video could be evidence of their children's abilities, which they can review as much as they wanted.

“ When we were in the sessions, we were not as aware of our responses or actions as when we reviewed the sessions, I feel like we are television stars and found it funny, I sometimes laugh at myself”

Rita (Paul's aunt 3/98/5)

“(The music therapist) probably wanted to show what we were doing in the sessions and from reviewing the video, it made me happy”

Dan (Nathan’s grandfather 2/122/8)

“When we reviewed the video excerpt, I was happy to see that we all supported each other...I participated in the sessions and also my grandson could show his abilities...it was delightful.”

Sue (Nathan’s grandmother 2/190/10)

The video recordings were not only viewed with the music therapist after the sessions because sometimes the carers requested to have a copy of the video to review again at home. One participant reported that replaying the moment of her nephew’s happiness and achievement brought her joy.

“I like to re-play it (the video excerpt) many times. I don’t know if other carers do the same thing, but when I watch it, it makes me smile ”

Tam (Pita’s aunt 3/116/13)

Besides using video to review the previous sessions, after all the treatment process had finished the participants were given a DVD that included various meaningful moments from the sessions. This DVD was a way of documenting the moment of pleasure and the accomplishment that the participants and their children experienced in the music therapy sessions. This could maintain the positive result from this process in the future (Davies, 2008).

Moreover, since the parents of all the children could not attend the sessions, the carers could use the video to describe the children’s achievements. Their parents could share their children’s enjoyment through the DVD. Consequently the rest of the family could share the music therapy process and have the same expectation of the children as those who were in the sessions. Good memories were not limited only to the sessions but were also expanded to the rest of the family.

“I just showed his mum this morning. I feel good about my involvement in the sessions. He laughed at himself while he was watching. He was able to watch from the beginning until it was finished and seemed to really enjoy it.”

Pat (Aden's aunt 3/106/11)

“His father and mother watched the video and they were pleased with what their son was able to do and gained more hope from watching it.”

Bam (Mark's grandmother 3/80/10)

Watching the video appeared to be rewarding for their carers as well as the children. They seemed to be proud when they watched themselves in the video.

“I think Paul thought that he is a television star, when he saw himself in the video, he would smile, laugh and seemed very happy.”

Rita (Paul's aunt 2/198/10)

“Nathan was very happy to see himself in the video, he would smile and laugh while we were watching it...sometimes he said “Nathan plays” while watching himself in the video excerpt.”

Sue (Nathan's grandmother 3/74/4)

B. The video reviewing enabled the participants to change their opinion of their children and themselves.

Oldfield (2006b) stated that video recording allowed her to examine and reflect on her work so she could gain new insight and skills. In addition, reviewing her video recordings of the sessions enabled her to see more positive sides of her sessions than she had previously thought had occurred. This statement was not only true for the music therapist but was also true for the carers who were involved in the sessions.

In the sessions, the carers were often busy engaging with their children and the music activities, therefore they did not always notice how their children responded in the

sessions. Also the carers were with their children all day and sometimes they got used to the children's habits. They found it hard to see the new behaviour. Video recordings provided the carers evidence of their children's new behaviour and gave them chances to review their children's achievement which they missed while they were in the sessions.

"...If we had enough time the music therapist would show me a video from the previous session. Sometimes from the video I could see how long she can concentrate and some words that she said. While we were engaging in the activities, we had fun and forgot to observe Nina."

Jan (Nina's aunt 2/101/15)

"...(when I saw Nina in the sessions) I thought she didn't have a good concentration but when I watched in the video I think she was okay and was able to engage for a long time."

Jan (Nina's aunt 3/70/12)

Normally the carers focused on helping their children and they were not so aware of their input. Reviewing the video helped them to be more aware of their own responses to the children. Not only their responses but also their mood and their feelings in the sessions could be seen. This led them to be more careful in their reactions. They would not notice their valuable support in the sessions, which affected so much of the child's progress. Having someone to point it out emphasised their positive input and mentally supported them. This might help them feel more confident in their parenting skills and less dependent on others.

Question: How do you feel to see yourself in the video?

"Sometimes I was surprised to see how funny and playful I could be. And I was able to see how well Nina engaged in the sessions even when I was in the sessions with her I could not notice that at the time. I am very pleased."

Jan (Nina's aunt 3/67-68/11)

“It was funny to see myself doing so many things that I have never done before.”

Tam (Pita’s aunt 3/116/13)

“When I was in the sessions, I did not have chance to be aware of what I was doing, so reviewing the video helped me to see myself and sometimes laugh at myself.”

Rita (Paul’s aunt 3/98/5)

“During the video reviewing, I was able to see how I could help and support the music therapist...without the video I would not have noticed that”

Dan (Nathan’s grandfather 2/118/8)

C. Video reviewing allowed the carers to see their children’s responses and their interactions in more detail

Statements from four participants suggested that the video reviewing process enabled them to see their children’s and their own responses more clearly. As the video can be replayed many times it can reveal more details when reviewing than in memory alone (Sharry et al., 2005). The video excerpt allowed the primary carers to observe small communication signals such as eye contact, body gestures, and facial expressions, which were very important in the case of the children who had limited communication skills. Sometimes when they watched themselves in the video, they were more emotionally involved than normal (Fukkink, 2008). While they were watching themselves in the video, they could witness themselves engaging well with their children. Therefore this enabled them to become their own role models instead of being told what to do by an expert or another person (Sharry et al., 2005). Also they could see more detail of how the music therapist interacted with their child and they could learn more from this observation.

“The music therapist pointed out what Pita is interested in...we noticed how his eyes followed the music therapist’s fingers while she was playing on a keyboard”

Tam (Pita’s aunt 2/94/13)

“(The video) enabled me to see what Nathan and the music therapist were doing. Also I could see how I could support the music therapist in the sessions”

Sue (Nathan’s Grandmother 3/74/4)

This enabled the carers and the music therapist to work toward the same goals. Moreover, the carers could see how their responses in the sessions influence the behaviour of their children and also the overall mood in the sessions. It was enjoyable to watch the children’s positive moments, however it was also very important for the participants and the music therapist to acknowledge the challenging behaviours. This also enabled the carers and the music therapist to discuss how to manage the difficult behaviour of their children.

Question: What did you gain from reviewing the video excerpt with the music therapist after the sessions?

“To see the differences because I didn’t attend in some sessions so the video showed me how he was when he was with only the music therapist...I wanted to see Aden with the music therapist alone in the session because with me he was willing to do most of the things but with the music therapist alone he didn’t want to do as much. So I want to see why, so that I can improve.”

Pat (Aden’s aunt 2/112 and 118/20)

“When we watched the video, we were able to see why he could not engage well in the sessions...maybe because he had done so much before coming to the sessions. Sometimes I also re-played it again at home and compared it with other sessions”

Tam (Pita’s aunt 2/178/23)

“I think she (the music therapist) wanted to show how much my grandchild had achieved and what should be the next step for him”

Bam (Mark’s grand mother 2/120/20)

As the project could only provide short term treatment, the carers still wanted to maintain the use of music in their children’s lives. So the DVD was one of the tools that brought back the memories, which encouraged the families to maintain the use of music. The carers could review the DVD carefully in order to remind them of what they did in the sessions and they could adjust ideas that they could then use with their children at home.

“Also after the treatment had finished, I could re-play the video and adjust the way of using music at home with my grandson”

Dan (Nathan’s grandfather 2/118-122/8)

“I think the music therapist showed the video to us because she might want us to review and find a way to help Pita to develop...also to adjust the way of using music at home”

Tam (Pita’s aunt 2/176/23)

5.2.5 The carers’ experiences of using music at home

This research aims to study the carers’ experiences of using music with their children both in the sessions and outside the sessions; visiting the children at home enabled me to explore more about the family and also to provide support to the family. A home visit also indicates willingness of the practitioner to step into the family’s territory and follow the family’s needs and schedule. This enables a less formal and more comfortable, friendly, and relaxed relationship between the practitioner and parent (Weiss, 1993). In this study, the carers, parents or other family members and the children were able to feel more relaxed and express their feelings during my home visits. Also, on some occasions I was able to meet other family members and see how they engaged with the children with special needs. Learning about the carers’ experiences of using music outside the

music therapy sessions allowed me to find ways to help the carers use music with their children in the home environment

The carers were asked in the second interview to explain how they used music at home during the days they did not have music therapy sessions and also how they planned to use music after the music therapy treatment was finished. In the third interview, the carers were asked to share their opinions on the home visits and how these visits affected their children and themselves. Each theme derived from the interview analysis, which was explained in 4.7. Table 10 shows overall themes in the “The carers’ experiences of using music at home” category.

Table 10 Themes in the “The carers’ experiences of using music at home” category

Category: The carers’ experiences of using music at home						
Themes	Participants (relationship to the children)					
	P.1 Jan (Nina’s aunt)	P.2 Pat (Aden’s aunt)	P.3 Tam (Pita’s aunt)	P.4 Bam (Mark’s grandmother)	P.5 Sue/Dan (Nathan’s grandparents)	P.6 Rita (Paul’s aunt)
A. The changes in using music at home after participating in the music therapy sessions	*	*	*	*	*	
B. The use of music at home creates a good atmosphere in the family		*			*	*
C. The differences between having music therapy sessions and using music at home	*	*	*			

D. The children's perception of the music therapist making visits		*		*		*
E. Home visits helped the music therapist to gain more understanding of the children		*		*		
F. Home visits encouraged the carer to use music			*			

The theme of “The changes in using music at home after participating the music therapy sessions” is the most common theme among the carers. The theme “home visits encouraged the carer to use music” was only brought up by Tam. Pat appeared to be the research participant who mentioned most about the themes.

A. The changes in using music at home after participating in the music therapy sessions

This project did not aim to train the carers to use music with their children therapeutically at home. However, I encouraged the carers to engage with their children through music at home when they had a chance to do so. Moreover, after the treatment process had finished, I provided the carers with a sheet of some simple music games that we did in the sessions together in order to encourage them to maintain the use of music at home. As this project was time-limited music therapy treatment and also it was difficult for the carers to find music therapy treatment for their children in the area, it was challenging to keep music in the children's life. However, with the family involvement, it was more possible to bring music into their home setting.

In the quotes, it is clear that the experiences of being in the music therapy sessions encouraged the carers to use music in the home environment. For the parents it was

encouraging to see how music could bring smiles to the children and also it has nurtured communication between them. Therefore, the carers became more interested and made more of an effort to include music in their routine at home.

For some of them, music had already been part of their children's life. However, being in the music therapy sessions with their children enabled the carers to use music with clearer purposes and to bring some techniques or games that they did in the music therapy sessions. Participating in the music therapy sessions enabled the carers to see more the value of their children's interaction with them through music.

“Before we had music therapy sessions I also turned the music channel on for him but he would just walk away and was not interested in it....but these days he shows more interest in the music...he would listen and move along when I encouraged him by singing “move your legs...I want to use music to engage (or to interact) with him, without music, he liked to play by himself...he was alone and did not know how to play (with others)”

Bam (Mark's grandmother 3/48-50/6)

Question: What makes you want to use music with Aden more? And what is your aim of using music with Aden?

“Encourage him to engage with me. When I use music, he will show interest in me right away. If he is in a bad mood I will use music to catch his attention.”

Pat (Aden 3/57-58/4)

“He was always in his own world and alone....sometimes when he heard me play music, he would come to me and check what I was doing... and showed some interest in what I was doing

Question: Would he come to you if you did not play music?

“Yeah, he would come and just hug me but we did not do anything together...but with

music, we would learn something...I would say to him "We are playing a guitar" then we would dance and have fun together"

Tam (Pita's aunt 3/40-42/6)

"We did exercise in the morning with the music turned on. Nina normally ran around the house then kicked the ball. Also we did the vocalisation (La La La) so Nina can exercise her lip/mouth too."

Jan (Nina's aunt 3/12/2)

Question: Did Nina sing along with you?

"Yes, but not for long. Just a few times was good enough. Then I encouraged her to run around the chair and climb up- down from the chair. And I asked her to say "climb up on the chair" then count 1-2-3 before jumping from the sofa. I clapped my hand for a signal as the music therapist did in the sessions. We do this activity almost every morning before we have a shower but we miss it out on the day Nina has a bad mood and is sick."

Jan (Nina's aunt 3/8/2)

Hart's study (2010) showed that children with autism are mostly engaged in interacting with objects such as toys, musical instruments and computer games and therefore the children's interests can be used as a foundation to build joint attention and parent-child interaction (Schertz & Robb, 2006). However, the effect of the parent-child music interactions at home was probably different from the effect from the interactions in the music therapy sessions. These interactions at home could be moments where the children and carer's moods are lifted and also influence other activities so that they go more smoothly. The musical activities could improve the children's mood and enable them to be ready to learn or practise new skills. In order to help the children to develop desired behaviour or skills, the children need to be engaged first (Harte, 2010).

In addition the interview showed that the children themselves were engaged and had good memories in the music therapy sessions. These experiences enabled them to bring

the moments they enjoyed into the home environment. The children were also more enthusiastic to use music and wanted to have fun with music again at home. Normally, the home environment was not specifically set up for music interacting. Usually some musical instruments were put in a corner of the living room or were mixed with other toys in a big box. The family did not design or set the timetable for interacting with their children on a specific day and time. The music interactions sometimes emerged on the children's initiative. The uses of music at home were more likely to be embedded in their routine/ daily life. Additionally, Aden's aunt found that Aden was more playful and appeared to be more relaxed than he was in the music therapy sessions at the school. Being in a familiar environment allowed the children to be more independent and control their own environment (Horne-Thompson, 2003)

“He had them (the instruments) before participating but he didn't play with them much and didn't know how to play. After participating, he seems more interested in playing the instruments and he knows how to play. For example, before he didn't know how to blow the recorder and he used to play with guitar as it is a toy but now he is able to blow and knows how to pluck on the guitar string.”

Pat (Aden's aunt 2/150/26)

“When he is at home, he is more confident...For example, at home he imitates the way the music therapist plays keyboard and vocalises (jah jaad jaa). Here (in the sessions) he sometimes joined in and sometimes didn't. But at home he normally just jumped up on the chair, plugged in the keyboard and played by himself and I don't have to encourage him to play.”

Pat (Aden's Aunt 2/152 and 154/26)

“We had some instruments at home but she did not show interest or play with them much but now she knows how to play them more properly so she seems interested in them more”

Jan (Nina's aunt 2/96/13)

Question: It seems that Nina is still impressed by the music therapy sessions. Was there any other occasion that Nina was involved with music?

“For example, I was upstairs and I heard Nina say “Wow”...at that time I wondered what she was doing. So I came down and saw her sitting on the staircase and pretending as she was playing piano and did “glissando” on the floor...We normally said “Wow” when we did that on the keyboard in the music therapy sessions...”

Jan (Nina’s aunt 3/4/1)

B. The use of music at home creates a good atmosphere in the family

Playing music at home provided chances for the children and other family to share a good moment. These small engagements between the family members could change the house’s atmosphere and affected the children and other family members’ moods. Using music as a bridge or a tool to spend a good moment together with the rest of the family was very helpful, especially for the children who always spent much time with their carers and did not have much time with their parents or siblings. The moments could help enrich the child-parent bond.

“During the weekends I am always away. He will stay with his parents and his dad plays guitar with him...We have guitars that have a button which when it is pressed the music will automatically come on. So Aden and his dad play those guitars together... His mother sings along.”

Pat (Aden’s aunt 3/48, 50 and 52/5)

“The atmosphere is more lively. If we are stressed, Aden brought the guitar out and played. This will bring the happiness to our home. Aden is the one who makes us happy.”

Pat (Aden’s aunt 3/102/10)

“Sometimes his granddad, his mum and I all played music together; each of us held different small percussion instruments and joined in. It was fun and we were engaged well.”

Sue (Nathan’s grandmother 3/66/3-4)

“When he was alone, he would bring the instrument to me and I joined with him but sometimes I did not play the instrument with him but just clapped along with his music instead. I felt closer to him....sometimes at the end of the musical interaction, he would come and kiss me on the cheek”

Sue (Nathan’s grandmother 2/226/12)

“Usually, he just listened to the music and sometimes his sister played the guitar; he would sing along and sometimes he moved with the music. He was able to engage with his sister for a while”

Rita (Paul’s aunt 3/14/1)

The musical interaction became a bridge for Nathan’s grandmother and Nathan to come closer. The music playing appeared to be a mutual activity that everyone in the family could enjoy. Not only the carers who participated in the music therapy sessions with the child, but also other family members who never attended the sessions could be part of it. In Aden’s family, everyone including his grandmother was able to join in although she was not in good health (3/92-94/5). The musical interactions are safe and easy activities to access for everyone in the family. These enabled the whole family to have a good time together.

C. The differences between having music therapy sessions and using music at home

The quotes show that the limitation of the carers’ musical skill affected the way the children engaged with the musical interactions at home and was a barrier to engaging well with their children. Since the beginning of the music therapy treatment, it was

common that most of the carers would worry about participating in music therapy sessions and had to play music with their children without previous experience of using music. Therefore, expecting them to use music with their children at home, the carers would find very challenging. Even Tam who employed other material such as turning on music from a television or radio and using karaoke, still saw the differences in Pita's responses in the music therapy sessions and in the home setting. Both Tam and Pat felt that their music skills could not gain the children's attention as much as the music therapist did. This can be very discouraging for the carers to maintain the use of music at home.

"...I don't know how to play music but when we sang karaoke, I was able to engage and sing along with him...however musical skills are the most challenging issue...I was bored with playing the same thing...Compared with in the music therapy sessions with the music therapist, Pita was able to engage better. The music therapist knows how to use music and the music is better and more interactive (fun)...but with my music I just plucked the guitar up and down...repetitively...I think Pita was not as much interested in my music as the music therapist's music. He was just interested to know what I was doing and wanted to be around me."

Tam (Pita's aunt 3/28-33/4)

Question: Is there any differences when Aden was in the music therapy sessions and when he was at home playing music with you?

"There is much difference. I am not a musician. I just play around randomly. But with the music therapist, she sang, made a song in different tempo. The music is better."

Pat (Aden's aunt 3/53-54/6)

D. The children's perception of the music therapist making visits

The interviews show that the carers felt that their children were pleased to have the music therapist visiting them at home. Aden and Paul were excited to have a visitor. In the family environment, the children appeared to be more relaxed and be able to join in

the music interaction more freely. Also, visiting them at home created the feeling of closeness between the family and me. The children became the host and they would feel more control over the place than in the music therapy sessions at the centre. They were eager to invite me to their place. They appeared to appreciate having me around and did some musical interactions together. In the music therapy sessions at the centre, normally Mark would not show affection to me, however during the home visit he smiled, gave me much eye contact and surprisingly before I left he kissed me on my cheek. The authority from the teacher's role is diminished when I visit their home therefore the children could feel closer and more relaxed with me.

"I think it was good to have her at our place and it brings Aden and the music therapist closer. If it is possible, I want the music therapist to come more often...I feel some differences when she came to our house. I feel that she is one of our family members. When Aden was in the sessions at the school, he kept some distance like teacher-student. But when the music therapist visited us here and she was going to leave, Aden wanted to go with her and kept waving good bye. Even when the music therapist got in her car he was still waving. It seemed like he was happy to have the music therapist at his house."

Pat (Aden's aunt 3/76 and 78/8)

"It was very nice to have her (the music therapist) visit us...I think Mark was lonely and missed her...when we opened the door for her, he was very happy."

Bam (Mark's grandmother 3/7/9)

"Paul is always excited to have people come around. He gave her a nice welcome feeling and he wanted to take care of her and played with her (the music therapist)...She played music for us and he seemed to be very much enjoying it and wanted to join in."

Rita (Paul's aunt 3/68/4)

E. Home visits helped the music therapist to gain more understanding of the children

During the home visits, I was able to see the children in their comfort zone where they could take more control and could be more themselves. Also I could see how other family members interact with them. This allowed me to see the children in a different perspective. Home visits support the visitor to learn about the children and their family in a more holistic way. They enable the visitor to see individual family circumstance and take them into account (Weiss, 1993). Moreover, the home visits helped in strengthening the relationship between the families and the visitor. The visits enabled the visitors and the parents to have a better communication, and this allowed the visitors to have a better understanding of the children and how the home environment impacts on the children (Meyer & Mann, 2006).

Question: Was it helpful that the music therapist briefly used music with Aden at home? How?

“Yes, it was very helpful. She gained trust and became closer to him. It was difficult for Aden to become close other people. If Aden becomes familiar with other people, he will be more confident and able to be himself and express himself more...”

Pat (Aden’s aunt 3/82/9)

" Umm, I think it would be better to have music therapy both at home and at the school. Having music therapy at home would make Aden feel too relaxed and also to have music therapy in both places could allow the music therapist to see the difference between Aden at his home and at the school."

Pat (Aden’s aunt 3/86/9)

“Before the home visit, his mother always was busy with her work...she did not know much about what Mark was doing at the school. When the music therapist paid a visit, she told Mark’s mother about Mark in the music therapy sessions. His mother was

pleased to learn about Mark and she said to me that she wanted to find some musical instrument for Mark”

Bam (Mark’s grandmother 3/64/8)

Aden’s aunt believed that Aden was different when he was in the sessions and at home. She suggested having the music therapy at both at the centre and also her place, as the environment could bring out different characters of the child. Pat also emphasised the importance of Aden becoming closer to me so that I was able to see Aden in a different way. Also in Mark’s case, home visits allowed me to see his mother and be able to explain to her about Mark in the sessions. This perspective could give his mother a different way to look at Mark.

F. Home visits encouraged the carers to use music

Normally home visits aim to provide the family with support. These home visits also aimed to follow up on how the music was employed in the family and how the children responded to music at home. The home visit made Pita’s aunt be keen to show Pita’s progression.

“(Home visit) was helpful...I was able to observe how the music therapist engaged with Pita and how she managed to gain his interest...because sometimes when I played with him, he would not join in but it seemed easy for the music therapist to get him to engage ...I tried to use music every day, when the music therapist came to visit, I did not want her to see that Pita had made no progress...this thought was kind of my motivation to use music with him every day...”

Tam (Pita’s aunt 3/78/10)

From the quote, the musical interactions with Pita, his aunt and the other family members during my visits enabled his aunt to get more enthusiastic to experiment different ways of using music. These also could give her some ideas of what to do and how to engage with her nephew through music at home.

Reviewing important findings from analysis of the interviews

It is interesting that the findings in the first two categories show that almost all the carers' expectations were achieved. Only Pat's expectation of increasing long concentration with Aden not achieved. Moreover, it seems that the music therapy could be more beneficial than they initially expected. The table 11 below shows that only Bam (Mark's grandmother) did not find more effect of music therapy on her grandson than what she expected initially.

Table 11 Comparing the carers' opinions regarding their expectations of their children before the music therapy treatment process had started and the impact after the process was finished

Comparing the carers' opinions before and after the music therapy treatment process												
Themes	Participants (relationship to the children)											
	Jan (Nina's aunt)		Pat (Aden's aunt)		Tam (Pita's aunt)		Bam (Mark's grandmother)		Sue/Dan (Nathan's grandparents)		Rita (Paul's aunt)	
Before (B)/ After (A)	B	A	B	A	B	A	B	A	B	A	B	A
A. Increasing long concentration	*	*	*			*			*	*	*	*
B. Understanding signals and accepting another's requests	*	*	*	*		*	*	*		*	*	*
C. Having more interest in engaging with others				*	*	*	*	*		*		
D. Improving motor skills	*	*		*			*	*				

E.	Being more active and enthusiastic			*	*		*						
F.	Vocalising more and using more verbal communication	*	*		*		*				*		*
G.	Learning to regulate his mood/Relax		*						*	*		*	

From the interviews, it can be summarised that the carers view their involvements in the music therapy sessions as very beneficial. First, they felt relaxed and had fun with their children in the sessions. Their involvement in the sessions encouraged their children to engage more in the sessions. In the sessions, the carers witness different ways to engage with their children; this encouraged them to engage with their children more. The carers felt that in the sessions they could share their opinions with the music therapist. Also the carers and the music therapist learnt from each other about the children. In addition, when the children presented some improvement and the carers learnt more about their children abilities, the carers were able to see hope and see their children in a different light.

The carers viewed the video reviewing process as way to remember meaningful moments from the sessions. The children and their carers could deliver these moments to the rest of the family by showing a DVD of the meaningful moments in the sessions. Some carers found having the DVD is useful for reminding them how they can use music at home with their children. Also the carers found that reviewing the video recordings allowed them to see their children's behaviour in more detail and recognise how much their children could achieve. Not only did they learn more about the children's abilities, the carers could recognise how their interactions were influencing the sessions.

The most important aim in visiting the children at home was to see how the music was employed after the music therapy treatment was finished. According to the interviews, the way the music was used was very simple and both the carers and their children brought some games or songs from the sessions to the home setting. However, it was more important to see how the carers' attitude toward using music at home was changed. They appeared to be more responsive to the children's use of music. They were more aware of the value of the musical interactions as it was a time when they could do something meaningful with the children and both of them had a good time together. Table 12 summarises all the 28 themes that emerged throughout the interviews. They were divided into five categories. These themes came from the data analysis process according to 4.7.

Table 12 Overall categories and themes from the interviews

Category	Theme
5.2.1 The carers' expectations of the music therapy	<ul style="list-style-type: none"> A. Increasing long concentration B. Understanding signals and accepting other's requests C. Having more interest in engaging with others D. Improving motor skills E. Becoming less shy and expressing themselves more F. Vocalising more and using more verbal communication G. Learning to regulate moods
5.2.2 The carers' experience of seeing their children in the music therapy sessions	<ul style="list-style-type: none"> A. Understanding signals and accepting other's requests B. Vocalising more and using more verbal communication C. Increasing their concentration D. Having more interest in engaging with others E. Relaxing F. Improving their motor skills G. Becoming less shy and expressing themselves more

5.2.3 The carers' experience of seeing themselves in the music therapy sessions with their children	<p>A. Involving the carers in the music therapy sessions enabled them to have a good time and a good experience together</p> <p>B. Involving the carers in the music therapy sessions encouraged their children to engage more</p> <p>C. Involving the carers in the music therapy sessions encouraged them to engage with their children more</p> <p>D. Involving the carers in the music therapy sessions enabled the carers to work in partnership with the music therapist</p> <p>E. Involving the carers in the music therapy sessions gave them hope and allowed them to see the children in a different light</p>
5.2.4 The carers' experiences of reviewing the video recordings from the music therapy sessions	<p>A. Providing good memories</p> <p>B. Changing their opinions toward their children and themselves.</p> <p>C. Seeing the children's responses and their interactions in more detail</p>
5.2.5 The carers' experiences of using music at home	<p>A. The changes in using music at home after participating in the music therapy sessions</p> <p>B. The use of music at home creates a good atmosphere in the family</p> <p>C. The differences between having music therapy sessions and using music at home</p> <p>D. The children's perception of the music therapist making visits</p> <p>E. Home visits helped the music therapist to gain more understanding of the children</p> <p>F. Home visits encouraged the carer to use music</p>

This chapter confirms that the children and their carers were positively affected by participating in the music therapy sessions. These results from both the case studies and the analysis of the interviews will be discussed in order to respond to the research objective and questions in the next chapter.

Chapter 6 Discussion and Conclusion

Introduction

The objective of this study was to explore the carers' experiences in participating in music therapy sessions with their children with special needs. The participants in this study include seven carers of six children with special needs. (One child was accompanied by his grandparents. His grandfather and grandmother took turns to come or both brought him to the sessions.) The six children are aged from 4-12 years old. All the children had learning disabilities and four of them also had a diagnosis of ASD.

Each participant expressed his or her experiences during the three semi-interviews, which took place before and after the treatment process and two months after the 24th music therapy session was finished. The interviews were analysed by IPA approach (Smith et al, 2009). The experience of participating in the music therapy sessions with the children of each carer was personal and different. Each carer's story was woven together in order to create an understanding of the overall experiences of all participants.

This chapter firstly presents the major findings from two main sources, which are the case studies, and the analysis of the interviews. The case studies were created from reviewing the clinical notes, research journals and video recordings. 28 themes, which emerged from the interviews, reflect the experiences of the carers participating in music therapy sessions with their children with special needs. Then the additional observations from the clinical work and the answers to the research questions will be mentioned. Finally, the limitations of the research process and future research will be discussed. Moreover, personal reflections will be presented in order to show my own development from this research journey.

6.1 Main findings from case studies

From the case studies, the findings can be divided into two sections. The first section relates to how music therapy can help the children which mainly focus on social and

communication skills and the second section relates to how the carers and the music therapist worked together in order to nurture communication with the children and to find ways that the carers could use music to help their children.

6.1.1 How music therapy can help the children who have special needs

Music therapy objectives were set for each child according to their individual needs. Some children shared similar objectives. The most common objective among the children who participated in this study was developing their social and communication skills. The case studies show that the music therapy sessions enabled all six children to develop social and communication skills. In this section, the children's achievements in developing social and communication skills are divided into three steps because although developing these skills was included in all six children's music therapy objectives, the children were expected to achieve this objective in different ways and at different levels. It should be noted that the children did not all start at step one and progress through the three steps, although this was the case for some children.

Step 1: From isolation to joint attentions

This step presents how the children who appeared to be isolated or shy became engaged with others in the music therapy sessions. In this study, Pita and Mark have ASD and did not have verbal communication but they sometimes made sounds, which were mostly a one-word sound. They also engaged in stereotypical behaviour such as spinning objects or flapping their arms. During the first period of the music therapy process, they did not give me much eye contact. They appeared to be very much in their own world and showed very few signs of interest in engaging with others, especially with a stranger. They tended to wander around the room and tended to play alone. The social interaction appears to be the most obvious characteristic area of differences in ASD (Jordan & Jones, 2012). The social interaction deficits of the children with ASD are mainly combined with two major areas: 1) the ability for joint attention and 2) the ability for symbol use which affects the way they learn shared meaning of symbols and understand of gestures, words, imitation and play (Wetherby, 2006).

However, both Pita and Mark appeared to be very motivated by musical instruments. Many children including those with ASD are naturally motivated by the music (Kern, 2008). They firstly wanted to explore instruments that I used such as a keyboard or a ukulele. Their first desire to play with the instrument encouraged them not to keep themselves away from others. Examples of this can be seen in the attached DVD (excerpts 1 and 2). In addition, their experiences of musical instrument exploring and tactile handling could lead to creative music making (Burrell, 2005). Moreover, having their carers in the sessions making music with the children could promote joint attention because the existing trust and relationship between them encouraged the children to share their enjoyment and interest in music with their carers.

Also, music helps to encourage the children to move and dance as well as allowing the music therapist to be flexible, to follow the children's lead and match their actions. Showing interest in their actions and following their lead can provide the children the sense of self and other person and this allows the shared focus and then can leads to mutuality (Oldfield, 1995, 2004).

Unlike Pita and Mark, Aden only has learning disability and was not in his own world but was very shy and tried to avoid engaging with me in the first few sessions. Also it seemed difficult for Aden to be independent from his aunt. In his case, playful and active musical games interested Aden and motivated him to be actively involved with me. Also, involving his aunt in the sessions and getting her to engage reassured Aden that the sessions were safe for him to explore. The music was very flexible so that it could match Aden's mood and feeling. Therefore, I could meet him where he was and make him feel comfortable. This enabled me to start building up a relationship with him, which was initially based on shared enjoyment of the music and the musical activities. Therefore he was able to engage with me confidently and less depended on his aunt through this experience.

Step 2: From joint attention to social game

Once the children started to share their attention with me, I gradually added some structures in our musical interactions in order to help them to engage in a social game.

During the initial phase, the children were allowed to have some space to explore the sessions and musical instruments. After I could engage them in simple turn-taking, playing on the instrument they wanted, I increased some structures which aimed to challenge them in ways that extended their social communications. This way of working is similar to Tomlinson (2010), which is that in the initial stage she provided the children space for exploration and then in the later stage, she increased structure and intensity of interaction.

Also the carers become more actively participant in the games. These games enabled the children to engage in a small group activity, in which they needed to be aware of the other's signals and they also were encouraged to give verbal signals to others. They were invited to join in the musical games with their carers and me. These musical games encouraged them to play in a group. The music which was employed in the musical games was always in a simple chord progression that led to a resolution (I-IV-V-I) and was repetitive. The patterns and structure of the song can encourage the children to remember their tasks and encouraged the children to follow each step along with the song (Kern et al., 2007). Structure, predictability and routine allowed them to anticipate and understand what is to come next (National Autism Center, 2009). This could promote the children's social skills such as listening to the requests, waiting for their turn, following the others' leads or being a leader.

Some children like Nathan and Paul, who struggled to follow other's requests. By enabling them to keep their sense of control over our musical interactions, they were able to engage in shared and co-operative interaction. Examples of this can be seen in the attached DVD (excerpts 3 and 4). Their joy and involvement in this process then enabled them to relax and loosen their control over the musical interaction (Tomlinson, 2010). Especially with Nathan, who struggled to wait his turn, a small group game was quite challenging for him. He had to wait longer when there were more members in the game particularly when both his grandmother and grandfather attended the sessions. However, music could maintain a playful atmosphere, which motivated him to engage with others without feeling forced to do so. The musical games emerged from the children's interests and on their initiative. The children were allowed to choose the

instrument, and then I initiated it into conducting or turn-taking games. Turn-taking is able to promote the children's communication skills as it encourages the children to influence others in a positive way through music, and it provided chances to experience a flow of interaction involving repeated turns in musical conversation. The conversation could be sustained within the musical framework (Rainey Perry, 2003). The conducting game helped the children to increase their awareness and attention. Moreover the children could develop their confidence from being a leader (Woodward, 2004). At the same time they were encouraged to accept the game rules and to respond to other requests.

Step 3: From social games to speech development

Some of the carers wanted me to encourage their children to use more verbal communication. Music has been a useful tool in helping the children's speech development. It can motivate people with learning disability to use more verbal communication (Talkington & Hall, 1970; Walker, 1972). Nina and Aden enjoyed vocalising and in the sessions they were encouraged to use different vowels through singing. An example of this can be seen in the attached DVD (excerpts 5 and 6). Moreover, in Nina's case, she was invited to vocalise through imitating animal sounds and during imitating, she was encouraged to move along to match the animal sounds. The action songs also motivated the children to verbalise their actions. The movement made the songs more interesting to the children as the actions and movements can increase the meaning of the songs (Rainey Perry, 2003; Wimpory & Nash, 1999). The music, which was employed during the vocalisations, was adapted from her favourite song. Moreover, it was sung in a playful and exciting way therefore it could encourage her to vocalize along. In conducting games, Nathan and Paul learnt to use simple and short phrases to direct other people to start and stop playing. The repetition and simplicity in the songs enabled the children to anticipate their turn to direct others by filling in simple phrases in the song. Also the lyrics were always clear with simple structure such as start/stop and whose turn to play. Once the children were familiar with the songs, I would leave them space to say the signals. An example of this can be seen in the attached DVD (excerpt 7).

6.1.2 Patterns in the way the relationship with the carers developed

The findings show that the carers' involvement in the music therapy sessions with their children could have a positive impact on the whole process, both for the children and for the carers themselves. Throughout the process, I learnt that the relationship between each carer and me was developed in similar ways. However, I am also aware that each music therapist has different ways of working. Through the case studies I discovered that there appeared to be three clear phases in the development of my relationship with carers; I will explain what these are here in the hope that this might be useful to other music therapists working in this context.

Phase 1: Introduce music therapy work and myself to the carers

As I was new to the children and the carers, the carers were probably nervous and uncertain about what would happen and what they were expected to do in the sessions. I gave the carers an information sheet to explain my research the first time we met. I explained to them that we would play different kinds of musical instruments together with the children and allow the children to be explorative and have fun, in order to find different ways of engaging with the children. From that we could work toward individual goals such as improving social skills or verbal communication.

During the first phase, I mainly aimed to establish relationships with the children and hoped that the carers could see the benefit from their children participating in the sessions. For some carers, inviting them to engage in music making could make them feel uncomfortable, therefore giving them some settling-in time is important (Molyneux, 2008). It was important to emphasise to the carers that the main aim of having them in the sessions was to allow them to witness their children's joyful moments and they could decide later when and how they wanted to engage in the musical interactions. Therefore, in this period, I mainly worked with the children and did not ask the carers to participate in the activities directly, as is shown in the diagram below.

Although during this initial phase my aim was to encourage the children to engage with me in the sessions, building rapport with the carers was also very important. It was crucial to show that in this process I was open to hear their thoughts and they were very

high valued and fully listened to (Hornby, 1995; Walworth, 2012). Their ways of taking care of the children were respected. The children and their strengths were more focused (Walworth, 2012). Holmes et al (2011) suggested that in order to make the family feel valued and heard, staff should be available to the family when needed and generally respectful of the family's perspectives.

Also some carers appeared to be very anxious if their children were not being engaged with me so they tended to push their child by holding the children's hand to play the musical instrument, or did not give the child enough time to respond naturally. This could stop the children from engaging or gave the children a negative impression of the music therapy sessions. As for the children who struggled to engage with other people or to share attention, it is very crucial to provide chances to respond and to wait long enough for the children to respond (Rainey Perry, 2003). Therefore it was very important for me to keep reminding the carers that the children were not expected to "learn" or "to be able to follow directions all the time". Instead, I aimed to explore different ways to use music to engage with them; therefore the children could engage with me at their own pace and in their own ways. Moreover, providing chances for the carers to see me waiting and listening to the children's responses and trying to match their responses in order to extend it to be a more meaningful interaction could enable the carers to appreciate this as the way the children engaged rather than believing that they were being naughty (Loth, 2008).

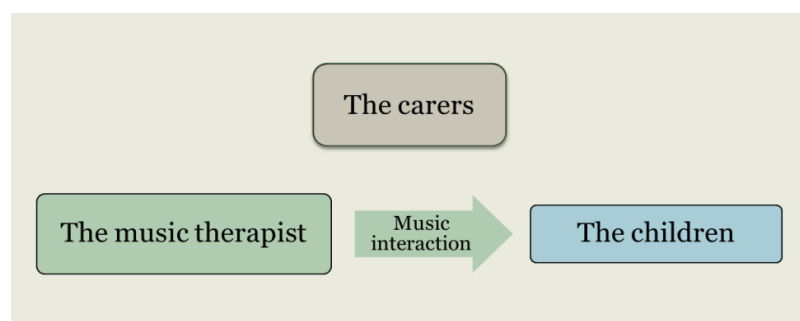


Diagram 1: Phase 1 Introduce music therapy work and myself to the carers

Phase 2: The carers joined in and provided input

In the second phase, I felt that the carers and their children started to be familiar with the activities and that they came to the session with the expectation that they would join in in some ways. I noticed that the carers started to know my signals so they could join in more naturally. They started to wait for the children to respond longer before playing for the children. I saw that the carers started to be more playful with their children. The carers started to extend their roles from passive participants who observed the sessions from one corner of the room to being active participants who engaged in the musical games with their children. I expected to work collaboratively with the carers, therefore in this phase I felt that I stepped down from my leading role a little bit in order to provide some space for the carers to join in and take some lead.

Moreover, I encouraged the carers to share their thoughts and take part in the therapeutic process more, rather than me taking the lead all the time. I wanted to balance power with the carers. The carers tended to believe that I was the expert and would know more than they did, and this was a challenge to getting their input. Also, being shy or reluctant to ask for favours, being humble, and not responding too quickly in interactions is considered polite and they are ways to gain social respect and recognition in Thai society (Chaidaroon, 2003). Thai people are taught not to reveal their emotions and to avoid open expression of their feelings and thoughts to others to prevent trouble, and to avoid challenge or confrontation (Pratomthong & Baker, 1983). However, these thoughts might not exist strongly in the young generation since western culture is getting more important in Thailand. It was still important to be aware of this character and give the carers time to feel comfortable and safe enough to make a suggestion regarding their children's therapeutic process. It is important to be open and emphasise the carers' ideas; even a small idea had to be acknowledged. Also when we agreed with the carers' suggestions, I turned them into action. From that acceptance and support from others, this could enable the carers to feel empowered and gradually play an important role in therapeutic process and development of their child's skills later on (Walworth, 2012). During this phase, the carers started to share with me their concerns regarding to their children's development, behaviour, and also their own personal concerns. Also they

gave me some suggestions of what the children liked to do and what they thought worked well with their children. As the carers know their children very well, they are willing to help. To be able to share the information and insight into their relationship with the children with the therapist, could enable the carers to gain confidence and to enjoy the positive abilities of their child (Twyford & Watson, 2008). This phase allowed me to learn more about both the children and the carers. Therefore, I could adjust the sessions and the expectations to match the carers.

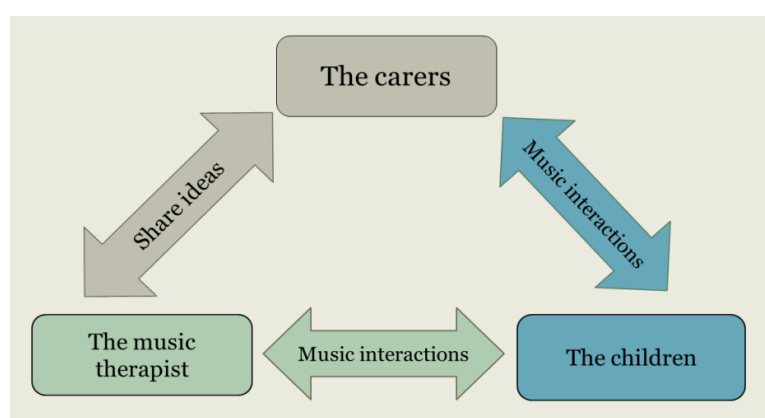


Diagram 2: Phase 2 The carers joined in and provided input

Phase 3: Let the carers lead and we work together

In the last phase, the relationship between the carers and me was firmly established. I saw them as part of the team. We exchanged ideas more often, both on the spot and after each session. I felt that we supported each other. Some of the carers did not only share with me their concern regarding the children in the sessions but also during the video reviewing process; they started to share with me the children's behaviour at home. When the carers' comments were employed in the sessions, the carers seemed to acknowledge their inputs. This enabled the carers to see themselves as an expert about their children who took part in this therapeutic process. When the carers and I reached this phase, I felt it was easier to work as we both supported each other and we were able to focus on nurturing the children's development.

I felt that the carers were willing to take more risks to try different things. They could respond to the music games or activities in the sessions naturally and appeared to be

more playful and childish with their children. They sometimes naturally took turns in leading both the children and me in the musical games. During this phase, I found the carers and I laughed together more often. They also appeared to have fun in the sessions with their children. They seemed to be more tolerant of the children being silly and noisy. I felt that I was a facilitator in the sessions to keep the interaction between all of us going. The carers just needed to be reminded that their children were allowed to be a leader in the sessions too. At this point, the carers only needed some space to explore their own creativity and encourage them to bring out their childishness and playfulness. They were able to take more control of the sessions such as choosing what they wanted their children to participate in, and made some comments on what should be included or emphasised in the sessions. Their feedback helped extend the activities and matched the children's needs and interests more. The carers devote their time and life to take care of their children and the more the children developed, I felt that the carers could have more hope.

The diagram below shows that in the third phase I positioned myself outside the cycle of the children and their carers' interaction, not only because I wanted to share power with the carers so we could work as a partnership, but I also realised that the level of the children's engagement depended very much on the carers' involvement and vice versa. I was aware that my practice was influenced greatly by the interactions between the carers and the children, not just the children alone or the carers alone. Although the children's interests and their needs are my first priority when I decided what intervention I should provide, I also expected intervention would affect the carers.

For carers, I always had in mind three main aims, which were to have a positive time together with their children, to witness the children's achievement so they could be more hopeful, and to explore a new way of engaging with the children; other aims would come later. Therefore, when I provided any intervention to the children, I always made sure that the carers could achieve these aims too.

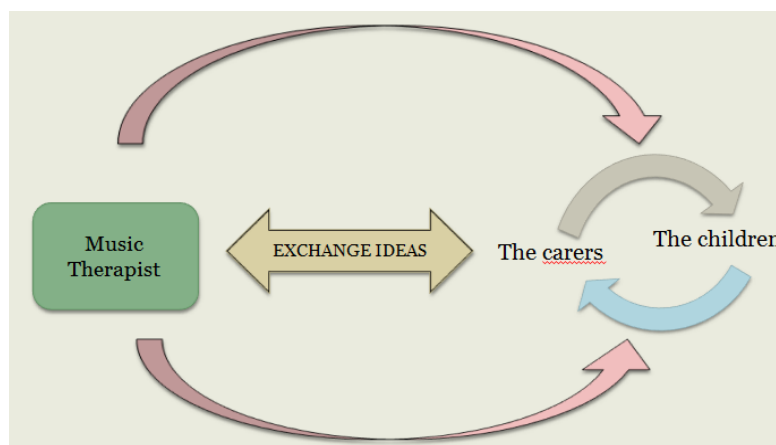


Diagram 3: Phase 3 Let the carers lead and we work together

This progression in three phases is a cyclical process. The carers and I sometimes returned to the previous phase. For example, in the third phase, the children appeared to respond well to the games and they were ready to move to a next level. So I introduced a new activity or added a new rule into the game in order to challenge the children to take a new step further or when the carers appeared to be tired and not very up to joining in. This made me take a lead more and let the carers observe and waited until they were familiar with the new games and ready to join in again. It is interesting that although the context of the study is different, the way I worked with the carers is similar to Oldfield's (2006a) approach in many ways. For example: the focus on what the children can do and are interested in doing, the empowerment given to the carers in having fun and the hope that the carers would pick up from the music therapy sessions some ways of communicating with their children in other contexts.

6.1.3 The different styles adopted by the carers

As I mentioned before, the carers' way of being in the sessions was influenced by the way I worked. From experience I found that the way carers were in the sessions fitted into several categories. However, some carers in this study did not always present in one way; instead their way of being developed all through the course of the study. These categories aim to provide some ideas of how to work with different carers, similarly to what Oldfield (2004) presented in her work and there are also some overlaps with her categories.

Shy and preferred to be an observer

The carers in this category appeared to be quite reserved in the first few months in the sessions. They tended to observe more than join in the activities. They kept themselves quite distanced from the children and me, as if they wanted me to lead and engage with the children directly. They seemed unsure of what they should do. Initially, I would not directly ask them to join in or rush them into the musical interactions as I felt that they would prefer to see what it was like in the sessions first. Also I thought that by giving a chance to the carers to see their children having a good time in the sessions, this would later encourage the carers to join in naturally. Additionally, when I invited them to join in the musical games, I wanted to make them feel that they joined in with their children not with me.

Supportive and willing to join in but without initiating their own ideas

These carers appeared to be relaxed and willing to join in the musical interactions. They closely engaged with and supported their children by clapping along and sometimes vocalising along with me. Although they did not initiate their own ideas, they naturally followed my musical cues and joined in. Sometimes they helped me to manage the children's challenging behaviours. I felt that these carers were not aware of how important their involvement was in the therapeutic process. Working with them, it was important to remind them of their involvement and giving compliments to their children created the safe and friendly environment, which could encourage the children to become more explorative. Although they did not participate very actively or initiate their ideas as much as some carers, in the sessions they were supporters and motivators. Their support could allow the children to engage. Also their feedback reassured me that what I was doing was suitable for their children.

Enthusiastic to participate and initiated their ideas.

This category could represent the carers who were enthusiastic, active and open to learn new things. At the beginning of the process all carers were reluctant and not sure of what they were expected to do in the sessions. Some carers became more relaxed and started

to be more confident in sharing their ideas. They appeared to take more control and it seemed natural for them to actively share their opinions with me. Examples of this can be seen in the attached DVD (excerpts 14 and 15). Working with them was very helpful for the children. I could encourage the carers to be a leader of the sessions in order to experience the use of music with their children directly so that they could have enough confidence in music and in themselves to be able to use music with their children at home.

6.1.4 The carers' roles in the music therapy sessions

The case studies showed that carers' involvements were very important to the children and the therapeutic process. All through the music therapy work I observed the different roles of the carers. Although the carers might unconsciously know what their roles are and how these affect the session, their presences in the sessions had so much impact on both the children and the music therapist. There were also some overlaps with what Loth described about the mother-child relationship which emerged in music therapy groups for pre-school children who have a learning disability and their parents or carers (Loth, 2008).

A secure base

The carers' presence reassured the children of being safe and secure. Therefore the children were enabled to feel more relaxed and this made it possible for the children to express themselves. Also when they felt anxious they could just turn to their carers to get support. Also the carers are bridges between the music therapist and the child. Some children found it was difficult to trust a stranger, but having the carers around, the children could feel safer in participating in the activities with the carers and me. Also, having someone they could trust in the session encouraged them to join in the sessions very effectively. For example in Aden's case, initially he did not want to engage with any musical game with me. He initially held his aunt's hand to pluck on the ukulele for him. He avoided direct contact with me. Having his aunt engaged in music-making with me first, reassured Aden that the music therapy session was safe for him to participate in.

A source of support

Every time the children turned to the carers and received feedback such as a smile, clapping or a cuddle all these meaningful expressions encouraged the children to engage for a longer amount of time. Examples of this can be seen in the attached DVD (excerpt 8). The children appeared to be happy to have support from two adults. Most of the children seemed to be enthusiastic to play music together. They seemed pleased to see their carers being playful and participating in their activities.

A bridge

The carers acted as a bridge, which connected the child and me. Initially the children preferred to follow their carers. They tended to be more interested in what their carers did. Instead of focusing on the children only, I turned my attention to the carers and waited for the children to re-engage with the carers and me later. Examples of this can be seen in the attached DVD (excerpt 9). Having the carers participate in the sessions could make the environment more familiar for the children.

A child expert

The carers could help me to understand the children more. They could interpret the children's signals and read their children's behaviour. They were often able to predict difficult behaviours which helped me avoid negative patterns of the behaviour. The carers also helped me to set the direction of the sessions. In addition, we regularly shared and discussed the children. The carers brought information from their observations of the children in the classroom and in the home environment so I was more aware of the children's overall needs. Their information influenced the way I ran the sessions, and the way I felt and thought about the children.

A band member

Having the carers in the session added more members to the music games. There were more people to play with and the children could learn to play in groups. The group play activities provided chances for the children to learn to take turns, learn to accept others'

suggestions, and learn to wait. They also learnt to share with another adult, other than someone in their family. Examples of this can be seen in the attached DVD (excerpts 10 and 11).

There were many times when we all interacted through music together which made me as if we also were musicians who listened to each other, accepted each other's ideas, and always communicated. Examples of this can be seen in the attached DVD (excerpts 12 and 13). In some cases the children seemed to be proud of being a part of the small creative work with adults and this also enabled them to gain confidence.

6.2 Main findings from the themes which emerged from the interviews

As explained in chapter 4, the semi-structured interviews with the carers were subjected to Interpretative Phenomenological Analysis. From this analysis, five categories of themes emerged. I will now summarise the main points in each category.

The first category shows **seven expectations, which the carers had for the children's participation in the music therapy sessions**. Their expectations are quite different from each other. Jan is the one who had more expectations than other carers, while Tam only had one expectation from music therapy for her nephew. To increase concentration and to understand signals and accept others' requests are most common expectations among six carers.

Themes under the category of **The carers' experiences of seeing their children in the music therapy sessions** show what changes (or development) in the children the carers witnessed after participating in the therapeutic process together. From seven themes under this category, four were related to the children's development of social and communication skills. It appears that the effect of music therapy on the children, which emerged from the interviews, is consistent with the findings in the case studies. The carers reported that their children vocalised and used more verbal communication, understood signals and accepted other's requests, had more interests to engage with others and became less shy and expressed their needs. These findings are similar to many previous studies and anecdotes, which recommend that music therapy with families is an effective intervention in developing social and communication skills in

children with special needs (Abad & Edwards, 2004; Chiang, 2008; Gilboa & Roginsky, 2010; Loth, 2008; Nicholson et al., 2008; Oldfield, 2004; Twyford & Watson, 2008; Warwick, 1995; Woodward, 2004).

Themes under **The carers' experiences of seeing themselves in the music therapy sessions with their children** category show that the carers were positively influenced by participating in the music therapy sessions with their children. They all reported that being in the sessions with their children allowed them to have a good time and good experiences together and this replicates the results from the previous studies (Gilboa & Roginsky, 2010; Loth, 2008; Oldfield et al., 2003; Oldfield & Bunce, 2001; Twyford & Watson, 2008). The carers said that to witness their children's enjoyment could lessen their worry and this finding is similar with earlier studies (Archer, 2004; Ayson, 2008; Chiang, 2008; O'Neill & Pavlicevic, 2003b; Shoemark, 1996).

Also the carers involving in the sessions encouraged the children to engage in the sessions more. From the interviews, the carers stated different ways they encouraged their children to engage. Some carers reported that when they gave praises or sang along with the children, the children appeared to be more enthusiastic and this enabled them to be more confident to engage in the sessions. Some carers said that their engagements in the music making encouraged the children to join in the sessions because sometimes the children were shy of a new person. So having the carers engaging in the sessions allowed the children to play with the carers first until the children were more familiar and ready to engage with another person and this finding is consistent with previous literatures (Loth, 2008; Woodward, 2008) which suggested that the parents could help the child to form a new relationship with a new person. Moreover, one of the carers stated that she knew the child very well so that she could help the music therapist manage the children's challenging behaviours.

Some carers reported that they found themselves motivated to engage more with their children. They stated that seeing the music therapist successfully engaged with the children encouraged them to experiment with different ways to engage with their children. This result is supported by previous studies (Davies, 2008; Hibben, 1992;

Horvat & O'Neill, 2008; Howden, 2008; Oldfield & Bunce, 2001; Thompson, 2012). Moreover with the music therapist's support, the carers could be motivated to engage with their children (Drake, 2008; K. Lindenfelser, 2005).

The carers felt that they could work in a partnership with the music therapist toward the same goals. Some carers reported that the music therapist was open and accepted their opinions. They felt that they could learn what the music therapist thought about their children and this enabled them to share their thoughts. This finding is consistent with the early studies which suggested that having the carers in the process provided chances to both the carers and the music therapist for joint thinking (Horvat & O'Neill, 2008; Oldfield, 2008; Woodward, 2008).

Some carers reported that being involved in the music therapy sessions enabled them to see the children in a different light and to give them more hope and this result replicates the previous studies (Alvin & Warwick, 1991; Oldfield & Bunce, 2001). The music therapy sessions provided many chances for the children to show their abilities more than focusing on their disabilities (Loth, 2008). When the carers could recognise more of the children's strengths, the carers were able to move on from dysfunctional patterns which stop the children from healthy grow (Elman, 1991)

There are three themes under the category of **The carers' experiences of reviewing the video recordings from the music therapy sessions**. First theme shows that the video reviewing provided good memories. Some carers stated that both the children and they found it was amusing to see themselves in the video excerpts. They also reported that they could see their children's abilities from reviewing the videos. This result is supported by Oldfield et al. (2003) which presented that reviewing the video excerpt allowed the families to be pleased with their children's changes. Moreover, after all the treatment process had finished the carers were given a DVD that included various meaningful moments from the sessions. The carers said that the video excerpts could also share the good moments to other members in the family. Moreover, the carers felt that when the parents saw the videos they also had more hope and became more enthusiastic about engaging in their children's activities. This finding is supported by

Davies (2008) which suggested that the DVD enabled the music therapy to be effective both during the therapy itself and also outside the sessions in the families' lives. Also it is similar to the music therapy work with adolescents by Derrington (2012) which one of her student who has chronic illness reported that the video excerpt allowed her mother to see her doing something else and not just being ill.

The second theme under this category shows that the video reviewing enabled the carers to change their opinion toward their children and themselves. The carers reported that the video reviewing allowed them to see what they were doing in the sessions and understand their children's responses. Therefore, they could adjust what they did in the sessions to use in the home setting. This is supported by Holmes et al (2011, p. 96) which suggested that *"watching a video also allows parents to take a step back from their face-to-face interactions with their child and to reflect on their interactions, both what the child is doing but also how their own behaviour and emotional tone are affecting the interactions"*. Moreover from reviewing the video, the carers said that they could see themselves engage with their children differently.

Another theme under this category is the video reviewing allowed the carers to see their children's responses and their interactions in more detail. The carers reported that from the video, they could see how their children responded more clearly than in the sessions as during the sessions they were busy engaging in the activities with their children. In addition, after the project had finished the carers reported that they could watch the DVD in order to review the sessions again and looked for ideas they could apply in home situations in order to maintain the use of music.

This study explored how the music was used after the treatment process had completed. A major finding under the category of **the carers' experiences of using music at home** is the changes in using music at home after participating in the music therapy sessions. The findings under this category are similar to the previous studies that providing good experiences and support for the children and their carers could encourage them to bring some activities back to home environments (Abad & Edwards, 2004; Archer, 2004; Chiang, 2008; Shoemark, 1996; Thompson, 2012). The carers reported that their

children responded and showed more enthusiasm to engage in simple musical activities at home. Also the carers stated that they were aware of their children's musical initiations more therefore the carers could respond back and extend the signals more effectively. Moreover, the carers said that when the children brought the music home, this allowed the rest of the family to join in and created a good atmosphere in the family and brought the carers and their children closer. These findings are similar to the previous work which suggested that music intervention at home could motivate the children to communicate and encourage the joint attention between the children and the rest of the family members (Walworth, 2012).

According to the interviews with the carers, using recording, singing or moving along with the music are common ways that the parents' normally engage with their children, which are similar to previous studies (Abad & Edwards, 2004; Chiang, 2008; Shoemark, 1996; Thompson, 2012). However, the carers still reported the limits of their uses of music. They mentioned that the lack of their music skill could be a barrier to maintaining the use of music at home. Their concern about their music skills are similar to Walworth's (2012) common myths surrounding why parents may hesitate to sing with their children. She reported that some parents felt that no one wanted to hear them sing or they never remember all the words to the song, so it was hopeless to try and sing. Moreover, some carers agreed that visiting the children at home allowed the music therapist to gain more understanding about the children and one carer in this project, stated that the visits encouraged her to use music with her nephew more as she wanted to show his improvement when the music therapist visited them.

6.3 Additional observations from the clinical work

6.3.1 Challenges arising from involving the carers in the sessions

Although the carers in the centre were familiar with participating in the children's activities, they appeared not to be very familiar with being in the sessions individually with the therapist and their child. Some carers initially thought that they were barriers for the children to engage with a new person. For example, in Aden's case, his aunt, Jan, initially wanted Aden to attend the sessions by himself because she was afraid that Aden

would feel forced to do things or engage in the sessions. Also she wanted Aden to be independent from her, as he was always shy with new people. Similarly with Pita who appeared to be attached to his aunt, Tam; she mentioned in the interview that she was concerned that when she was in the sessions, Pita was always clingy and did not want to engage in anything. These challenges made me think to what degree the carers' involvement was suitable in individual music therapy? Would having less carers' involvement allow the process to be more effective?

In this study, the carers were encouraged to be involved as much as possible. The carers were asked to attend every session. However, the carers were free to decide when and how much they wanted to participate in the musical interactions. Nevertheless, it was my aim to make the carers feel interested in joining in, and in creating sessions that were suitable for both the children and the carers. From the experiences of working with the carers during this project, I believe that the work with the carers itself can be challenging during the first period. However, once the carers and I became a team and I was able to find suitable ways to work with each carer, the carer's involvement could largely empower the work of music therapy with the children. When the carers and the children found ways to interact through music, the carers could bridge between the children and the music therapist. To go back to the two examples in the previous paragraph, when the carers and I took turns being a music partner with Aden and Pita, this enabled the children to gradually increase their interactions and communications with me and become less clingy with their carers and this allowed them to form a new relationship with a new person (Woodward, 2008). The carers were an important piece of the jigsaw that I had to find a right place to fit in the whole picture. The carers' suggestions, their parenting style or relationship with their child led the way to find the right place to put the jigsaw together.

6.3.2 Music therapy in the special education centre

The teachers and staff at the centre acknowledged the value of music. Music was used widely in the classroom. The teachers normally sang a greeting song before the class started. Also recordings were used to accompany physical exercises and were used to encourage the children to move and copy actions, and in other cases recorded music was

used to calm the children down. Therefore the teachers and staff had positive feelings about music therapy. They seemed to be enthusiastic to refer their students to the music therapy. From informal conversations with some teachers, I found that the teachers believed that the music could help the children to regulate their mood and to be relaxed. They also believed that the children and carers could share positive moments together in the music therapy sessions. As the teachers had a heavy workload, I did not have many chances to discuss the children's care plans with them and could not work collaboratively with the teachers during this study. I learnt that there were some similarities between the teachers' approach and my music therapy approach. Importantly, this centre emphasised the value of family's involvement. They encouraged the carers to engage in all activities or classes with their children. They provided educational material for the carers to use at home. Although the classroom and the music therapy sessions were conducted differently, the experience of being in the classroom allowed the carers to be familiar with participating in their children's activities. The carers could bring games, songs or other materials they had learnt from the classroom to share with me in the sessions. Moreover, the carers seemed to relate their children's progress to the Individual Education Plan (IEP) goals, which were set by the teachers. Therefore, the carers were able to share the children's development and what the children were learning. This enabled me to integrate what the children were learning in the classroom into the music therapy sessions. Besides the family involvement during the daily activities, staff from the centre visit the children and their families at home during the holidays. They aim to support and create a learning environment for the family as well as to follow up and evaluate the children's progress in their homes. I therefore felt that the centre's philosophy supported the music therapy work, and this particular project which involved carers and home visits. Evidence of this support is that the centre has suggested that music therapy continues in the future at the unit and is now prepared to fund this work.

6.3.3 Transferring a western-influenced music therapy approach to the Thai context

During the setting-up period, I observed in the classrooms in order to learn about the referred participants and to become familiar with the centre's routine and educational material (such as activities, songs and games). I learnt that the teachers mainly led the class, and the carers were therefore familiar with a directive style, in which many structures were suggested by the teachers. This is different from the music therapy sessions, where children are normally free to do things and there were not many directions or rules. In fact adults sometimes become their followers instead of their leaders. This made some carers anxious when they participated in music therapy. I felt that the carers related my role at the centre to that of the teachers', and expected me to be directive. They struggled to respond to this non-directive approach. The carers also may have felt that this therapeutic process was not efficient because they did not receive direct advice (D' Ardenne, 1999). They wanted to give me the authority to decide what to do in the sessions with their children. This is different from the western context where parents of clients usually take control of their life by making their own decisions and having an active role in their own treatment plan (Bates & Linder-Pelz, 1990). The carers in this study have very high regard for teachers and my suggestions and they did feel comfortable negotiating with me as the professional. This is similar to the findings in Pongsakri's study (2004) which she stated that *Thai clients believe in health professionals, readily rely on them to treat diseases, assume they know the best way to manage the problem, and therefore do not express their own views about their problems (p.205)*. In some ways it was good that the carers took my advice very seriously and tried to follow the structures in order to help their children to develop. However, the carers could be too dependent on the professionals' suggestions and it was then hard for them to increase their confidence in their own parenting skills. Also, it was a challenge for me to know if my suggestions were really suitable for their children or their situations outside of the music therapy session. I consider the carers' experiences and opinions very important because they know the children better than me as they spend more time with the children and they support the children in various situations. So

without the carers' input, it was challenging to develop a therapeutic process to suit the children and the family's situations.

In addition, Thai people tend to avoid confrontations and they are not encouraged to reveal their emotions. Influenced by Buddhism, Thai people value the ability to control their facial expression, and their verbal and physical expressions. In a conflict situation, Thai people withdraw or stay calm rather than show aggressive behaviours (Sethabouppha & Kane, 2005). This is similar to the way Thai mothers of mentally ill children cope with their children. When their children show negative behaviours, the parents tend to be patient, speak gently and distance themselves from the situation (Rungreangkulkij & Chesla, 2001). The lack of negotiation between the family and the professional made it more challenging to establish partnership and it could lessen the family's involvement. It is necessary in this setting to give the carers some time to feel familiar with this less structured practice. Showing respect for their opinions is necessary in order to gain their trust and let them feel safe enough to share more of their own opinions. At the beginning I give some clear directions to reassure them but also tried to bring out and value their ideas and gradually give them opportunities to direct and lead as much as possible.

As it shows in this study, not only the parents, but also other family members such as the grandparents and aunts play an important role in taking care of the children. It is vital in this setting to be aware of the source of support from the extended family and their needs. Thai people put very high value on being able to take care of family members with illness or disabilities. Influenced by Buddhist teaching, Thai people believe that each family member has an obligation not only to take care of him/herself but also has to take care of others and share responsibilities with other family members (Payutto, 2003; Pongsaksri, 2004). On the other hand, people in western culture are likely to be more independent and look after themselves and their immediate nuclear family (Hofstede, 2001). In this study I initially aimed to work with the children's parents, however all the children who were referred to me were accompanied to the centre by other family members such as their grandparents and their aunts. Among the six children, only Mark lived with his parents and his grandmother while the other five children lived in another

town to their parents. These children lived with their carers and their parents come to visit them during the weekends, long holidays and term breaks. Some carers took over the parents' role because the parents themselves were very busy with work. The children were therefore separated from their parents. The parents felt this separation was justified because they could not afford to stop working, but felt that their child with special needs would get better care in a big town. Therefore the extended family takes the primary role to take care of the children while the parents support the children and the carers financially. During the home visits I also found that some parents blamed themselves and struggled to engage with their children because they felt that they had failed at being parents. I realised that while I was meeting the carers' needs, I was not able to address the birth parents' needs. The nature of this study meant that my focus could only be on the carers in the sessions with the child. Encouraging the child and their carer to have a good experience together not only strengthens the relationship between them but it could also nurture the relationship between the birth parents and the children, similar to the case of the children who live with foster parents. *A responsive foster parent can offer a child a chance to learn and strengthen the development of secure attachments as well as his sense of relating to others* (Temple-Plotz et al., 2002, p. 10). It is important for the foster parent to create an environment for the child to feel safe enough to develop attachment with them and this could lead the children to learn to trust and be able to build relationship with others (ibid). Furthermore, the finding from this study also supports the argument that a child can have more than one attachment figures, although his/her mother is always the primary one (Music, 2011). However, the children in this study seemed to have their aunts or grandparents as a primary attachment figures and, *"the children benefit from consistent, positive, warm, and ongoing relationships with stable figures who provide security, safety, and stimulation and who are interested in their minds and emotions"* (p.158, ibid).

Each carer decided to take responsibility for the children for similar reasons. All the carers empathised with and pitied the children and their parents. Some of them were concerned that if no one took care of the children, how would the children survive in the world? Also the carers believed that people outside the family would not be able to take

care of the children as well as people in the family. Out of the six carers, only Paul's aunt, Rita, was asked to take care of Paul. The rest of the carers volunteered to take care of their nieces, nephews or grandchildren. From the interviews or during our discussion in the sessions, they never mentioned that taking care of their children was a burden or appeared to regret taking these responsibilities. Thai people perceive taking care of a loved one with an illness as an integral part of a caregiver's life (Meecharoen et al., 2013). Moreover, bonds and trusts, which already exist among the family members, enabled the carers to sacrifice and have patience to take care of their niece, nephew or grandchildren. From the interviews, the carers reported that their happiness was directly influenced by their children's joy and development.

Some of the carers themselves also felt isolated from the family, as they had to live alone with the children with not much support from their family. Some carers needed more input and support from the child's parents and felt that the child was left out from the rest of the family. These carers become like single parents. They were exhausted and felt they could not respond well to the children all the time. They felt the children should have other family members to stimulate them to communicate or to help them get outside of their own world. It was vital to encourage these carers to acknowledge their contribution to the children and their family. Having a positive experience with the children could provide courage and hope to get through the difficult times. When I was working with the carers I considered them as the parents of the child and they enjoyed being given this role. They were involved in the children's life in all aspects. The children had a very close and strong relationship with their carers. However, I had to remember that these experiences or the children's progress should also be delivered to their parents. It was important to find a chance to communicate with the children's parents during home visits, giving them a DVD of music therapy excerpts and encouraging the use of music at home could deliver a positive experience to the rest of the family members.

Music in Thailand today is very much influenced by western music. Thai people can easily access all kinds of media from around the world via the internet, television or radio. All through the course of this study, I did not employ Thai traditional musical

instruments because the children tended to be more familiar with western musical instruments. In addition, Thai children songs have been adapted from western children's tunes. Therefore, the music resources I developed during my music therapy training in New Zealand were easy to adapt the children in this context.

6.4 Answers to the research questions

This information confirms data from the literature review, the case studies and the Interpretation Phenomenological Analysis of the interview.

Research question 1) Can music therapy help to achieve aims set out for individual children with special needs and their carers?

From my clinical notes, video reviewing, and the interviews of the carers I could see each child who participated in this study, achieved their individual aims in these four categories:

- All the children who participated in this study developed their social and communication skills
- Nina, Aden and Mark developed their motor skills
- All the children except, Mark developed their learning skills such as increasing concentration
- Nina, Nathan and Paul could regulate their moods

The music therapy helped the carers of the children involved in the project in following ways:

- All the carers had positive experiences with their children
- All the carers except Pat were more enthusiastic to engage in their children's activities
- All the carers except Rita had chances to work in a partnership with the music therapist
- Jan, Pat, Tam and Bam witnessed their children's achievements. This then enabled these carers to see their children in a different light and have more hope of their children's development

While this is a positive result, we cannot be sure that the progress made is definitely because of the music therapy intervention. It could be argued that the children might have made progress as a result of natural development. It is also not possible to say that other children would necessarily benefit from music therapy. In order to generalise these results and ascertain that music therapy is effective, it would have been necessary to have a control group of children similar to those in this study, not receiving music therapy, to make a comparison.

Research question 2) What are the functions of music therapy in nurturing communication between carers and their children?

According to the diagram 3, I summarised the main functions of the music therapy in nurturing communication between carers and their children by saying that;

- Music therapy provided a safe and friendly space to explore and experience new ways of interacting to each other through music
- Music therapy provided an opportunity for both the children and their carers to lead, follow and interact together
- Music therapy created a playful environment which supports carers and the children through music while the carers lead or interact with their children
- Music therapy allowed carers to re-direct the focus on the children's abilities or their positive behaviours, rather than dwelling on their difficulties

Research question 3) How can the music therapist develop ways in which carers can use music to help their children?

This study indicates that from the music therapy sessions the carers could pick up ways of interacting with their children. Importantly, the experiences in the music therapy sessions during the course of this study enabled the carers to feel confident to use music with their children in and outside the sessions. According to the positive outcome from the music therapy sessions, the carers were more aware of the music's value and felt more relaxed to use music with their children. From this study, here are important

guidelines that might be useful to a music therapist to develop ways in which carers can use music to help their children. The music therapist should:

- Provide the carers with various chances to witness how the music could motivate the children to positively engage with the music therapist. The carers could then become more enthusiastic to join in and to transfer the experiences to the home settings
- Allow the carers to observe how the music can be used differently to interact with their children
- Encourage the carers to experience different ways to interact with their children through music and support the carers to take a leading role in the sessions with the music therapist's support in the contained and non-judgmental environment
- Simplify the musical interactions and incorporate music into the children's routine
- Emphasise to the carers the goals for using music with the children such as increasing interactions with their children and increasing the use of verbal communications
- Create DVDs of meaningful moments in the music therapy sessions in order to remind the carers and their children how they interacted through music
- Provide the carers with some examples of simple ways of using music in the home setting
- Review the video with the carers and show how the children responded well to the carers' musical signals. Also the carers will witness themselves engaging well with their children which will enable them to become their own role models

6.5 Limitation of the research process

Although I have previous experience of working with children with special needs, I was very new to working with children and their carers in the music therapy sessions. This was also my first time conducting research at this academic level. I was learning through

doing this research, therefore the findings have their limitations. Nevertheless, this study was planned and conducted very carefully and thoughtfully. In this section, five limitations to the research process are considered;

Small number of research participants

Six families participating in this study could be considered a small number. A larger study would have provided more opportunities to learn from different viewpoints and it would have allowed the possibility of other themes emerging. The findings from such a small number of research participants did not allow for generalisability or representation of the general views of other carers in different contexts. However, the data from six participants was sufficient for this study, which aimed to present the individual's experience in a specific context. Readers may see similarities to their own situations and could compare the relevance of the findings to their own circumstances.

Translation

All the interviews were conducted in Thai. English and Thai grammatical structures are different therefore it was challenging to convey the exact and full meaning and feeling from the carers to the readers of this thesis. The translations possibly were influenced by my interpretations so the readers are not able to receive the messages directly from the carers. However, translations were done very carefully by me as a researcher. I made sure that the quotes represented the carers' stories as faithfully as possible, even if occasionally there were changes in sentence structures. Interviews from two carers were fully translated (Appendix 10) in order to demonstrate the interviews analysis and also to give examples to the readers of the overall experiences of the carers. However, time limitation has meant that only two lots of data have been translated.

Semi-structured interview with Thai carers

The semi-structured interviews in this study were quite different from the semi-structured interview that the IPA (Eatough & Smith, 2008) had suggested. The IPA suggested that the researcher should provide a broad structure for the interview in order to allow the interviewees to express their thoughts and feelings freely about their

experience. The interviewer was expected to just facilitate the interview but not to control the direction or structure of the interview (Willig, 2008). The interviewer had to allow the interview to be led by the interviewee. However, Thai carers appeared to be not very familiar with this kind of interview. According to the two pilot interviews (3.4.7), which were conducted with the carers who did not participate in the study but had the music therapy sessions with their children, I found that they tended to answer with short responses and it seemed difficult for them to respond to these open-ended questions. They appeared to be reluctant to express their thoughts without specific questions possible because in Thai culture it would be unusual to express an opinion without being asked to do so. In order to help the carers feel more comfortable and engaged in the interviews, I changed my semi structured interview guideline to be more structured and gave more suggested questions to the research assistant to use during the interviews.

However, the research assistant adapted the interviews to match each individual the situation at that moment and did not have to ask the exactly same questions in the same order with every carer. This lack of standardisation of the interviews, which was necessary to enable the project to be more flexible, could lead to concerns about reliability.

Research assistant

It was important to have a research assistant to carry out the interviews so that carers did not feel they should say polite things to please the music therapist. However, the disadvantage of having a research assistant who did not know the carers well was that the carers possibly felt uncomfortable about sharing their opinion and personal experiences with someone they had not built up a previous relationship with. Especially when I had to find a new research assistant after finishing the first interview because she found a new job and her work hour did not allow her to conduct the rest of the interview. However, in order to keep the continuity between the first, second and third interviews, I explained the new research assistant about my project and asked her to listen to two pilot

interview recordings before conducting the interviews. Moreover, I gave to her a set of guideline questions.

Interpretation – Lack of the researcher's experience

The nature of the Interpretative Phenomenology Analysis approach emphasises that the ability to understand the participant's experience depends on the researcher's ability to conceptualise and make sense of the participant's personal world through a process of interpretative activity. My lack of research experience could therefore have limited the results of this project. However, numerous efforts have been made to thoroughly review the interview transcriptions and to consult closely with my supervisors in order to strengthen the findings.

The researcher's bias

I took two roles during this study which were that of a researcher and that of a music therapist who ran all 24 music therapy sessions with the children and their carers. So the relationship between the children, the carers and myself developed during the study. My involvement while we were in the music therapy sessions could influenced the way the carers felt and understood their experiences during the course of this study. In addition, it was impossible to completely separate my thoughts, feelings and understanding toward the carers and the children while I was doing the data analysis. Therefore, the results of this study are possibly biased by my feelings towrd the children and their families. However, by being aware of my double roles in this study, consulting with my supervisors and recording my ongoing thoughts, I was able to minimise these bias.

The lack of control and experimental groups

This study is a qualitative research study which mainly looks at the process of involving the family members in the music therapy sessions with their children with special needs so it does not aim to test the effectiveness of the music therapy intervention. From reviewing the case studies and the carers' interviews, I outlined the positive results regarding the benefits which the children and their carers gained from participating in the music therapy sessions in this study. However, it cannot be said definitely that the

results were solely influenced by the music therapy intervention. It was possible that the positive changes in the children could have been caused by their natural development. Also the carers' feedback about being more enthusiastic to engage in their children's activities, seeing their children in a different light and having more hope about their children's development, could be a result of experiences other than music therapy. In order to test the effectiveness of the music therapy intervention, I would have needed a comparison control group of children similar to those included in the study who did not receive music therapy.

6.6 Future research

Undertaking this research brought up many questions and ideas, which could be developed into other studies. Here are some suggestions for further research investigations:

Involving the teachers and other members of the disciplinary team more in the music therapy process

When I did my clinical work in the special education centre in Thailand, I learnt that the teachers had a huge influence on the children's families. There were some children who had attended the centre for more than two years and whose families had a good relationship with the teachers and trusted them. In addition, the teachers showed interest in the music therapy work. It would be very encouraging if the teachers could be part of the therapeutic process and help the carers maintain the use of music. One way of doing this would be to invite the teachers to attend a music therapy video review, with or without the carers. To incorporate the teachers' opinions would strengthen the process and enable the carers and the teachers to work together in different situations. Seeing the children and their carers in the music therapy sessions would enable the teacher to see the children and their carers in a different light and possibly provide the music therapist with new ideas on the children's involvement in music therapy. Working collaboratively with the multi-disciplinary team can allow each professional member to support and learn from the others. In addition, as music therapy is still in an infant stage

of development in Thailand; involving other professions in the therapeutic process will allow other professions to understand music therapy.

Maintaining the use of music outside the sessions

It is obvious to me that the children responded positively through music in the music therapy sessions. It would be interesting to learn whether and how these positive effects from the music therapy sessions lasted, in the classroom or in other contexts, after the treatment process finished. A future study could involve interviews with teachers or members of the multi-disciplinary team. The immediate effects of music therapy, as well as longer term effects could be evaluated in this way.

Impact from the use of music at home

From the findings in this study, children and their carers used music differently after they participated in the music therapy sessions. The carers and the children gave more value to music-making in the home and showed more interest in engaging with music activities at home. It would be interesting to carry out further home visits a year after the music therapy intervention to find out whether this extended interest was maintained. In addition, it might have been useful to carry out home visits before and during the music therapy sessions, to extend the trust and working relationship between the music therapist and the families. Pre-treatment home visits would also have enabled the music therapist to make a clearer evaluation of how music was used in the home before the intervention started.

As mentioned in the literature review, there is evidence to suggest that music therapy interventions in the home can be effective (Thompson, 2012), so home visits by the music therapist might well have enhanced the effectiveness of the work within the educational settings.

Music therapy and families in other context

It would be interesting to research music therapy and children with their families in a different context such as in a paediatric ward. It would be very interesting to see how the

children in a paediatric ward and their parents or carers would respond to music therapy and how to adjust the approach to be suitable for this setting and client group. From my experience in the paediatric ward, the family of the children are always on the ward in order to give the children comfort in a distressing situation, especially for a young child. Most of the family wanted to be involved in their child's care in some way such as basic care, technical care, seeking information to help improve their child's care, and emotional nurturance (Pongjaturawit & Harrigan, 2003). Music therapy would address the needs of both children and family in this type of setting both in Thailand and elsewhere in the world.

6.7 Personal reflections

Conducting this project has affected me immensely. This research has been an opportunity for me to improve some personal skills necessary both in music therapy work and in other aspects of my life. As I have been an international student living abroad, I have sometimes struggled to live in the western environment. Everything that has happened in my new environment has served as a learning experience. Living outside my comfort zone and having freedom from cultural expectations, did not only allow me to grow and become more independent but also enabled me to learn and explore myself and my beliefs. Since I have lived abroad, I have been learning to understand western culture and adapted myself into this context. There were many occasions when I observed how people in this context think and respond to things differently from me. These occasions made me compare and question my own responses. Sometimes I asked myself what influenced me to think and respond in these ways. This allowed me to be an outsider looking back on myself. The self-reflection process helped me to adapt to differences and become more open-minded to accept the differences in others and also in myself.

For example, when I first came into this context and saw elderly or people with special needs go outside by themselves, I felt sad for them that they did not have anyone to take care of them. Also I wondered why their families let their family members struggle by themselves. Later I learnt that Western culture puts more value on self-sufficiency, freedom, and independence. They were encouraged to take care of themselves. While in

non-western culture there is more focus on interdependence. We were taught that our lives are related and involved with the lives of others. Consequently, helping each other is valued as a good action or a moral obligation (Triandis, 1995). Moreover, when I saw people give comments and questions in conferences or seminars, these events encouraged me to have a different perspective and to think in new ways. Initially, it was shocking for me to hear different music therapists openly criticising one another. However, I realised that the process of arguing or disagreeing could lead to new perspectives and enable people to explore several solutions to individual question. Usually the criticism was not personal or destructive.

Undertaking a PhD is a very stressful process because, as I mentioned earlier, I am new to conducting research at this academic level. All through the research process I have been intimidated by big words, big theories and complicated research processes. I have doubted my capability to undertake this study and at times felt insecure and powerless in supporting my own study. It has been very difficult to rest my mind from thinking about the research even when I have wanted to do so. I have often felt very weary, and this situation has enabled me to relate to the carers' feelings who have children with special needs. They have to devote their time and energy to take care of their children. In some ways it is difficult to compare these two different things, however, undertaking this project enables me to get some sense of having a big responsibility and challenges to manage every day. During this period of time, it has been important to be able to take care of my mind and cope with feelings of stress, in the same way that it is important to look after oneself as a working music therapist.

Although there have been many stressful moments on this journey, I have found myself feeling well rewarded every time I have managed some things or achieved in some way. This occurred especially when I had to work with children with special needs who may not change in big ways, but where even small improvements could be very rewarding for me as a music therapist. I strongly believe that some of the skills I have been developing are very important for me as a music therapist and that these skills are still developing along with my learning process every day.

Being involved in this research project has left me with enthusiasm to conduct more research. As I mentioned above, this research has brought out many questions, which I hope I may find the answer to in the future. This study has also been a good starting point for me to set up music therapy work in Thailand as I have gained some confidence in setting up a music therapy service for children with special needs and their families. The feedback from the carers and the enthusiasm from the teachers have enabled me to see the potential of music therapy work in this context.

Conclusion

This investigation is unique because it is the first music therapy PhD involving music therapy treatment in Thailand, the first study to investigate children receiving music therapy with their extended families and to my knowledge the first research project into music therapy with families in Asia. So far it is the only study which has combined music therapy family work both in an educational setting and a home setting.

The findings from this study show that the family involvement positively influenced the children, the families and music therapeutic process, and this is consistent with the existing literature. Moreover, these findings contribute to the body of literature by explaining how music therapy could support children with different needs, in developing social and communication skills in three steps (namely Step 1: From isolation to joint attentions, Step 2: From joint attention to social game and Step 3: From social games to speech development). The study presented here also expands upon previous studies by explaining how the music therapist and the family members develop their relationship into a partnership by going through different phases. It also explained how their partnership empowered the children's development and strengthened the relationship between the children and their family members. This led to the creation of guidelines regarding how to work with parents, or other family members, and to help them use music with their children in the home environment.

This study was conducted in an educational setting in Thailand, which is quite different from the Western contexts of the previous literature. One of the important differences in this study context was the closeness in the family members and a focus on

interdependence, which allowed the family members such as an aunt or grandparent to take a role as a primary carer. Therefore the results from this study can formulate a platform for developing music therapy approaches with children and families in a Thai context.

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APPENDICES

Appendix 1 Ethical Approval Letter

Pornpan Kaenampornpan
Room 244 Peter Taylor House
East Road
Cambridge
CB1 1PT



May 2011

Dear Pornpan

Project Number: RESC082
Project Title: The inclusion of parents in music therapy sessions with their children in a special needs school: how does this help the child and the parents?
Principal Investigator: Pornpan Kaenampornpan

Thank you for supplying revisions to your ethics application in consultation with your Sponsor Dr Stephen Moore.

The Chair of Research Ethics Sub-Committee (RESC), acting on behalf of the Committee, has now agreed to grant ethical approval for your research. Under the terms of Anglia Ruskin University's *Policy and Code of Practice for the Conduct of Research with Human Participants* approval is for a period of three years from 18 May 2011.

Your research should start within 6 months of the date of this approval. If it does not, you need to refer back to the ethics committee.

It is your responsibility to ensure that you comply with Anglia Ruskin University's Policy and Code of Practice for Research with Human Participants and specifically:

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these changes until you have received approval from RESC for them.
- The procedure for reporting adverse events and incidents.
- The Data Protection Act (1998) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the RESC Secretary copies of this documentation.
- Any laws of the country where you are carrying the research out (if these conflict with any aspects of the ethical approval given, please notify RESC prior to starting the research).
- Any professional codes of conduct relating to research or research or requirements from your funding body (please note that for externally funded research, a project risk assessment must have been carried out prior to starting the research).
- Notifying the RESC Secretary when your study has ended.

Information about the above can be obtained on our website at:

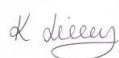
<http://web.anglia.ac.uk/anet/rdcs/ethics/index.phtml>

Please also note that your research may be subject to random monitoring by the committee.

Please be advised that, if your research has not been completed within three years, you will need to apply to our Research Ethics Sub-Committee for an extension of ethics approval prior to the date your approval expires. The procedure for this can also be found on the above website.

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely



Kimberley Lilley
Executive Secretary, Research Ethics Sub-Committee

T: +44 (0)1245 493131, ext 4211
F: +44 (0)1245 684212
E: Kimberley.lilley@anglia.ac.uk

cc Sponsor
Supervisor(s)
Faculty Secretary
FRDSC Secretary (if PhD Student)

Appendix 2 Participant Information Sheet for Parents or Family Members

PARTICIPANT INFORMATION SHEET FOR PARENTS OR FAMILY MEMBERS

Section A: The Research Project

1. Title of project

The inclusion of parents in music therapy sessions with their children in a special needs school: how does this help the child and the parents?

2. Purpose and value of study

Previous studies have demonstrated the positive results for both parents and their children after they have experienced music therapy sessions together. In addition, to provide enough music therapy services in Thailand will be challenging because this type of therapy is still in an infant stage of development. Working together with families and encouraging them to use music with their children at home may enable them to overcome some of the challenges posed by limited institutional resources. Furthermore, exploring the parent's experience of employing music with their child will enable a researcher to develop more suitable approaches to help both parents and their special needs children get the greatest benefits from music therapy.

Research objective:

To investigate the family's experience of using music with their children with special needs, both in music therapy sessions and outside music therapy sessions.

3. Invitation to participate

You are invited to take part in this study because first of all I believe your child may benefit from music therapy sessions. Secondly, you will be offered opportunities to engage in a positive experience with your child in the sessions. Lastly, you will be helped to use music therapy techniques and encouraged to use them at home with your children.

4. Who is organising the research

This research is conducted by me, Pornpan Kaenampornpan who is a MPhil/PhD student of Music Therapy program at faculty of Arts, Law and Social Sciences, Anglia Ruskin University.

5. What will happen to the results of the study

The data will be kept in a locked cupboard to ensure confidentiality. Once the process is complete, a copy of the dissertation will be held in the Anglia Ruskin University libraries

6. Source of funding for the research

Thai government

7. Contact for further information

Do not hesitate to contact me or my supervisors if you have any questions.

Researcher

Pornpan Kaenampornpan

Email: pornpan.kaenampornpan@student.anglia.ac.uk

Phone: +44 7954 914 012

Researcher Supervisor

Dr. Amelia Oldfield

Senior Lecturer - Music Therapy Programme

Department of Music and Performing Arts,

Anglia Ruskin University

Email: Amelia.Oldfield@anglia.ac.uk

Phone: +44 1223 363271 ext 2979

Section B: Your Participation in the Research Project

1. Why you have been invited to take part

Firstly, I believe that your child may benefit from participating in music therapy sessions. Your perception and responses to your experience of music therapy with your child will be very valuable in order to improve more suitable music therapy for other parents and their children with special needs.

2. Whether you can refuse to take part

Participation in this research is entirely voluntary. If you wish to participate, I would be very grateful. If you would prefer not to, you do not have to.

3. Whether you can withdraw at any time, and how

If you want to withdraw from the study, you can inform me or other staff in the school at any time. This study involves participation in music therapy sessions, and even if you want to withdraw from the study you are still able to continue receiving music therapy service from me.

4. What will happen if you agree to take part (brief description of procedures/tests)

You will be invited to participate in 24 music therapy sessions with your child. Each session will be videoed and the video recordings will be discussed at the end of each session with you, focusing on you and your child's interactions and your child's responses. You will also be interviewed 3 times. The first interview will be conducted before the first music therapy session with you and your child, but after your child's first two individual music therapy assessment sessions. The second interview will be conducted after the 24th music therapy session is finished. The last interview will be held two months after the end of the music therapy treatment. I will not be conducting the interviews, they will be carried out by someone else not me. All the interviews will be audio recorded in order to transcribe and analyse the data. In addition, there will be two visits to your home to look at how you use music with your child within the family setting. During these visits, you and your child will be briefly videoed. The first home visit will be

taken place one month after the music therapy treatment has finished. The second visit will be two month after the music therapy treatment has finished.

5. Whether there are any risks involved (e.g. side effects from taking part) and if so what will be done to ensure your wellbeing/safety

There is very slight risk that you could be identified. Therefore, pseudonyms will be used throughout this study so that data is never linked to your identity. All the data from both video and audio records will be reviewed only by me and my supervisors. These records will be kept in a locked cupboard to ensure the confidentiality.

6. Agreement to participate in this research should not compromise your legal rights.

7. Whether there are any special precautions you must take before, during or after taking part in the study

Music therapy sessions and interviews will be held in a friendly and safe environment. If you and your child are well enough to attend school, no additional precautions need to be taken regarding to music therapy sessions.

8. What will happen to any information/data/samples that are collected from you

The video recordings will be discussed at the end of each session with you focusing on your interactions and your child's responses. Moreover, the video recordings during the home visits will be discussed with you focussing on how you using music with your child within the family setting. The audio records of interviews will be transcribed. Then the data will be categorised, themed and analysed. Most of the data will be store on my personal laptop and on an external hard drive. This laptop needs a password to be accessed and will only used by me. Video and audio recordings will be kept in a locked cupboard to ensure confidentiality.

9. Whether there are any benefits from taking part

Music therapy sessions will provide a positive experience for you and your child. You will explore different ways of positively interacting with your child and have the opportunity to see different aspects of their personalities. Your child will be able to express their feeling in a safe way. Moreover, you will be encourage to use the techniques that you have experienced in the sessions in your home and everyday life. After the study has been completed, I hope to develop more suitable approaches to help other parents employ music with their special needs children.

10. How your participation in the project will be kept confidential

Pseudonyms will be used throughout this study. Data will be kept confidentially.

Thank you for reading this information sheet

Pornpan Kaenampornpan

Researcher and music therapist

**YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM**

Appendix 3 Participant Consent Form for the Parents or Family Member

Participant Consent Form for the Parents

NAME OF PARTICIPANT:

TITLE OF THE PROJECT:

The inclusion of parents in music therapy sessions with their children in a special needs school: how does this help the child and the parents?

MAIN INVESTIGATOR AND CONTACT DETAILS:

Researcher

Pornpan Kaenampornpan

Email:

pornpan.kaenampornpan@student.anglia.ac.uk

Phone: +44 7954 914 012

Researcher Supervisor

Dr. Amelia Oldfield

Senior Lecturer –

Music Therapy Programme

Department of Music and Performing
Arts,

Anglia Ruskin University

Email: Amelia.Oldfield@anglia.ac.uk

Phone: +44 1223 363271 ext 2979

1. I agree to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.
2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.
3. I have been informed that the confidentiality of the information I provide will be safeguarded.
4. I am free to ask any questions at any time before and during the study.
5. I have been provided with a copy of this form and the Participant Information Sheet.

6. I agree to data collected through this study being read by the University¹ for any purposes connected with the Research Project as outlined to me*

Name of participant (print) _____

Signed _____ Date _____

Name of witness (print) _____

Signed _____ Date _____

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

TITLE OF PROJECT:

The inclusion of parents in music therapy sessions with their children in a special needs school: how does this help the child and the parents?

I WISH TO WITHDRAW FROM THIS STUDY

Signed: _____ Date: _____

¹ "The University" includes Anglia Ruskin University and its partner colleges

Appendix 4 Information Sheet for Children

Information sheet for children



Hello! My name is Pornpan Kaenampornpan. I am here to invite you to take part in my study.

What will I do in this study?

In this study, you will be invited to music therapy sessions. There, we will be singing, dancing, playing and exploring music instruments together with your parents. We will meet twice a week for 3 months and after 3 months I will visit you at home twice to see you and your parents playing music together.

Why should I take part in this study?

You will be able to help me understand and learn how you and your parents interact with each other within and outside music therapy sessions. You and your parents will spend time together making music. Sessions with you and your friends will help me to make music therapy with other children better in the future. We will make a video recording each session.

What should I do next?

On the next page, please tick the box to tell me whether you **do or do not** want to participate in this study. You can ask your parents or teachers to help you decide this. Your participation in this study is completely voluntary and you can choose to stop taking part in this study at any time and for any reason.

I look forward to working with you and I hope you will enjoy our music therapy sessions. If you have any questions, please feel free to ask me.

Pornpan Kaenampornpan

Researcher

Email:

pornpan.kaenampornpan@student.anglia.ac.uk

Phone: +44 7954 914 012

Appendix 5 Consent Form for Children**Consent form for Children****Title of the project:**

“The inclusion of parents in music therapy sessions with their children in a special needs school: how does this help the child and the parents?”

My name is _____

I have read the Information Sheet and have had the details of the study explained to me. I would like to say:

☐ **Yes**, I do want to participate in this study.

☐ **No**, I do not want to participate in this study.

Signed

Date

Appendix 6 Parental Permission Letter to Give Permission to their Child to Participate in Two Assessment Music Therapy Sessions

Parental Permission Letter to give permission to their child to participate in 2 assessment music therapy sessions

Date

Dear Parent:

I am Pornpan Kaenampornpan, a MPhil/PhD student of the Music Therapy program at the faculty of Arts, Law and Social Sciences, Anglia Ruskin University. I would like to invite your child to participate in 2 sessions of music therapy assessment. These 2 sessions are part of my study "The inclusion of parents in music therapy sessions with their children in a special needs school: how does this help the child and the parents?" which aims to investigate the family's experience of using music with their children with special needs both in music therapy sessions and outside music therapy sessions. Therefore, if the music therapy sessions appear to be beneficial to your child, you will also be invited to participate in this study afterwards and you will join your child for two weekly music therapy sessions over a period of 3 months.

These two assessment sessions will be 30 minutes long and will be held once a week for 2 weeks. The sessions' aims are to assess whether your child will benefit from music therapy sessions. During the sessions, the child will be invited to sing, explore and play the musical instrument with me. When writing notes after each session, I will use a pseudonym instead of your child's name. This is because during the research process there is a very slight risk that your child will be identified.

Your child's participation in this project is completely voluntary and they can choose to stop taking part in the sessions anytime. You are free to withdraw your permission for your child's participation at any time and for any reason without penalty. These decisions will have no affect on your future relationship with the school or your child's status there.

The information that is obtained during these 2 sessions will be kept strictly confidential and will not become a part of your child's school record.

In the space at the bottom of this letter, please indicate whether you **do or do not** want your child to participate in these 2 sessions. Please keep the second copy of this form for your records.

I look forward to working with your child and I hope my music therapy sessions will be enjoyable for your child. Thank you very much for reading this letter.

Do not hesitate to contact me or my supervisors if you have any questions:

Researcher

Pornpan Kaenampornpan

Email: pornpan.kaenampornpan@student.anglia.ac.uk

Phone: +44 7954 914 012

Researcher Supervisor

Dr. Amelia Oldfield

Senior Lecturer - Music Therapy Programme

Department of Music and Performing Arts, Anglia Ruskin University

Email:

Amelia.Oldfield@anglia.ac.uk

Phone: +44 1223 363271 ext 2979

☐ I **do** give permission for my child _____ (name of child) to participate in 2 music therapy assessment sessions described above.

☐ I **do not** give permission for my child _____ (name of child) to participate in 2 music therapy assessment sessions described above.

Parent's name (Print)

Parent's signature

Date

Appendix 7 Permission Letter for the Director of Khon Kaen Special Education School, Region 9

Date

To The Director of Khon Kaen Special Education School, region 9

This letter is written in order to ask for your permission for me, Pornpan Kaenampornpan, to conduct my research project in your facility for the completion of MPhil/PhD of Music Therapy Program, Anglia Ruskin University. **Five** children with special needs at your school and their parents will be the main participants in the study. They will also be asked to give consent to participate in the study. The families will participate in 24 music therapy sessions, twice a week during a three months period. Furthermore, the parents will be interviewed three times, before the treatment process starts, after it is finished and again after 2 months from finishing. There will be audio recording during these interviews. The interviews will closely investigate the parents' experience of using music with their children with special needs both in music therapy sessions and outside music therapy sessions.

I also would like to ask for your permission to video each music therapy session. The video recording will be discussed at the end of each session with the parents focusing on their interactions and their children's responses. The video recordings, audio tapes and music therapy notes will be kept in a locked cupboard to ensure the confidentiality. They will be reviewed only by me and my supervisors.

During the research and writing process, your children's and their families' and your staffs' names as well as your facility's name and location will not be mentioned. A pseudonym will be used to protect the identity of them and your facility. My intention to research music therapy sessions with the children and their parents is to enhance the children's and their parents' wellbeing. Every effort will be made to fit in and not to interrupt the school routine.

If you have any questions about this study, please do not hesitate to contact my research supervisor, Amelia Oldfield or myself:

Researcher

Pornpan Kaenampornpan

Email: [pornpan.kaenampornpan@student\(anglia.ac.uk\)](mailto:pornpan.kaenampornpan@student(anglia.ac.uk))

Phone: +44 7954 914 012

Researcher Supervisor

Dr. Amelia Oldfield

Senior Lecturer - Music Therapy Programme

Department of Music and Performing Arts, Anglia Ruskin University

Email: [Amelia.Oldfield\(anglia.ac.uk\)](mailto:Amelia.Oldfield(anglia.ac.uk))

Phone: +44 1223 363271 ext 2979

Letter of Permission for School

TITLE OF THE PROJECT:

“The inclusion of parents in music therapy sessions with their children in a special needs school: how does this help the child and the parents?”

Please tick YES/NO to indicate whether you **do or do not** want to give me permission on the requests I have asked. Please keep the second copy of this form for your records.

YES NO

☐ ☐

1. As Director of Khon Kaen Special Education Needs School, Region 9, I give permission to Pornpan Kaenampornpan to conduct MPhil/PhD research at this school.

☐ ☐

2. I give permission for her to conduct music therapy sessions with the children and their families.

☐ ☐

3. Once the permissions from families have been obtained I am happy for notes to be taken and reviewed, also video recording and audio tapes to be made.

☐ ☐

4. She or suitably appointed research assistants may conduct interviews with the parents.

The Director's name (Print)

The Director's signature

Date

Appendix 8 Parental Permission Form for Use of Photos and Video Excerpts

เรื่อง ขออนุญาตใช้ภาพ และวีดีโอจากกิจกรรมดนตรีบำบัดของนักเรียน และผู้ปกครอง

เรียน ผู้ปกครองของ (ชื่อนักเรียน)

เนื่องจากบุตรหลาน และตัวท่าน ได้เป็นส่วนหนึ่งของงานวิจัยในหัวข้อ "การมีส่วนร่วมของผู้ปกครองในกิจกรรมดนตรีบำบัดกับบุตรหลาน ที่เข้าเรียนในศูนย์การศึกษาพิเศษ เขต 9 จ.ขอนแก่น" และได้เข้าร่วมกิจกรรมดนตรีบำบัด ในช่วงเดือน กันยายน 2554 จนถึง เดือนมีนาคม 2555 โดยในระหว่างกิจกรรมดนตรีบำบัด ได้มีการบันทึกภาพวีดีโอไว้ เพื่อใช้เป็นส่วนหนึ่งของข้อมูลงานวิจัยนั้น นักวิจัยมีความประสงค์ที่จะขออนุญาตท่าน ในการนำภาพถ่าย และบันทึกวีดีโอนี้ ไปใช้ประกอบการนำเสนอในงานโอกาสต่างๆ เพื่อเป็นการเผยแพร่ และต่อยอดการศึกษาในหัวข้อดังกล่าวต่อไป

จึงเรียนมาเพื่อขออนุญาตนำภาพถ่าย และบันทึกวีดีโอไปใช้ และขอขอบพระคุณมา ณ โอกาสนี้

ขอแสดงความนับถือ

(นางสาวพรพรรณ แก่นอำพรพันธ์)

นักวิจัย

E-mail: pornpan.kaenampornpan@student.anglia.ac.uk

ใบตอบรับ เรื่อง ขออนุญาตใช้ภาพ และวีดีโอจากกิจกรรมดนตรีบำบัดของนักเรียน และผู้ปกครอง

ข้าพเจ้า (ชื่อผู้ปกครอง) เป็นผู้ปกครองของ (ชื่อนักเรียน)

ได้รับทราบหนังสือ เรื่องขออนุญาตใช้ภาพ และวีดีโอจากกิจกรรมดนตรีบำบัดแล้ว

☐ อนุญาต

☐ ไม่อนุญาต ให้ใช้ภาพ และวีดีโอจากกิจกรรมดนตรีบำบัด

ลงชื่อ.....ผู้ปกครอง

...../...../.....

PARENTAL PERMISSION FORM FOR USE OF PHOTOS AND VIDEO EXERPTS

For your protection and privacy, we ask your permission to use your child's and your pictures and video excerpts in presentations and/or in publications, should we desire.

☐ I give my permission my child's and your pictures and video excerpts

☐ Do not use my child's and your pictures and video excerpts

Child's Name: _____

Parent or Guardian Signature: _____ Date: _____

Appendix 9 Sample Semi- Structured Interview Guideline

This sample took from the 2nd interview.

Objectives	Possibly use questions
<p>1. To understand the parents' experience of being in the music therapy sessions with their children.</p>	<ul style="list-style-type: none"> ○ What was your first feeling about being in the session with your child? ○ Have your feeling changed over time? ○ After participating in many music therapy sessions, did your thoughts about music therapy changed? ○ What made your feeling and understanding change? ○ What did you think about your role in the session during the first few sessions? ○ After participating in the sessions, were there any changes in your roles? How the roles had been changed? What made them changed? ○ What made you feel good in the sessions? ○ What made you feel worry and uncomfortable? ○ What do you feel watching your child participating in the music therapy sessions? ○ How did you feel to be involving in the music therapy activities? ○ In the music therapy sessions, what were the important roles of the music therapist? Please give some example. ○ What were the important characters of the music therapist or approach she used which very important for the overall sessions? ○ How useful and helpful for your child to have you in the session with him? Please give some example.

Appendix 10 Sample Translated Interview transcription of Jan and Pat

Translation of the 1st Interview with Jan (Nina's aunt)
RA2: Do you live in Mahasarakham? And go back there every weekend?
Aunt: Yes, I come here on Monday and go back to Mahasarakham on Friday.
RA: Do you have a place to stay during weekday around here?
Aunt: I used to live in the centre's accommodation. I just moved out from here last week because Nina is growing up. She is not a little girl any more.
RA: How long has Nina attend the classes at this centre?
Aunt: Around 3 years, since 2009
RA: Where did she have education before she came here?
Aunt: Before we came here, we went to the special education centre in Bangkok.
RA: How long did you and Nina stay there?
Aunt: Around 3-4 months
RA: When did Nina first receive her diagnosis?
Aunt: I'm not sure whether we found out since she born or not. Her grandmother took care of her back then and she was the one who first noticed that Nina didn't make much eye contact.
RA: Not much eye contact?
Aunt: Yes. A doctor at Srinakarin hospital referred us to this centre. After we were here for a few months, until Nina was 2 years old, her grandmother came to stay with her but she was old and worried about her work. So they moved back to our hometown. Then Nina was raised by her grandparents who do not have much knowledge about children with special needs.
RA: During the time her grandmother took care of Nina, did you work?
Aunt: Yes I did

² RA refers to a research assistant

RA: Where did you work?
Aunt: Udon
RA: Did you know there was a special education centre at Mahasarakham too?
Aunt: I just knew when we already came to the special education centre at Khon Kaen. However, It was not convenient for me if Nina stays in Mahasarakham.
RA: So you knew her condition when Nina was 2, is that right?
Aunt: Yes
RA: How did you feel when you found out?
Aunt: I did not know much about her condition...so I was worried how to take care of Nina...Some people might think that Nina is very strange. I wonder why she has this condition. I heard someone said this condition might be genetic. But there is no one from both her father's or mother's side has this condition. The doctor told me that this condition is very similar to Down syndrome and it is a very rare condition. During the first few years of Nina's life, we regularly met the doctor. The doctor explained her condition and ways to take care of her...We have been coming to this centre for 3 years. Before we came here I took her to different places to receive different treatment. I also attended workshops and employed what I learnt in the workshops with her. However, I felt that it is better to have someone else...not me to teach Nina. I think Nina doesn't listen to me as well as she does with teachers.
RA: Was it difficult to quit your job and become a full time carer?
Aunt: It was a difficult decision. The first thing I worried about was money and convenience. As Nina needed to see the doctor very often during her first few years, I couldn't quit my job officially because we still had a lot of expenses. The year later, I was able to quit my job and Nina's father supported us financially.
RA: Did her grandmother fully take care of her before you quit the job?
Aunt: Yes.
RA: And now you take all the responsible for Nina?
Aunt: Yes, but her dad keeps contact her constantly and she goes back home to see her dad some weekends.
RA: Does her dad work in Udon?

Aunt: Yes
RA: Not far...How did her dad feel when he first knew the diagnosis?
Aunt: He was always by Nina's crib as she was very tiny and he could not play much with her. He liked to look at her and asked Nina's grandmother...what's wrong with Nina...and the grandmother would just said...she doesn't know too but we have to take care of her...
RA: Does Nina have any siblings?
Aunt: Yes, she has one younger sister. Her sister is 7 years old
RA: How does her sister react to Nina?
Aunt: They used to attend the same school...but her sister's friends teased her about Nina. So her sister started to separate herself from Nina. Her sister could not understand Nina's condition...she used to shout at Nina and was angry at her. So we decided to remove Nina from that school and brought her here. Nina will see her little sister only at the weekends and the school breaks. We gradually explained to her sister about Nina's condition. I think her sister learnt to accept it and they have a better relationship now.
RA: I see...at that time Nina's sister was still too young to understand.
Aunt: Yes, she was too young and no one explained to her
RA: Do you think Nina made any improvement after she attended the centre?
Aunt: Nina has been improving in many ways such as her verbal communication and her motor skills.
RA: Do you employ any techniques that the teachers at the centre teach for Nina to use at home?
Aunt: To be honest, I haven't trained her much at home. As I don't know how and sometimes I am quite busy. Now I just try different thing from other parents' suggestions
RA: Can you give me some example?
Aunt: For example, I do some lip massage to encourage her to talk. I also saw the teacher at the centre teaching her to use a straw to decrease dribbling. So at home, I encouraged her to use a straw and showed her how to use it.
RA: Oh, lip exercise
Aunt: Yes.

RA: What do you normally do with Nina at home?
Aunt: The teacher suggested me to keep the routine that's similar to the centre to maintain her development. So we usually do things similar to what we do at the centre. After she showers, I will make her run up and down the stairs a few times to up her mood. Then we run around the house and run up and down the sofa. After that I put a chair or a pillow for her to jump across. It is similar to the teacher at school to encourage her to improve her gross motor skill. Sometimes she doesn't want to do it. It is up to her mood.
RA: It depends on to her mood at that moment?
Aunt: Yes...but she still has to do it anyway but the length might vary. But she has to do some exercise when she gets up. In the afternoon, I used to bring her to her grandparents' rice field to help her grandparents plant rice.
RA: Did she like to do it?
Aunt: Yes. I also teach her about agriculture. I explained her how the rice is grown and point out cows to her along the way from home to the rice field. I try to teach her in a natural way.
RA: Can she remember?
Aunt: Yes. She can remember but not long after I told her.
RA: What does Nina enjoy to do and do well?
Aunt: She likes to clean dishes, even the dishes that have been washed...Nina would wash them again
RA: Are the dishes she washes clean?
Aunt: Not really. After she finished washing them, I have to rinse them again for safety.
RA: What Nina's behaviour that concerns you and what to improve?
Aunt: I hope her verbal communication can be improved and I also worry about her body posture
RA: Did you mean her movement and balancing herself?
Aunt: When she walks and sits, she has a little hunch back. So I am not sure why. Maybe her body is quite big compare to her legs?
RA: But she doesn't have any problem when she runs, does she? As you said that she has a

hunch back sometimes, how do you encourage her to adjust her posture?
Aunt: I have to remind her frequently and she will adjust and keep a proper posture of a while before returning to her usual posture.
RA: Do you and Nina have any experience relating to music?
Aunt: For Nina, I think she likes music...she likes listening to the music. I think, music seems to help everyone no matter if they have special needs or not. I want to know how music can help a child like Nina
RA: What do you expect Nina and yourself to do in the music therapy sessions?
Aunt: Dancing along with the drum beating?? ...but I definitely do not expect the child to have a music lesson. I just think if Nina can learn to listen to the music and can move along with different tempo, these might help Nina to have longer concentration and learn to listen to others.
RA: What benefit will you gain from participating in music therapy with your child?
Aunt: I don't focus on myself much. I just think about Nina. Will she be able to focus on one thing longer or will she listen to other's direction?
RA: Okay...I think we have gone through all the questions. Thank you very much for your time today.
Translation of the 2nd Interview with Jan (Nina's aunt)
1. RA: Hello, are you the mother of the girl?
2. Aunt: No, I am not her mother. I am her aunt
3. RA: How long have you participated in the music therapy program?
4. Aunt: I think we have been participating many times now. In the beginning, I thought we would try for a few times to see how Nina responded in the music therapy sessions because I was afraid that Nina would not engage well. After a few times she started to get more engaged in the sessions.
5. RA: This interview will be used as part of the music therapist's research project and this information will be very helpful for developing the music therapy work to be more suitable with the children in Thailand. There are many questions for you today. It will take lot of time so hope you don't mind.

6. Aunt: No not at all. That's fine for me.
7. RA: I would like you to talk openly, please feel free to give suggestions. How did you feel when you first knew that you will participate in the music therapy program with your child?
8. Aunt: I wondered what it would be like in the music therapy sessions, what kind of the therapy it is. It took me a while for me to decide but I really wanted to give it a go. Also the teachers at the centre recommended me to participate. I am familiar with the speech therapy which is one on one intervention. I took quite a while to decide whether to participate in the program or not. I firstly thought that the music therapist is not Thai so I was worried that we couldn't communicate. But the teachers (at the centre) told me not to worry because the music therapist is Thai. The first time I met the music therapist, she told me that her time table is very busy and she was not sure that she could take any more student. She was straightforward so I told her directly that I don't mind to wait. Nina and I are always available. Just anytime for my child, only 30 minutes for her is enough. I just want to know whether my child is able to engage or participate in this activity or not.
9. RA: What did you think the music therapy sessions will be like for the first time?
10. Aunt: I thought in the sessions, the music therapist would probably teach my child to read music. For example, the music therapist plays keyboard and child sings a long and plays along. Or the music therapist plays guitar and teaches the child to sing a song. I wondered whether my child will be able to learn or not because my child cannot speak properly. However, in the first session, the music therapist firstly told me that we will start by making the child feel relaxed and happy and since then I started to get more understanding about the music therapy work.
11. RA: Let's come back to talk about the child, what conditions or special needs does she have?
12. Aunt: Do you mean in the beginning?
13. RA: I mean before participating in the music therapy sessions, what is she like?
14. Aunt: Nina always likes music. She has had experiences with the keyboard and recorder before. The music therapist brought her to sing along without any force and she had fun. Nina doesn't like to do things when she is forced. The music therapist allowed her to do things in her way but before she moved to a new thing the music therapist asked her to say "finish". And the music therapist will bring an instrument one at a time, put it back when we finish. This helps her to learn about boundaries more.

15. RA: Did your feelings change after participating in the sessions?
16. Aunt: My feeling hadn't changed after a few sessions. I still wondered how Nina is going to learn and will she be able to do it? After the 5th session, I could feel the changes.
17. RA: You still wondered how she would be able learn...??
18. Aunt: Yes, I still was not sure that Nina could participate well in the sessions. But after the 5th session, I started to see some changes
19. RA: So after the 5th session, what made you feel differently? what situation made you see the changes?
20. Aunt: Nina is more engaged and shows more interested in participating in the activities and understand about boundaries. In the beginning, the music therapist asked me what are the goals that I want to set for Nina? I told the music therapist that I want Nina to improve (strengthen?) her gross motor skill. There was one activity where we threw a ball and run around the room with funny movement..it was like exercise. She was not interested to engage in this activity in the first few times. But gradually, she started to participate. Nina sometimes liked to say "let's go to bed" so the music therapist played the music which sounds like a cock crowing to wake everyone up but Nina is sometimes lazy so does not wake up so the music therapist added more excitement on the music to encourage Nina to re-join the activity. After a few times Nina got more interested in the sessions.
21. RA: From your experience, can you explain what is music therapy from your point of view?
22. Aunt: I think it is like a relaxed mind. Similar to when we listen to the music and the music helps us to feel relaxed and creates a good mood.
23. RA: In the first few sessions, what did you think your roles are?
24. Aunt: Before the music therapist talked to me about my roles, I thought the music therapist invited the parents in the sessions because she wanted the parents to observe and bring some techniques to use with Nina at home so Nina could maintain (continue) what she gains in the sessions. Then after a while I asked the music therapist about the purposes of involving the parents in the sessions and the music therapist's answer was similar to my ideas.
25. RA: After participating for sometimes, did you feel any changes in your roles? And how or what made things changes? Did you do or respond to things differently?
26. Aunt: Yes, my role had changed. When we are all together participating in the activities in the session, I feel like I am also a teacher. Sometimes the music therapist led

the sessions first and then we took turns. Also sometimes Nina led us. We all helped each other.
27. RA: What did you think made your role change? From an observer to be a teacher, what made things change?
28. Aunt: I think because when Nina started to get more engaged and show more interest in the sessions that made me feel enjoyment not bored. For example, in the beginning when she didn't engage well I felt discouraged but later when she appeared to be enthusiastic, that gave me so much encouragement to be more involved in her life.
29. RA: Could you tell me any situations that impressed you from participating in music therapy session?
30. Aunt: I was impressed with the later sessions after the 5th session or 3rd session I am not sure. In the 3rd session, Nina did not engage well. She was distracted by other things but in the later sessions, she was able to engage well and was looking forward to come back to the sessions. After the long weekend or school holiday, I worried that she was not able to engage well like before, but it turned out that she engaged very well. Some sessions she could concentrate for an hour. When there is no other kid waiting to come to meet the music therapist outside the room, Nina would not get distracted and could engage with the music therapist in the sessions for quite a long time.
31. RA: If there are other kids waiting, what would happen?
32. Aunt: The music therapist has many students each day therefore her time table quite tight. She had to manage the time quite strictly. Sometimes Nina still wanted to continue doing music therapy but the time is up so we had to leave. I worried about the music therapist that she might be so tired.
33. RA: To be part of the sessions, what made you feel good? Could you give some examples? Just imagine if the music therapist invited only Nina and you had to wait outside, and didn't have much contact with the music therapist... comparing with involving you in the process.
34. Aunt: It is good to be in the session because I can observe Nina's weakness and sometimes the music therapist didn't understand Nina's behaviours well and she couldn't respond back to her properly. As there are so many children and they are different from each other. So by involving me in the session, I could help the music therapist to understand more about Nina's behaviours. For example, Nina got distracted, pointing at the air condition while we were playing the keyboard. If we told her to stop and come back to join us, Nina would just not stop pointing and won't come back so I recommended to the music therapist to ignore that behaviour. So she would return to us. The music therapist told me

that was a good thing from involving the parents. We can help each other to improve Nina's behaviour.
35. RA: Do you have any worries or anything that seems to be the most difficult or challenging things that you have been encountering?
36. Aunt: There was a soft mattress in the room and in some sessions, when Nina moved closer to the mattress I started to get worried that she would lie down. Nina sometimes can be lazy and doesn't like to engage in activity which has to move around...she just made herself too comfortable. When she lied down she moved her legs like she was swimming.
37. RA: How do you feel about being involved in the music therapy sessions?
38. Aunt: I feel good because Nina likes music. When she was in the music therapy sessions she was relaxed, not similar to when she was in her classroom. In the classroom she was forced to learn how to write the alphabet, she doesn't like some things too academic especially with numbers (math). In the music therapy session, Nina learnt about number by using colour and sound after this I felt that she showed much more interest in numbers.
39. AR: How do you feel about participating in the music therapy sessions?
40. Aunt: I am glad to be part of the sessions because I was able to observe and bring some techniques to use with Nina at home. For example, there are two things that Nina remembers very well. She likes two songs which are the Hello song and Good bye song. Nina likes to have me sing these two songs for her. When the songs came to the verse that she could remember she would fill in very well and sometimes pretended to play piano on the floor along with me singing. We got some (blowing) instruments at home that she likes to play with and pretended that we were in the sessions with the music therapist. Although this doesn't happen every day. Sometimes she does say no to music even when I wanted us to play music. If she said no, we could not force her to do so.
41. AR: How do you feel to work along with the music therapist? During the sessions, you normally have a chance to talk with the music therapist, do you find this communication with the music therapist helpful?
42. Aunt: It's good. I like to be involved in this process. I don't know if other parents think this way but I think it is good to participate in the session. I learn the way to encourage the child to engage in (other's) activities and also to support/help the music therapist when Nina presented challenging behaviours.
43. RA: Did the music therapist provide you with enough space to share your ideas and did

she provide suitable activities to your child?
44. Aunt: Yes, the music therapist provided a lot of space for me to share my ideas. The music therapist asked me to share songs that I use with Nina, and the music therapist always asked my opinions and. I told her about Nina's problem that Nina cannot open her mouth properly because her jaws are not so flexible as it should be and her tongue is very big. I wanted the music therapist to encourage Nina to increase vocalisation (exercise her mouth, to move her mouth in different movement so her speech skills can be improved.) The music therapist engaged her in vocalising in different vowel such as Oo Aa Aa
45. RA: Can Nina sing?
46. Aunt: Once in a while, she likes to sing the Good Bye song and Turtle song
47. RA: Can Nina communicate or speak?
48. Aunt: She sometimes uses verbal communication.
49. RA: In the music therapy sessions, is there any time that Nina spontaneously speaks without any encouragement?
50. Aunt: Yeah, just today she said "play the drum"Today the music therapist asked Nina "what do you like to play?" and she said "play the drum". The music therapist said Nina's sentence was almost completed. It comprises with verb and object. Just her saying that, the music therapist was so pleased. Besides that I never met any (teacher) who is so energetic and sacrifice like her before. When the music therapist saw any improvement in Nina, the way she expressed her feeling toward the child's success is similar to me as a parent. That made me feel very pleased.
51. RA: Did the music therapist create a friendly atmosphere? Did she make you feel uncomfortable?
52. Aunt: The atmosphere was very friendly and comfortable.
53. RA: Did the music therapist provide suitable music activities and use suitable music and instruments with your child?
54. Aunt: Yes, she did. The music that we use is okay.
55. RA: Did Nina seem to be over excited when she saw many musical instruments in the room? Did she try to rummage around the room? Or she sit and wait for the music therapist to get the instrument?
56. Aunt: In the first few sessions or after a long school break, she did run around the room

and search things on the shelves and didn't wait for the music therapist to get the instrument out for her. There are some days that she has good concentration and can wait and listen to the music therapist.
57. RA: Did the music therapist lead the sessions appropriately to Nina?
58. Aunt: Yes, she did.
59. RA: When Nina presented challenging behaviours, how did the music therapist manage that? Are you happy with the way she managed it?
60. Aunt: We normally worked corroboratively, supported each other and managed Nina's challenging behaviour together.
61. RA: Do you have any things in your mind that you afraid to say?
62. Aunt: No No not at all...
63. RA: What impressed you when working with the music therapist and why? Can you give me some examples? Like you just said that you like the way the music therapist communicated and express how she was pleased with your child's improvement.
64. Aunt: Yes, I am very impressed with that. The music therapist was very good at gaining Nina's attention. And when Nina could achieve something even a small progression, the music therapist appeared to be very proud of Nina.
65. RA: Did you mean the music therapist has a good mind for being a teacher?
66. Aunt: Yes, she did..I don't know how to explain so I gave examples instead.
67. RA: What kind of things should the music therapist improve or change? or how to make the sessions to be more effective for Nina? any suggestions?
68. Aunt: I think about the time (table). For some children who didn't have concentration for the sessions on that day and wanted to leave earlier, I would suggest the music therapist to let them leave early. Don't have to hold the child until completing the 30 minutes. However, I never see her did that to any child.
69. RA: How about Nina? can she wait?
70. Aunt: As you see, the room is not able to prevent the noise from getting outside so when other kids who heard the sound and wanted to come in and they interrupt the child who was having a session.
71. RA: In your opinion, what is the most important thing in the music therapy work and

what is the music therapist trying to achieve from her program here?
72. Aunt: I think the music therapist probably wants to share this knowledge with other people and find the way to improve the challenges that other people encounter.
73. RA: for the activities that your child and you just participated in, the music therapist didn't give your child a proper music lesson so what did she try to do for your child? (what was her aim to engage Nina in this music activities?)
74. Aunt: It probably was for Nina to improve her concentration span. Adults like me, when listen to the music I feel relax and calmer.
75. RA: What made you feel like you want to join in the activities? What made you feel enjoyment?
76. Aunt: When I saw Nina having a good time and she was able to concentrate longer. All these things encouraged me to feel interested in what the music therapist did.
77. RA: Were you shy (to engage along in the activities) when you were in the sessions?
78. Aunt: Not at all. the music therapist said that she never saw any parents react this playfully and naturally like me before. I wanted to help Nina to be better and wanted to engage with her. Sometimes when my friends came to visit and saw me with Nina, they said that I am acting like Nina. I replied that as I have a child with special needs so I have to be like her sometimes (to put my feet on her shoes) so Nina wouldn't feel inferior. I have ideas that I want to play with her this way to engage her with me so Nina wouldn't be alone.
79. RA: In your opinion, what make the program successful?
80. Aunt: Music is a medium. Everyone likes music.
81. RA: What are barriers in this process?
82. Aunt: Sometimes Nina didn't feel like coming to the sessions or not in a good mood.
83. RA: How did Nina act when she didn't want to attend the sessions? Did she show any challenging behaviour?
84. Aunt: She never refused to get into the sessions but she wouldn't wait for the music therapist to get her the instrument. She couldn't concentrate well. She was not able to stay long with one thing. Not long enough to learn anything but she already wanted to move to other things. These are all the barriers.

85. RA: Can she wait longer now?
86. Aunt: Her concentration span has increased since the first session. She started to learn to wait and became more able to follow the rules (accept boundary). For example she learnt that she had to return the instrument she finished playing, before she getting another one.
87. RA: Did you have enough space to get involved in the music activities with your child during the music therapy sessions? Do you want to be more involved in the sessions?
88. Aunt: She did give me enough space to be involved in the sessions
89. RA: After you got some ideas about how to use music with your child, have you tried to use it at home? What techniques did you use?
90. Aunt: Yes, some of them
91. RA: What did you do, what kind of activities did you use at home?
92. Aunt: We got a small bamboo pipe (traditional blowing music instrument). It sounds like a whistle and now Nina likes to play with it.
93. RA: Did you buy the instrument before or after having the music therapy program?
94. Aunt: I bought it before we participated in the sessions but back then Nina didn't show much interest in it and we also had a trumpet toy. Before (participating in the music therapy sessions) she did not know how to play with these toy instruments properly and she liked to break it. But now she learnt how to blow in the sessions, so now she is able to use them more properly.
95. RA: Has Nina tried to break/open/lever the music therapist's instrument?
96. Aunt: I haven't seen her try to do that.
97. RA: Have you ever discussed or exchanged ideas about music therapy work with other parents?
98. Aunt: I rarely discussed it with other parents because we are all always busy with the children. If we got chances to talk, we tended to talk about other things.
100. RA: During you discussion with the music therapist, did the music therapist provide you enough information about your child's progress?
101. Aunt: Yeah, the music therapist talked to me after every session about how she did in the sessions. If we had enough time the music therapist would show me a video from the previous session. Sometimes from the video I could see how long she can concentrate and

some words that she said. While we were engaging in the activities, we had fun and forgot to observe Nina.
102. RA: Yeah, this seemed to be the benefits from watching/reviewing the video. Did you watch the video at least twice a month? Is it enough?
103. Aunt: Sometimes we missed it out but I don't think we need to watch it every time.
104. RA: What are the objectives of reviewing the video in your opinion?
105. Aunt: I think the music therapist wanted to show me that Nina was able to engage well in the sessions.
106. RA: What do you think of how to make the video reviewing to be more effective?
107. Aunt: If I want to use the video clip, I have to copy it to my USB drive and review to see what are her strengths and weaknesses. So I know what she needs to develop.
108. RA: What are the benefits of after session discussion with the music therapist?
109. Aunt: I feel comfortable and feel closer (and more familiar) to the music therapist.
110. RA: As you said that the numbers of the music therapy sessions are not enough? So what is your suggestion?
111. Aunt: There are 7 days in a week, isn't there? So having music therapy sessions 4 days a week should be good. 30 minutes per sessions but it depends on the child's needs too.
112. RA: What component of music therapy that makes it helpful to your child? Please give some examples.
113. Aunt: For example sometimes we blew the bubble along with the music. From this activity Nina did some exercise on fine motor by using hands to catch the bubble while saying "catch (the bubble)"
114. RA: Besides using music, what other components made music therapy helpful? As you said that in the sessions, Nina developed her fine motor skill and increased vocalisation, is there anything else?
115. Aunt: I think Nina's mind and my mind. I wasn't stressed and worried whether she could do it well or not in the sessions. Nina was interested in us (me and the music therapist) so she was mostly willing to engage in the activities. Besides that Nina was able to join along singing with the music therapist on Hello and Good Bye songs.

116. RA: Has Nina sung the songs at home?
117. Aunt: She sang the songs yesterday. As we had the session today so I asked her to sing the songs with me and she did the actions along with the songs.
118. RA: What has Nina been gaining from participating the music therapy sessions? Why?
119. Aunt: We know more about music. Today Nina showed much interest in playing keyboard. She started to play with each finger separately. Before, she didn't know how to play by a finger at a time. She normally played with all five fingers together. From the first session until now, she has been better.
120. RA: How about you? What did you get from participating in the music therapy session?
121. Aunt: I observed how the music therapist engages Nina and made Nina interested in the sessions and able to engage Nina for a long time. I also observe how to help Nina understand more about boundary and learn to share and to wait for her turn.
122. RA: From participating in the session, is your relationship between Nina and you better? Do you understand Nina better about her thoughts and her behaviour?
123. Aunt: I started to understand her more and Nina asked me more often to sing for her.
124. RA: Does Nina have any favourite song?
125. Aunt: The songs she learns from the school and the song from the music therapy sessions. Now when she wants to do something she will sing first. For example, I would ask her are you ready? Then she will sing "I am ready and I am excited" and did the actions.
126. RA: Is there any skill that she learnt from the sessions and she brings that skill to use in her daily life?
127. Aunt: As we don't have the instrument like here but she still like to sing a hello and goodbye song at home.
128. RA: What is the most obvious development she has made so far?
129. Aunt: Have longer concentration
130. RA: the music therapist gave you the progression report, was Nina able to achieve the goals that were set out before?

131. Aunt: Nina probably achieved around 80% of the goals.
132. RA: Was that more than you expected?
133. Aunt: Yeah, I guess...I think the music therapist would be pleased with Nina's development. Also Nina seems to be more interested in the sessions.
134. RA: What do you expect Nina to be like in the music therapy sessions?
135. Aunt: I would like her to have long concentration...I mean long enough to learn to listen to differences of sound (learn to differentiate the sound). If she plays piano, I'd like her to learn to control her fine motor skill and concentrates on the piano longer.
136. RA: Do you expect her to be able to play music?
137. Aunt: No, I would like her to have longer concentration and be able to sense the differences of sound.
138. RA: What else makes you concerned or worry when you see Nina in the sessions?
139. Aunt: One thing is that she is sleepy sometimes and another thing is that sometimes she won't wait until she finishes one instrument before she runs to get a new one.
140. RA: After Nina participated in the music therapy program, how is her behaviour outside the sessions?
141. Aunt: I think she understands more about boundaries.
142. RA: Does Nina able to understand and follow rules at home?
143. Aunt: When Nina wakes up, she always goes straight to play and doesn't bother to wash her face and brush her teeth. Also, the first thing Nina thinks of when she wakes up is food. So I have to tell her that "if you are hungry, you have to brush your teeth and wash your face first."
144. RA: Does she listen to you?
145. Aunt: Yes, she does. Nina also helps me to clean the dishes after we finished eating.
146. RA: Is there any moment that you were impressed when you were in the music therapy sessions with Nina?
147. Aunt: Almost every session that Nina showed interest, not naughty and behaved well.
149. RA: How did you feel when you saw Nina accomplish something?

150. Aunt: I am pleased with her increased concentration span. I would like her to be able to fit into society.
151. RA: After participating in the music therapy program, how has Nina changed? And what made her change?
152. Aunt: She listens and understands about rules (boundary). For example, after having a meal, she would clean her dishes. Before, she would run straight to the television after she finished her shower and not even finish putting on her clothes on and without hanging her towel. But now when I asked her to finish putting on clothes and hang her towel, she would listen and follow.
153. RA: How about you? Have you changed?
154. Aunt: I am interested in her more. Before, I didn't pay much attention to her because I don't know what the point of training her was. I am not sure if Nina will get better. But when I considered again I think to participate in the sessions can help Nina to have longer concentration.
155. RA: Do you feel more confident to use music with Nina?
156. Aunt: Absolutely 100%!
157. RA: Will you use music at home?
158. Aunt: Yes I already use it and Nina also participates. I brought her to sing along and dance along with her like we did in the sessions and I am not shy.
159. RA: Did you dance along with her like this before?
160. Aunt: No I never danced with her. Before (participating in the music therapy sessions), I normally let Nina dance by herself and I just watched her dance but now I join with her.
161. RA: Besides coming to the centre and participating in music therapy, what other training or workshops did you attend? Also is there any other kind of therapy that Nina participates in?
162. Aunt: Yes, Nina also attends speech training at a hospital.
163. RA: Besides dancing with Nina, what else do you do with your child Nina home?
164. Aunt: I would like her to sing.

165. RA: What was the barrier of using music at home?
166. Aunt: Her mood, if she doesn't want to participate
167. RA: What are the differences between participating in music therapy activities and using music at home with your child?
168. Aunt: Lot of differences
169. RA: It is different because in the music therapy sessions there are many different kinds of musical instruments or what it is that make Nina respond differently through music at home and in the sessions?
170. Aunt: I am not sure if it is an instrument that encourages Nina to engage more in the sessions. As normally in the music therapy sessions when we sing a good bye song, would play the drum along. However, we don't have a drum at home so Nina would tap the table instead. Then I asked her to do some exercise by running around the sofa and climb up the chair. Then jump down. I sang along for her and Nina asked me to tap the table to give her rhythm.
171. RA: It seems like Nina is creative to think what can be used instead of the drum.
172. Aunt: Nina initiated all the ideas to me. I think it might because (tapping on the table) the sound is similar to playing on the drum.
173. RA: Between the music therapy sessions and at home, where does she better respond to music?
174. Aunt: I think here (in the music therapy sessions) she responds better. At home her concentration is quite short. After playing in a short time, she would ask to sing the good bye song.
175. RA: After the music therapy program is finished, what kind of help you would like to have from the music therapist in order to maintain the use of music at home?
176. Aunt: I want the music instrument
177. RA: If there is a way for you to learn music then you are able to use it with your child, will you try?
178. Aunt: I want to learn to play guitar.
179. RA: How will you maintain the use of music at home?
180. Aunt: I don't think that we will use the music instrument but to listen to music, move

along and vocalise, we might keep doing these.
181. RA: What are the important elements in using music at home with your child? If you have the instrument like here, will you act as the music therapist?
182. Aunt: The music therapist told me to exaggerate the way we play along with Nina. I think I can do that.
183. RA: If your child has a chance to continue receiving music therapy service, what will be the objectives?
184. Aunt: Increase her attention span and engage in one thing longer.
185. RA: We are coming to the last part of the interview. Let's evaluate the way the music therapist works. Is there anything regarding the music therapist's personality that you want her to improve?
186. Aunt: Her personality is suitable with the child. She never scolds or raises her voice with Nina
187. RA: How about the management? Do you think the room setting is suitable for the child?
188. Aunt: I think the setting should be improved. Other children should not stay or play nearby the room. The room should be well protected from noise, but it seems impossible.
189. RA: How about the way the music therapist communicates, providing information about Nina's progress to you? Anything should be improved?
190. Aunt: No, I think it's good.
191. RA: What do you think about the way the music therapist chooses the songs, activities or other material?
192. Aunt: I think all the materials are suitable. The hello and good bye songs are very appropriate.
193. RA: Do you want the music therapist to improve anything involving with the way she works with you?
194. Aunt: Don't think so
195. RA: Do you want the music therapist to improve on the way she manages Nina's challenging behaviour?

196. Aunt: When Nina presented challenging behaviour, we tended to work together. The music therapist would try to manage first and if it didn't work then I would offer my help.
197. RA: Do you have any other suggestion?
198. Aunt: No,,don't think so
199. RA: Okay I think we have covered every question. Thank you very much.
Translation of the 3rd Interview with Jan (Nina's aunt)
RA: During the past 2 months, have you used music with your child?
Aunt: During the school holiday, the music therapist taught me how to use it and I also observed while we had the music therapy sessions. As we don't have any music instrument we adapted things that we have at home to use such as easy percussions and also use songs that the music therapist provided for us... We used the music that the music therapist provided us while we played the ball games (where we passed the ball to each other)... We did not do it everyday ...it depended on Nina's mood. However there was one thing that Nina always did which was after she had a shower, she would clap on the wall and sang Bye Bye songs.
RA: It seems that Nina is still impressed by the music therapy sessions. Was there any other occasion that Nina was involved with music?
Aunt: For example, I was upstairs and I heard Nina say "Wow",...at that time I wondered what she was doing. So I came down and saw her sitting on the stair case and pretending as she was playing piano and did "glissando" on the floor... We normally said "Wow" when we did that on the keyboard in the music therapy sessions. She also sang the Turtle song. I think she still remembers and think about keyboard but when she saw a real keyboard she wouldn't play...I don't know why...
RA: What activities do you use often with your child?
Aunt: We did exercise in the morning and turn the music on along. Nina normally ran around the house then kicks the ball. Also we did the vocalisation (La La La) so Nina can exercise her lip/mouth too.
RA: Did Nina sing along with you?
Aunt: Yes, but not long. Just a few times was good enough. Then I encouraged her to run around the chair and climb up- down from the chair. And I asked her to say "climb up on the chair" then count 1-2-3 before jump from the sofa. I clapped my hand for a signal as the music therapist did in the sessions. We do this activity almost every morning before we

have a shower but we miss it out on the day Nina has a bad mood and is sick.
RA: Is she sick often?
Aunt: It depends on the weather.
RA: Did she normally get a cold?
Aunt: Nina normally got asthma at night. So she couldn't get enough sleep and when she got up she will be tired and don't want to get up. When she gets up but don't want to do the exercise.
RA: Which activity do you think she likes most?
Aunt: It is probably when she finishes showering and she always sings the Good bye song which means finish...finish and tap on the wall as she did play on the drum in the music therapy session. Also, she likes the hello song even though she can't sing but I will sing for her and she will do the action.
RA: How is her mood? Is she always in a good mood?
Aunt: During the time she had the music therapy sessions, she was always in a good mood.
RA: Is it always like this?
Aunt: Yes, this is her nature.
RA: Is she ever in a bad mood?
Aunt: She always has a bad mood when she wasn't well besides that she is a lively girl.
RA: Is Nina able to follow your direction?
Aunt: If she is forced to do things, she wouldn't do them. However, after I participated in the music therapy sessions, I learnt the technique of how to engage her in the activities. For example, if I want her to do the colouring and she doesn't want to join in, I would ask another person to join in and then she will like to be part of it so she will gradually join in. I won't force her because she won't engage.
RA: What is the barrier of using music at home with your child?
Aunt: Her mood whether she wants to join in or not
RA: Is there any difference when you use music at home with Nina and when Nina was in the music therapy sessions? Did Nina respond differently?

Aunt: There are many differences
RA: What is the obvious difference?
Aunt: In many different ways, for example in the music therapy session Nina was more willing to engage in the activities longer and was able to complete it. But when I used music with her at home, she would join in but not for as long as in the music therapy sessions. Even in the sessions in last 2 months, sometimes she was not willing to join in but when we (the music therapist and I) started to give her signal, count 1-2-3 and pretended that I played with the music therapist then she wanted to be part of it and gradually join in herself.
RA: So in the sessions you didn't force her to do anything?
Aunt: No
RA: After you participated in the music therapy sessions, what encouraged you to use music with Nina at home?
Aunt: It affects on Nina to have a better mood.
RA: What is your plan to use music with Nina?
Aunt: Now, Nina seems not to understand better about music. So I probably help her see the differences of sound and keep the steady beat/ understand about rhythm.
RA: You definitely use music?
Aunt: Yes, if she is still interested in music.
RA: If you put the keyboard here, will Nina come and play?
Aunt: Not really, I have to encourage her to
RA: Do you have to turn it on for her?
Aunt: Even with it turned on. She sometimes doesn't play it.
RA: She doesn't play? I'm surprised.
Aunt: If I encourage her to play. She would play but not long.
RA: How will you maintain the use of music at home?
Aunt: If Nina is still interested in music, the use of music will be continued.

RA: Does Nina like music?
Aunt: Yes, she does
RA: As you said that if Nina still show the interest and responds well to music, you will keep using music with her. How can the music therapist help you to maintain the use of music?
Aunt: If it is possible, I want the music therapist to continue providing the music therapy sessions as she did. If possible I would like her to provide the sessions at our place or anywhere. I wish the music therapist could have time for Nina because Nina seems to be very impressed by the music therapist. Nina keeps waiting for the music therapist to come to visit.
RA: What did you gain from the music therapist's home visit?
Aunt: I was able to discuss things with the music therapist. Also Nina appeared to be very pleased to have the music therapist visit her at home. She was able to learn to have a guest in her space because not many people outside the family visit us at home.
RA: Before the music therapist paid you a visit, what did you imagine how the home visit would be like?
Aunt: I thought the music therapist was going to play music with Nina and do the music activities.
RA: What should be changed to improve the home visit service?
Aunt: No, I think this way is okay. I just want Nina to know that the music therapist visits her.
RA: Is it useful to have the music therapist engaged Nina in music during home visit?
Aunt: Yes. The music therapist employed music the same way as they did in the sessions. Nina still wanted to engage and she could remember.
RA: It seems like even when the music therapy program was finished for a while but Nina still remembers what she experienced in the music therapy sessions...
Aunt: I told the music therapist that Nina pretended to play piano on the floor and when the music therapist visited us, Nina went straight to show the music therapist her spot where she played "piano".
RA: If Nina couldn't have music therapy sessions twice a week, will home visits help you

to maintain the use of music?
Aunt: Yes. It would be helpful. However, at home Nina would remind me to use music with her. We have a music collection in our flash drive which Nina likes to listen to. She likes to listen to the music while she is doing her homework from the centre. Also sometimes we play a ball passing game which we would turn the music on while we were passing the ball to each other. This game could help Nina improving her motor skills. Sometimes she would not want to join so I did not force her to do...it depends on her mood.
RA: Do other members in the family use music with Nina?
Aunt: Not really, because they don't understand Nina well. Also they don't take good care of her much. For them taking care of her means spoiling her. When I left Nina with her grandparents not a long time, Nina would let herself free from all the discipline. For example, she would not go to toilet but instead she would just wet herself.
RA: It seems that Nina has more discipline when you are around... What did you gain from using music with Nina?
Aunt: We can play together like playing keyboard, if I let Nina play by herself she would just play around/randomly. If I was with her I could encourage her to play with more structure at least she would be able to exercise her finger.
RA: Will you still use music with Nina in the future?
Aunt: I will and if Nina still shows interests. If Nina could engage well, I believe she will gain lots of benefits.
RA: How do you feel to see yourself in the video?
Aunt: Sometimes I was surprised to see how funny and playful I could be. And I was able to see how well Nina engaged in the sessions even I was in the sessions with her I could not notice that at the time. I am very pleased.
RA: Is there a difference between seeing her in the sessions and watching her from the video, right?
Aunt: Yes, (when I saw Nina in the sessions) I thought she didn't have a good concentration but when I watched in the video I think she was okay and was able to engage for a long time.
RA: What is your important philosophy in raising/taking care of your child? If you want to give the suggestion to someone who have similar problems what would you tell them?

Aunt: I would tell them to be patient. The children with special needs have to learn about discipline. During the school holiday, my other nieces and nephews come to stay with us and they don't have a good discipline compared to Nina. Their parents complain that they don't have time to teach their children and when they see Nina have such good discipline they want me to teach their children. So I told them only just 2 months during the term break I could not change them and also they are all grown up. Teaching discipline needs continuity.

RA: Okay, this is very helpful information. Thank you very much for your time today.

Translation of the 1st Interview with Pat (Aden's aunt)

RA: My name is Ann. I am the music therapist's assistant. May I record this interview?

Aunt: I am Aden's aunt.

RA: How long have you looked after Aden?

Aunt: 1 year

RA: How old is he now?

Aunt: Now he is 3 years and 11 months. He will turn 4 next months.

RA: How long has Aden been coming to this centre?

Aunt: Just 3 months

RA: So where did Aden go to school before he came here?

Aunt: Before coming here, he did not attend any classes...I taught him at home

RA: You taught him?

Aunt: Yes,

RA: Where did you get information about taking care and teaching a child with special needs?

Aunt: I searched on the internet.

RA: You searched on the internet and followed it?

Aunt: Yes, I just tried simple things

RA: When did you know about his condition?
Aunt: When he was born, the doctor told us.
RA: Does Aden live with his parents too?
Aunt: Yes, he does
RA: Before you became Aden's primary carer, what did you do?
Aunt: I lived aboard and worked for myself
RA: Was it difficult to quit your job and stay with him?
Aunt: Not at all. I normally came to visit his family every year. When he was born and we learnt that he has some special needs I visited him more often...once in 2 or 3 months. But his grandmother was sick so I decided to look after him.
RA: His grandmother was the one who took care of him before you moved here permanently?
Aunt: Yes, his grandmother was.
RA: Who recommend you to come to this centre?
Aunt: I took Aden to a hospital every 6 or 3 months and while we were waiting, there was a mother of a boy who asked us "did we meet before at the centre?". So I asked her what is the centre and she explained to me. So we came here the next morning and the teachers here gave us very good advice so I decided to bring him here.
RA: What do you expect Aden to gain from this centre?
Aunt: I didn't expect much at first. I just wanted to see how things are at the centre. I think after Aden attended the classes here. He learnt a lot and made some progress
RA: In what area?
Aunt: He is better at taking care of himself. He can speak more and seems like he wants to speak more.
RA: Is he different when he is at the school and at home? And how is that so?
Aunt: He is different. At the school he is quite shy but at home he would do anything and he usually brought things from the centre to do and teach his parents at home. He normally talks to everyone at home but at the school he rarely talks. He will only talk and play with someone who he feels familiar with.

RA: When you are home with him, do you teach him more?
Aunt: When he got home, he also has homework. He likes music so I will play and sing with him.
RA: Do you have anyone to help you at home?
Aunt: During the weekday there is just me...but his parents come to see him every weekend
RA: Are you tired?
Aunt: Yes I am
RA: Have you ever want to give up?
Aunt: No. When Aden is better it makes me feel that I want to help him more and look forward to see more of his improvement. When he is improved I am very happy.
RA: How was the situation in your family when you all knew about his condition?
Aunt: (silent)
RA: You and the rest of the family struggle to accept...So how did you all get through that time?
Aunt: We need to be strong
RA: Supporting each other?
Aunt: We have to be very patient
RA: Does Aden have any siblings?
Aunt: No. During that time, his parents had arguments every day. I felt very bad and this was the reason why I want to help them. But now everything is better.
RA: Does he have any friends to play with when he is at home, besides family members?
Aunt: No. Before he moved to Khon Kaen, he used to have his relatives to play with when he was young and lived in other city.
RA: Does he have any problem and behaviour that concerns you? What is it?
Aunt: Aden cannot look after himself. He cannot tell when he wants to go to the toilet.
RA: How do you manage and help him with that?

Aunt: I keep asking him “do you need to go to toilet?” every 10 or 20 minute. He will say “umm” and if he doesn’t want to he will say “na..na”
RA: If you ask and he can respond, can’t he?
Aunt: Yes.
RA: Does he have any music experience? And what is it?
Aunt: I got a diploma degree in Thai traditional dance. So I like to sing to him and he also likes singing. Phai (Thai musician) is his favourite singer.
RA: What does he like to do when listening to music?
Aunt: He likes to sing along but he is able to sing only the last word of each sentence. Now I think he is getting better.
RA: Does he have any musical instruments at home?
Aunt: He has a keyboard and a drum.
RA: Does he like any instrument in particular?
Aunt: He likes guitar. He likes to play when he is in the music therapy sessions. When he were watching the music video which the musician plays guitar, he likes to copy the way the musician play the guitar.
RA: What do you expect from the music therapy service? Why did you want Aden to take part and what can it help Aden with?
Aunt: Music therapy is very helpful.
RA: In what way?
Aunt: I think it will help Aden to engage in one thing for longer and to help Aden listen to my directions more.
RA: Before participating in music therapy, what did you think a music therapy session will be like?
Aunt: I don’t know but when I knew that we were referred to music therapy service, I was very happy because it is not often that we get a chance like this. I expect to see Aden become more active and livelier.
RA: How many sessions has Aden had now?

Aunt: A few times, Aden likes it. He enjoys it. (Jan had to attend the music therapy assessment sessions, as Aden was quite upset to be in the room with the music therapist alone.)
RA: What did you do in the sessions?
Aunt: Just sit and observe
RA: Didn't you play with him?
Aunt: Just watch him...I wanted him to play with the music therapist
RA: Besides guitar, what else does he like to play?
Aunt: Now he shows more interest in playing the recorder.
RA: Is there any instrument that he doesn't like?
Aunt: He seems to enjoy playing every instrument.
RA: He likes music very much, doesn't he?
Aunt: He both likes playing music instrument and listening to music.
RA: Besides Aden gaining some benefits from the sessions, what will you gain from participating with Aden in the sessions?
Aunt: I will teach him at home. I just said to the music therapist that it was a shame that I didn't learn to play music. I only learnt dancing. If I know how to play music, I would be able to teach him more but I will try anyway.
RA: You can teach him to dance.
Aunt: Yeah, we dance simple tunes for example the "ANT" song. He can dance along with me and can follow me most of the steps of the action song. He is better this year since he comes here.
RA: What should be improved in the music therapy sessions?
Aunt: Talk to him more. However I think the music therapist is doing great now. It's not easy to get this chance to participate in music therapy service.
RA: Besides you observing the session, what else you want to do together there?
Aunt: Playing music together and sing along

RA: What does Aden need to be improved?
Aunt: He is still shy to the music therapist. If he starts to be familiar with the music therapist more, he would be able to express more.
RA: Does he want to continue participating the music therapy sessions?
Aunt: Yes. I really want him to regularly attend the music therapy sessions.
RA: Okay, I think we have finished the interview today. Thank you very much for your time.
Aunt: Thank you
Translation of the 2nd Interview with Pat (Aden' aunt)
RA: Hello, today I am going to interview you about your experience in the music therapy sessions with Aden. Can you tell me about Aden?
Aunt: Aden has down syndrome. He was very tiny when he was first born and when he was young he was always sick. He went to see the doctor every 2 months.
RA: Why was that?
Aunt: He got allergy and asthma. But when he was three, he started to be better.
RA: How long has he come to this centre?
Aunt: Just only 1 year
RA: How is his development?
Aunt: He is getting better. He is a shy boy and doesn't like to speak to strangers. After he has been here, he has chances to meet many people and starts to get familiar with them and talks to them. But he still doesn't speak to someone whom he is not familiar with.
RA: How about his language?
Aunt: He is better compare to before.
RA: Can he say any word or making sentence?
Aunt: He can say a few words such as my name, his parents' names and his grandmother.
RA: I have got many questions for you today and we will take time to talk. And please feel free to express your thoughts. How did you feel when you first know about Aden participating in music therapy sessions?

Aunt: I was pleased because Aden likes music. At home, he likes to listen to music on FAN TV channel (Thai music TV channel). Before, he just only listened to music but now he sings along. And when he saw a musician play guitar, he would copy the way the musician plays guitar.
RA: After participating in the sessions, has your feeling changed about the music therapy?
Aunt: It doesn't really change because Aden usually plays music at home. After he participated in music therapy session, he can do better.
RA: From your experience, what is music therapy?
Aunt: Music therapy can be used in many ways. It helps improve his brain and brings academic skill closer to Aden.
RA: Did you participate in the music therapy sessions?
Aunt: Yes, almost every session.
RA: During the first few sessions, what did the music therapist ask you to do? Or what was your role?
Aunt: Maybe observing. But sometimes Aden didn't want to participate in the activities. He was shy when he was with the music therapist alone. But when I went along with him he was more confident and he was willing to do it. So I played along with him.
RA: From the first sessions until now, has your role changed?
Aunt: Yes, I started to play along with Aden and Aden enjoyed with me.
RA: Can you tell me some experience in the music therapy that you impressed?
Aunt: I was impressed to see Aden was more engaged and expressed himself more. Normally Aden doesn't talk to strangers.
RA: Does he open himself to others?
Aunt: Yes. These days he starts to communicate with me and asks me to play with him more. Before, he normally watched television alone but nowadays, he shows an interest in having me play with him. This morning at home, he called out for me to sit with him to play a keyboard, it seemed that he imitated what the music therapist did in the sessions. He wanted to be a teacher and teach me to play music and not only me; he also asked his parents to play along with him.

RA: What did he do?
Aunt: He told his mother to come and play with him on the keyboard and sang together.
RA: How did he communicate with his mother?
Aunt: He took his mother's hand to play the keyboard and vocalised along. Sometimes when the music was on, Aden would suggest to his dad to move along to the music with him.
RA: It seemed that he was listening to the music.
Aunt: Yes. He is good with listening to the tempo
RA: What made you feel good about being part of the music therapy sessions?
Aunt: He is livelier and more active. He is able to respond (to music) very well and quickly.
RA: If you had to stay outside and didn't take part in the sessions, what would you miss out on?
Aunt: I would miss out a lot. Sometimes I observed what the music therapist did in the sessions and I brought the techniques back to use with Aden at home. But I can't play the instruments. I have guitar at home but I just played around with it.
RA: Did you mean you can play?
Aunt: No. I just pretended to play along with his tempo.
RA: Are you still working/teaching?
Aunt: No. I am now only taking care of Aden. I used to teach (Thai traditional dancing) in Japan.
RA: Were you a lecturer in a university?
Aunt: No. I was a private teacher. In Japan I provided a short course, 3-6 months in Thai traditional dancing
RA: Have you ever encourage Aden to dance with you?
Aunt: Yes.
RA: Did he join in?
Aunt: Yes. I used children songs with him and he danced along with me while I was singing.

RA: What are you concerned most about with Aden when he is in the sessions?
Aunt: I worry that he won't engage. If he is in a bad mood, he would just ignore everything.
RA: what if he is forced to do something?
Aunt: He won't do it at all.
RA: How do feel when you saw him participating in the sessions?
Aunt: I enjoy with him. Seeing him having a good time and being active and lively makes me feel joyful. I want him to be this way. Also I want him to continue participating in this kind of activities.
RA: In your opinion, what is the music therapist's role in the sessions? What is she trying to achieve?
Aunt: She is a very determined person. There was one day that Aden's mother also participated in the session. It was her first time and she told me after the session was finished that the music therapist has a fighter's mind and she did a great job. It is unusual to see people devote this much. Even me, as his aunt, I don't think I work that hard. Or maybe it is because this is her job or her passion in this profession. I am not sure about that but anyway she is very determined to engage with the child. I think she is successful...even Aden, she could engage with him very well.
RA: How do you feel about working alongside with the music therapist? and what did you do to help your child and the music therapist?
Aunt: I helped the music therapist in encouraging Aden to participate. Sometimes when I just observed Aden and the music therapist in the session, Aden would not engage as much as when I also joined in with them.
RA: Where do you normally sit in the sessions?
Aunt: I normally sat behind him but lately I sat in front of him to see how he participated in the activities with the music therapist. If he didn't engage well, I would join in.
RA: What benefit did you gain from talking with the music therapist after each session was finished?
Aunt: I think it is good so I learn how the music therapist thinks and feels about Aden and myself. In fact I want to attend all the sessions but if I attend every session I am afraid that I will push Aden too much. So sometimes I want him to be alone with the music therapist and I want to know how he is.

RA: When you didn't attend the sessions, did the music therapist show you the video from the sessions instead?
Aunt: Yes. Lately, the music therapist told me that he engaged in the sessions better even though I didn't participate. But when I was in the sessions he is usually more expressive...he shouted out loud and sang freely.
RA: Did you have enough freedom to lead the activities? Also did Aden have enough freedom to play the musical instruments?
Aunt: Yes. We have enough freedom.
RA: Did the music therapist force or push you and Aden too much?
Aunt: No, not at all. I wish she would force us more but maybe Aden cannot take it.
RA: When Aden came to the room, did Aden search (instrument or toys) around the room?
Aunt: No. Normally when he got into the room, he would walk to his seat and sang Hello song with the music therapist.
RA: Aden was not too active, was he?
Aunt: Not at all. He is too calm sometimes. I told the music therapist that Aden at home and at school is totally different. At home, he is very playful and sometimes can be naughty. But when he is with the music therapist, he is probably nervous and didn't express much.
RA: Was the music therapist able to create a comfortable atmosphere?
Aunt: Yes very much. She wanted me to join in and said "Auntie, let's do it together"
RA: Did the music therapist choose suitable activities with your child?
Aunt: Yes. However there were sometimes the music therapist provided some things too difficult for him
RA: What activities do you think are too difficult for him?
Aunt: When the music therapist asked him to follow her signals by playing bells on the right colour. He doesn't know much about colours, but sometimes he is able to choose the right colour. But I wonder maybe it is a coincidence.
RA: How did the music therapist manage Aden's challenging behaviour?
Aunt: I haven't seen him present challenged behaviour (in the sessions)

RA: In some children, they presented aggressive behaviour or were wandering around the room most of the time. Does Aden have some kind of these behaviours?
Aunt: Not really
RA: What were you impressed most with from working alongside the music therapist?
Aunt: She is very easy going. We get along really well. I feel very relaxed in the sessions with her or maybe I am an easy going person too so it was quite easy to work with her.
RA: What is the most important component in music therapy work, from your opinion?
Aunt: Her ways of expressions
RA: What about that?
Aunt: The performance that can bring the child to engage with and gain the child's attention. The dynamic in her voice can encourage Aden to engage with her. Her responses to the child aim to make the child understand and gain the child's attention. Her responses also make the child excited.
RA: Did the music therapist run or dance in the sessions?
Aunt: Yes. She did most of the things, walk, run, jump, and dance
RA: What made you enjoy the music therapy sessions? Why?
Aunt: My determination to help Aden to be better. I want to see him improving because music makes him lively/happy.
RA: Did you feel shy or uncomfortable to act childish sometimes in the sessions?
Aunt: No because I always perform on stage.
RA: What is the important thing that made you and the music therapist work collaboratively?
Aunt: We shared our opinions.
RA: Is there any barrier in working with the music therapist?
Aunt: For me, I don't think so.
RA: Do you have enough time playing music/using music with your child in the sessions?
Aunt: Umm...I think 30 minutes is not much but it's okay for the child

RA: Does Aden participate all along during 30 minutes?
Aunt: Yes. He is able to participate all through the sessions and he has good fun.
RA: Is there any time that you and the music therapist have disagreement?
Aunt: No because we always work together.
RA: Is there any techniques that the music therapist told you and you brought it back to use outside the music therapy sessions?
Aunt: The music therapist normally gives signal 1-2-3 for start and stop and at home Aden likes to do that which helps him in academic (number)
RA: Have you ever shared your experience in music therapy sessions with other parents?
Aunt: Never
RA: Do you want the music therapist to improve on anything in order to make the sessions more valuable for your child?
Aunt: I want her to talk and play with Aden more. As Aden has intellectual difficulty so it is good for him to learn and do things many times until he can do it well. But the music therapist has already done her best.
RA: What did you gain from reviewing the video excerpt with the music therapist after the sessions?
Aunt: To see the differences because I didn't attend in some sessions so the video showed me how he was when he was with only the music therapist.
RA: Is it enough to see the video only twice a month?
Aunt: I want to see it more often.
RA: In your opinion, what are the objectives of video reviewing with the music therapist?
Aunt: I think to observe Aden, to see how he respond in the sessions
RA: What should be improved and changed in order to gain more benefit from the video reviewing?
Aunt: I wanted to see Aden with the music therapist alone in the session because with me he was willing to do most of the things but with the music therapist alone he didn't want to do as much. So I want to see why, so that I can improve.

RA: Is he shy with strangers?
Aunt: Yes. For example, there are 3 teachers in his class but he chooses to talk with only 1 teacher.
RA: Is it often enough for you and the child to come to the sessions twice a week?
Aunt: At least 2 times a week.
RA: Do you have enough space to discuss with the music therapist after sessions?
Aunt: Yes
RA: What is the most important things in the music therapy sessions.
Aunt: Aden's mind and his health. He is a lively boy but when he is sleepy, he doesn't want to do anything. Sometimes I had to let him sleep before we came to the sessions.
RA: Besides music, what does Aden gain from participating in the sessions?
Aunt: The music therapist encourages Aden to talk (to vocalise). She usually vocalises and asks Aden to repeat.
RA: Can you give me some example of your positive experience you have with Aden in the music therapy sessions?
Aunt: We played recorders together and moved together along with the music the music therapist played. We always have the moment that we all played together in the sessions which it is nice.
RA: What has Aden been improving most so far?
Aunt: His ability to talk. Aden was used to be very shy and quiet in the session. He didn't make much sound but after a few months participating in the sessions, he started to vocalise a lot if he is in a good mood.
RA: According to a report the music therapist gave you, how much did Aden achieve from your point of view? Are you happy with his achievement? How much do you score out from 100%?
Aunt: umm...probably more than 80%
RA: That's more than half. How much has music therapy been of value to you and Aden?
Aunt: It's a valuable service. It made him livelier and more active.

RA: If he can continue coming to music therapy sessions, what would you expect or you want to see Aden achieve?
Aunt: I want him to be able to learn to play an instrument.
RA: What is his favourite instrument?
Aunt: I think he likes guitar most and another one is a new instrument that the music therapist just introduced to him. It is a drum but looks like a lollypop.
RA: Oh...lollypop drum. Was there any time that that he responded to music in the way you didn't expect?
Aunt: Many times. He surprised me many times...I sometimes thought to myself "is he able to do that??" One day, he was playing the guitar while imitating the music therapist's movement and sometimes he was playing a recorder while he played the keyboard with another hand.
RA: What is the positive change that he has shown to you since he participates in the sessions?
Aunt: He listens more to the signals. When the music therapist told him to stop he did. He is better in keeping the steady beat.
RA: What are you concern most about him when he was in the sessions?
Aunt: When he is upset, he won't do anything. I don't want him to be like that but he isn't like that very often.
RA: Outside of the music therapy sessions, how has he changed since he has participated in the sessions?
Aunt: He has changed a lot in a good way. He is able to express himself more. He gained more confident. When he is at home, he wants to play all the musical instruments he has at home.
RA: At home? Do you already have the instrument before participating in music therapy service?
Aunt: He has them before participating but he didn't play with them much and didn't know how to play. After participating, he seems more interested in playing the instruments and he knows how to play. For example, before he didn't know how to blow the recorder and he used to play with guitar as it is a toy but now he is able to blow and knows how to pluck on the guitar string.

RA: When Aden is in the sessions, does he act differently from when he is outside the sessions?
Aunt: When he is at home, he is more confident.
RA: When he is in the sessions, sometimes he didn't want to do or engage in things?
Aunt: Yes. For example, at home he imitates the way the music therapist plays keyboard and vocalises (jah jaad jaa). Here (in the sessions) he sometimes joined in and sometimes didn't. But at home he normally just jumped up on the chair, plugged on the keyboard and played by himself and I don't have to encourage him to play.
RA: Plug it on himself?
Aunt: Yes. If he cannot plug the keyboard on by himself, he would ask me to do it. He has guitars and when his favourite songs are on the television, he will bring the guitar out and play along with the songs by himself.
RA: How did you feel when Aden doesn't respond the way you expect?
Aunt: Upset.
RA: What did you do when he did not want to join in?
Aunt: I asked him to join in and (I would say) why don't you join in, you joined in last time.
RA: How did he respond back?
Aunt: He didn't join in anyway.
RA: How do you feel when he joined in?
Aunt: Pleased. This is him, this is the real him
RA: Have your feelings toward him changed after participating in the music therapy sessions?
Aunt: Yes. He is better. From a shy boy he now becomes more confident and able to do many things.
RA: How about yourself?
Aunt: I am enjoying it
RA: Do you feel more confident using music with your child? And will you use music with your child?

Aunt: Yes. I normally bring music to him. For example, every morning, if he plays keyboard briefly, I would be happy.
RA: At home, Aden has his own space to play, doesn't he?
Aunt: Yes,
RA: Does participating in the session help you to be able to understand Aden's behaviours more?
Aunt: Aden always changes. I found it hard to understand him sometime.
RA: Does Aden change after participating in the music therapy sessions?
Aunt: Yes. He has changed a lot. Now he is more active. He played around the house with his instrument. He likes guitar so I bought him both electronic guitar toy which you can just press the key to create the music, he also has got a normal guitar toy.
RA: Where do you get the knowledge and information about using music with the child, besides from coming to the sessions?
Aunt: I read from the internet and talk with my friends
RA: How will you use music with your child at home?
Aunt: I told the music therapist that I wanted Aden to learn the drum set because he seems to like it a lot. I am not sure whether he likes it or not. So I told the music therapist that when he is older I will take him to the drum lesson.
RA: What is the barrier of using music at home?
Aunt: Maybe it will be noisy for our neighbour but I am not worried about that now. I let him play as long as he wants. (I want) him to use music as much as he wants.
RA: What do you want the music therapist to help you with in order to maintain the use of music at home?
Aunt: Nothing for now because I can remember most of the things she did in the sessions. I also try to buy some instrument to play with him. I like the bell set that each bell has different colour.
RA: The bell set?
Aunt: Yes, I think he can learn about colours too when the music therapist sang the song to conduct him which bell to play by saying the colour of the bell.

RA: What is the most important factor for using music at home with your child?
Aunt: Me? I have rhythm in my heart. For Aden, I think if I can encourage him to be more interested and excited in the activities, it should be okay.
RA: If there is a chance that Aden can continue having music therapy service, what do you want him to get from the service?
Aunt: He will definitely get benefit from it. I want him to keep coming to the sessions. Even school holiday, I don't want him to stop.
RA: Does he always come to the sessions?
Aunt: Yes, he does. Even though he was late he still attended.
RA: Is there anything that the music therapist should improve?
Aunt: I don't think she has to improve anything. She is great. I am not trying to over praise her. I was there in the sessions and I saw that she is very good in engaging the child. She made Aden want to learn and I was really enjoying with them in the sessions.
RA: How about the management, the setting and making appointments?
Aunt: I think the room is not suitable for the child.
RA: Did you mean the room down stairs?
Aunt: Yes. This room is good but it is noisy. There are always children running around in front of this room. Aden always got distracted from seeing other children playing outside.
RA: How about her communication about Aden's development?
Aunt: It's okay.
RA: How about her choices of materials or music that were used in the sessions?
Aunt: It's good and suitable with Aden's age.
RA: Is there any concern you have for Aden?
Aunt: Only one thing I worry about is when he is not in a good mood, he would not engage in anything at all.
RA: Would you like to make any suggestion regarding the music therapy programme Aden received?

Aunt: I think the music therapy is very helpful to Aden. It seems helpful for both children with special needs and without special needs.
RA: Okay...Thank you so much for today. I think I have a lot of useful information today.
Translation of the 3rd Interview with Pat (Aden' aunt)
RA: Have you use music with Aden during the last 2 months?
Aunt: Almost every day. When there is a music video in which the musician is playing guitar on the television, Aden will bring his guitar to play along.
RA: Did you bring the guitar to him or he went to grab it himself?
Aunt: He grabbed it and imitated the musician on television.
RA: Did you join along with him? Or did you do something similar to what you did in the music therapy sessions? Could you tell me what it was like when you use music with Aden?
Aunt: He would join in most of the things I brought up. For example, when he had dinner I brought the keyboard out and played along as he had dinner
RA: Did he already have the instrument before he participated in the music therapy sessions?
Aunt: Yes, he already did.
RA: He already has guitar and keyboard, right?
Aunt: Yes, but he didn't play much before.
RA: Aden didn't show this much interest so after participating in music therapy sessions he showed more interest in music, didn't he?
Aunt: Yes. Before Aden attended the music therapy sessions, when he listened to the music he wouldn't pay much attention. But now when the music is on, he will tap on the table as he taps on the drum in the music therapy sessions along with the music. He is quite good at keeping to the beat of the music.
RA: Who normally plays the guitar and the keyboard at home?
Aunt: Just me and Aden
RA: Can you play music?

Aunt: No, I can't I just play randomly on the keyboard.
RA: Can you accompany him on the keyboard?
Aunt: No,
RA: Oh..you just were just playing along with him.
Aunt: Yes, I just played along with the beat. I can't play anything
RA: Does your keyboard have songs or rhythm pattern?
Aunt: Yes, it does. There are the button which he pressed and the music will be played.
RA: So he knows how to turn the music on from the keyboard or he just randomly press on all the buttons?
Aunt: No, if he wants to listen to music he will press on the button to switch to the next song.
RA: Does he know how to turn on/off the keyboard?
Aunt: Yes. He normally turns on/off by himself and if I turn the volume down he knows how to turn it up.
RA: So he knows how to use the electronic instrument? Who normally initiates to play music?
Aunt: Aden
RA: Do you have to encourage him to play or lead him to the instrument?
Aunt: Normally he would sit and play where the music instruments are laid down. And when I feed him I would say "come come let's play music together"
RA: Which is his favourite musical activity? Playing guitar?
Aunt: Playing guitar
RA: Did he sing along?
Aunt: He would vocalise..."maa maaa" along
RA: Does he have any song that he always sings?
Aunt: He loves "แฟนโคริโทรมา" (Thai song) and when the song is on the television he would vocalise along with it.

RA: Can he speak?
Aunt: Not very clearly
RA: Compare to before he had music therapy service and now, did he make any progression?
Aunt: Yes, he starts to get better and a lot better.
RA: Is he able to say any words?
Aunt: Yes, he can say some words. For example, when listening to the song he likes he will try to repeat the word even if it's not clear but it's like his talking.
RA: Does he spend much time in his own world?
Aunt: Yes. Sometimes when I am tired, I will have a nap. He will play and talk to himself, pretend as he was talking on the phone. Saying..."mmmum mmmummm"..He loves doing that.
RA: Does he imitate you when you were answering the phone?
Aunt: Yes, he does and he likes to imitate. He imitates almost everything.
RA: What is the barrier of using music at home during the last 2 months?
Aunt: During the weekends I am always away. He will stay with his parents and his dad plays guitar with him. The barrier would be his mood, when he doesn't feel like playing or things don't go as he wants. He will not do anything.
RA: So besides you, his dad also plays music with him. Can he play any instrument?
Aunt: We have guitars that have a button which when it is pressed the music will automatically come on. So Aden and his dad play those guitars together.
RA: How about his mother?
Aunt: His mother sings along.
RA: Is there any differences when Aden was in the music therapy sessions and when he was at home playing music with you?
Aunt: There is much difference. I am not a musician. I just play around randomly. But with the music therapist, she sang, made a song in different tempo. The music is better.
RA: Does participating in music therapy sessions encourage you to use music at home more?
Aunt: Yes,

RA: What makes you want to use music with Aden more? And what is your aim of using music with Aden?
Aunt: Encourage him to engage with me. When I use music, he will show interest in me right away. If he is in a bad mood I will use music to change his attention.
RA: Is there any other activity that he likes to do besides music?
Aunt: Playing computer game and game on the mobile.
RA: What are the aims of the music therapy service, in your opinion?
Aunt: I want to increase his attention span and nurture his mood
RA: What causes him to be in a bad mood?
Aunt: Sometimes he is sleepy and things doesn't go his way. Or when he doesn't want to do what I ask him to.
RA: Will you maintain the use of music and what is your plan of using it?
Aunt: I will maintain using music with him. I want him to have a music session once or twice in a week. It might be better to only me employing music with him at home.
RA: How to maintain the use of music at home?
Aunt: Keep doing what I do
RA: What is the reason you maintain using music with Aden?
Aunt: After I saw his development. His fingers gain strength from playing guitar and keyboard.
RA: Did you and your child gain anything from the music therapist's home visit? If so, what?
Aunt: To know each other better. The music therapist can see how different Aden is between when he was at home and at the school.
RA: What did you expect or think would happen in the home visit from the music therapist?
Aunt: Just me and the music therapist discussing?
RA: How many times did the music therapist come to visit you?
Aunt: 2 times. I think it was good to have her at our place and it brings Aden and the music

therapist closer. If it is possible, I want the music therapist to come more often.
RA: What should the music therapist do in order to improve the home visit? Did the music therapist use music with Aden?
Aunt: Yes, she did. I feel some differences when she came to our house. I feel that she is one of our family members. When Aden was in the sessions at the school, he kept some distance like teacher-student. But when the music therapist visited us here and she was going to leave, Aden wanted to go with her and kept waving good bye. Even when the music therapist got in her car he was still waving. It seemed like he was happy to have the music therapist at his house.
RA: Is it because he felt safer at home?
Aunt: Yes. Aden engaged in the activities more than he did at the school.
RA: Was it helpful that the music therapist briefly used music with Aden at home? How?
Aunt: Yes, it was very helpful. She gained trust and became closer to him. It was difficult for Aden to become close other people. If Aden becomes familiar with other people, he will be more confident and able to be himself and express himself more. Aden normally doesn't say hi to every teacher at the school. He will pick one who he feels familiar with to say hi.
RA: Why? Is it because the teacher is nice/kind??
Aunt: No, he will choose from his feeling of familiarity ,, Besides that Aden doesn't like to be forced or when people talk to him loudly
RA: Instead of having weekly music therapy, will home visits help the parents maintain using music with the child at home?
Aunt: Umm, I think it would be better to have music therapy both at home and at the school. Having music therapy at home would make Aden feel too relaxed and also to have music therapy in both places could allow the music therapist to see the difference between Aden at his home and at the school.
RA: If there are more home visits before the music therapy process was finished, will it be more helpful to the overall process?
Aunt: Yes, it will be very good. Aden had music therapy sessions 2 times a week at the school and if the music therapist can come to us once a week at our place, I think I can have a good time with Aden more.
RA: As you said that you and Aden's parents all use music with him...

Aunt: Also his grandmother
RA: Oh! Grandmother too?
Aunt: His grandmother sang along. It is a shame that you cannot come to see when we all did music together.
RA: How did his grandmother participate in the music interaction?
Aunt: She encouraged Aden “Let’s do it Aden, let’s play music!”
RA: Didn’t she want to take part?
Aunt: She sometimes danced along.
RA: Do you feel more confident to use music at home with Aden?
Aunt: Yes.
RA: In what way?
Aunt: I feel more confident in understanding the rhythm (tempo). I want to learn to play music. I want to know how to play just one instrument would be good.
RA: I feel that the music is good for everyone in the family. How is the house atmosphere?
Aunt: The atmosphere is more lively. If we are stressed and Aden brought the guitar out and play. This will bring the happiness to our home. Aden is the one who makes us happy.
RA: Will you continue using music?
Aunt: Yes, I will.
RA: How do you feel watching yourself in the video?
Aunt: I feel good...don’t know how to say. I just showed his mom this morning. I feel good about my involvement in the sessions. He laughed at himself while he was watching. He was able to watch from the beginning until it was finished and seemed to really enjoy.
RA: He just stayed and finished watching the DVD and wasn’t distracted by anything?
Aunt: No. He just sat there. While he was watching, he said “who” and I told him “(the music therapist’s name)” and he repeated me saying the name of that person”...When he was watching the DVD, sometimes he brought the instrument to play along.
RA: That’s very good..I hope you can continue using music with him... I have been

interviewing many parents. They all sacrifice their life to take care of their niece, nephew or their grandchild.

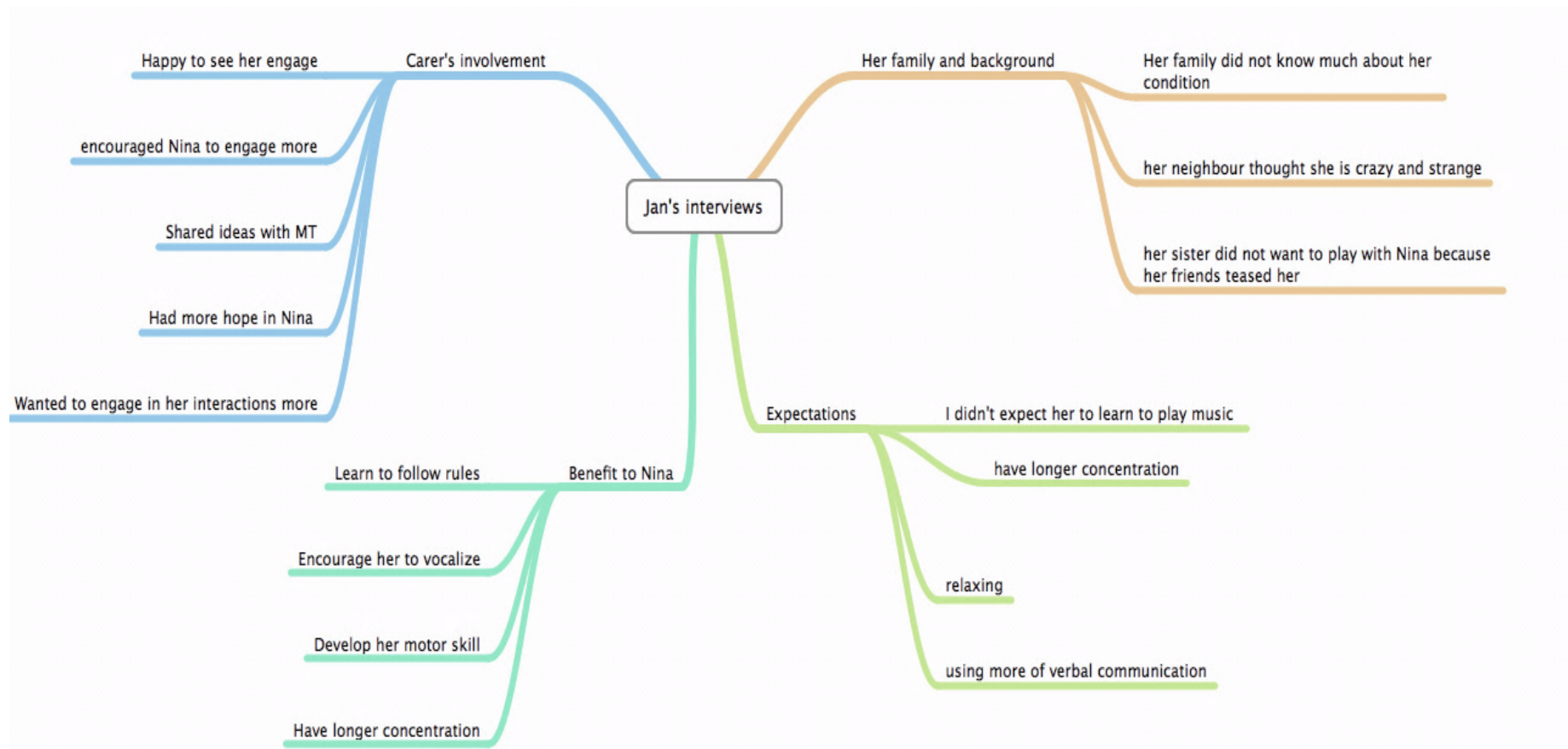
Aunt: Yes, we are. Most of the parents here are aunts and grandmothers

RA: Not many are the children's father and mother

Aunt: Yes, we have to sacrifice our life for the children. When I came to this centre and see other children who have more challenging conditions...this gives me more encouragement to get through difficult times. I felt that they struggle more than Aden and I do, they are still fighting to help their children to get better. So I have to fight to help Aden too. I also have to encourage his parents to have more hope and stop having argument to blame each other. Actually, my children are grown up. So why do I have to take this responsibility for this kid. To be in this point, I have to sacrifice for him. It is like in the past life I did something with him. I feel sad and sorry for him when I just look at him. I cannot go anywhere. I was going to live aboard and move on with my life but when I think about him. I cannot go. I have to stay with him and don't know how long I have to be here for him.

RA: I admire of what you have done for Aden...Okay, I think we have gone through all the questions. Thank you very much.

Appendix 11 Sample of Mind Map



Appendix 12 Sample of important phases from the Interviews

	Initial concerns and expectations	Benefits for children	Benefits of having parents in the sessions	Video reviewing	Music at home and home visits
Jan (Nina's aunt)	<ul style="list-style-type: none"> - To improve language skills - To increase concentration - To learn to listen to others (Accept others' ideas) 	<ul style="list-style-type: none"> - To accept others' requests - Able to engage in the activities longer - To increase vocalisation - To encourage her to use verbal communication - To be able to wait longer - To understand more about boundaries - To engage in group activities - To improve academic skills (colours and numbers) 	<ul style="list-style-type: none"> - To witness for themselves the unfolding of each session - To help each other in managing challenging behaviours - To gain encouragement to get more involved with the child's activities - To encourage the child to engage in the sessions - To learn how to engage with their child - To be relaxed and happy - To understand and pay more attention to their child and start to use music more with her - To encourage them to feel more hopeful - To be more playful with their child - To observe and to learn - To be a leader 	<ul style="list-style-type: none"> - To see the child in a different way - To review again and improve - To see themselves (carers) differently and was very pleased to see how much their child was able to achieve 	<ul style="list-style-type: none"> - Home visits reminded the carers of what they had done in the session and to maintain the progress made - The carers imitated what she had learnt from the session - The carers became more playful at home as in the sessions with the child - The carers involved music in the children's life

Appendix 13 Sample of Parents or Family Members Validation of the Interview Analysis

Section 3) Impacts from participating in the music therapy sessions with their children		
Quotes from the interviews	The researcher's thoughts	The carer's agreement
<i>"I think because when Nina started to get more engaged and show more interest in the sessions that made me feel enjoyment not bored. For example, in the beginning when she didn't engage well I felt discouraged but later when she appeared to be enthusiastic, that gave me so much encouragement to be more involved in her life."</i> (Jan_2/28/5)	- To be able to see the child's ability to participate in the sessions and this enabled me to have more hope in relation the child	Agree Not Agree Comments.....
<i>"It is good to be in the session because I can observe Nina's weakness and sometimes the music therapist didn't understand Nina's behaviours well... As there are so many children and they are different from each other. So by involving me in the session, I could help the music therapist to understand more about Nina's behaviours...We can help each other to improve Nina's behaviour."</i> (Jan_2/34/6)	- To be able to work with the music therapist and to manage the child's challenging behaviour	Agree Not Agree Comments.....
<i>"When I saw Nina having a good time and she was able to concentrate longer. All these things encouraged me to feel interested in what the music therapist did."</i> (Jan_2/76/12)	- To have more courage to participate in the child's musical engagements	Agree Not Agree Comments.....
<i>"I wasn't stressed and worried whether she could do it well or not in the sessions. Nina was interested in us (me and the music therapist) so she was mostly willing to engage in the activities."</i> (Jan_2/115/17)	- To be able to relax	Agree Not Agree Comments.....

Appendix 14 Sample Clinical Notes Form

Date	Objective 1 To help Nina to engage in one activity for longer	Objective 2 To develop her social skills such as turn taking, and accepting others' requests	Objective 3 To encourage her to vocalise and use more verbal communication	Comments
13 September 2011	After putting away some instruments in the baskets and taking them out of Nina's sight, she seemed to engage for longer, with one instrument at a time, but sometimes she ran around the room finding other instruments.	While we moved along with the music, she sometimes looked at me to give her signals to start and stop dancing.	- She tried to verbally communicate to me to ask for other instruments - She gave signals: 1-2-3 stop	Ask the carer next time if Nina can understand number or colour.
15 September 2011	She showed more interest in ukulele and keyboard. She spent more time exploring on these instruments while I improvised a song to accompany her music playing...however, I was not sure if she was aware of my music.	She initiated her ideas of a waking up game. She seemed to enjoy leading the adults' actions	- She sang her favourite song with her aunt. With her aunt's help, Nina was able to fill in some words to complete the song	
4 October 2011	- Listened to MT playing the piano and ukulele without trying to stop MT or take away the instrument from MT's hands. - Participated in the drum playing while MT played ukulele along for a while.	Followed the actions in Hello songs. - Was able to wait for her turn choosing the instruments - Followed the start and stop signals very well in conducting game, on the ocean drum.	She tried to sing the Hello song along with me	Her aunt was very supportive and playful. She helped MT to understand Nina's signals when Nina wanted to tell MT what song she wanted to sing

11 October 2011	She chose what she wanted to play and was willing to spend time on the small percussion while I was playing on the keyboard. I extended her exploration into a conducting game and she could respond to my signals quite well	I felt that when I was able to engage her longer and she was not so busy changing from 1 instrument to another, I was able to get her to listen to the rules of our simple game. Also when I insisted that she waited for me to finish our game before moving on to another, she was willing to wait but still needed some help from her aunt.	She could name some instruments such as a keyboard and a drum, even though it was not clear. This meant she could give me verbal signals for what she wanted to play	
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Appendix 15 Sample Music Therapy Report after the Treatment Process

Music Therapy Report

Name: Nina **Age:** 12 years old

The music therapy objectives

1. To help Nina to engage in one activity for longer
2. To encourage her to vocalise and use more verbal communication
3. To develop her social skills such as turn taking, and accepting others' requests

Music therapy process

Nina is a lively girl and always smiles. She showed interests in many different instruments. In the first few sessions, she appeared to have a very short concentration span. She did not spend long time on each instrument. Once she started to become more familiar with the new atmosphere in the sessions and with the instruments, she could engage in one musical interaction for longer, especially in interactions where she initiated ideas or chose the instrument. I often extended her music instrument explorations into turn taking games or conducting games and this enabled her to concentrate on one thing at a time for longer. However, it seemed difficult for her to wait for her turn. She sometimes took the instrument from her aunt without asking. Moreover, she enjoyed leading adults in the musical games. I felt that as she was becoming a teenager it was important to show her that other adults respect and accept her initiations.

In the music therapy sessions, I aimed to create an atmosphere similar to a playground, where children had the freedom to explore and experiment with different things, with a few simple boundaries. This enabled Nina to express herself more and also to become a leader. This meant that she could gain more confidence. Moreover, when her ideas or initiations were accepted and extended to form a musical game, she seemed to be

more willing to engage in the sessions. However, when I added more structure in the musical game, she would accept and join in the sessions very well.

In order to encourage Nina to vocalise and to use more verbal communication, I provided opportunities for Nina to fill in the lyrics when we were singing her favourite songs, to say the signals to lead the musical games and also to vocalize along with the music in different vowels. Her enjoyment of lively music and her controlling of adults' actions motivated her to join in and engage playfully.

Working with Jan

Involving Nina's aunt, Jan, in the sessions had positive impacts on Nina. Jan naturally participated in Nina's musical engagements and when she started to become familiar with the sessions she took turn leading the sessions. Her involvement encouraged Nina to engage more in the sessions. Also she shared her opinions about Nina's behaviour and what she likes to do. In addition, one of the main achievements in this therapeutic process was to provide positive experiences for Nina and Jan to share together.

Recommendations

Nina certainly enjoyed music. Music could motivate her to try difficult tasks with less resistance. I would recommend the family to bring music into the home environment. In particular, Nina appeared to be very pleased to have her aunt in the sessions, and engaged with her musical games. Moreover, Jan could take some suggestions from me to try different ways of using music with her niece very well. Therefore, Jan or other family members can help Nina develop her verbal communication by encouraging her to sing along to very simple songs and inviting her to say the signals in turn taking games. Moreover, as Nina becomes a teenager it is crucial for the family to acknowledge her voice and show that she is heard. Her participation in musical engagement can show her that her interests are valued by other adults.

Appendix 16 Sample Simple Musical Activities at Home

The suggestions of different ways of using music with your child

Objectives of using music

- To strengthen the relationship between the family and the child
- To share some quality time together
- To encourage Aden to vocalise and use more of verbal communication

Introduction

This musical activities sheet aims to encourage you to use music with your child outside the music therapy sessions and to familiarise you with using music with your child. Moreover, you and your child have experienced most of the activities which are suggested here in the music therapy sessions, therefore I hope it will be easy for you to bring these different ways of using music into your home environment. You can use these suggestions in your daily routine, depending on your child's needs at that time. The primary goal of these musical engagements is to nurture the relationship between your child and the rest of family. Also, these musical engagements enable your child to develop their social skills such as being able to wait for their turn and learning to accept others' requests.

Simple Musical Engagements

1. Turn Taking



Just turn some music on, either from a radio or a television, and then you can use small percussion instruments that you have at home, to practise turn taking on the instruments

with your child. Also you can invite him to give signals for whose turn it is to play. In addition, if you sing a song with your child, you can change the tempo or dynamic and suggest your child adjusts the way he plays to match the music.



You can incorporate other toys at home in your musical engagement, such as a ball or a bubble blower. For example, you can turn soft and quite slow music on and take turns to blow bubbles. From my observations during the sessions, your child was very interested in catching the bubbles and in order to encourage him to say a word, you can encourage him to say his action of catching the bubble and invite him to say signals for whose turn it is to blow.

2. Sing along with his favourite songs



While you are singing his favourite song, you can leave some words out and let him fill in the lyrics. Also you can vocalise the familiar melody and use different vowels. While you are vocalising, it is good to position yourself in front of the child so he can imitate your mouth movement.

3. Listening to music



While listening to the music you can invite your child to clap along. This can extend into a clapping game in which you can encourage the child to clap in different places or to clap with you. This could help them to learn to follow signals.

4. Move along with your child



When you move along with your child in a playful and childish way this can gain the child's attention and encourage him to join in the musical engagement very well.

5. Giving praise



Praising your child's achievements could help him to gain more self confidence, even in a small achievement. When he has more confidence, he can be more creative and also express himself more. Smiles and cuddles from you have very a positive influence on your child's feelings.

6. Clapping along with his music



When you are clapping along with your child in the musical engagement, this enables the child to recognise that someone is listening to him and helps him to want to have fun in this engagement.

7. Giving signals



Giving signals, such as 1-2-3 start and 1-2-3 finish, allow your child to prepare and to be ready for the next activities. Also the signals enable the child to be aware that you want to do something with him.

Hello Song

Hello...I'm glad to see you today,

Let's smile to each other to brighten up the day,

and then we say Hello again.

Good Bye Song

It's time to say Good Bye to each other.

And it's time to say Good Bye to music.

Let's see you again soon